

Advocacy for sexual and reproductive health and rights

Report of the short course

Sept. 14 – 23, 2006

Surajkund

**Organised by
Coalition for Maternal - Neonatal Health and Safe Abortion**

**Supported by
The David and Lucile Packard Foundation**

I. Introduction

The short course on advocacy for sexual and reproductive health and rights, held in Surajkund, Haryana during 14-23 September 2006, was organised by the Coalition for maternal-neonatal health and safe abortion. Funding support for the course was from the David and Lucile Packard Foundation.

1. The organisers

The Coalition for Maternal-Neonatal Health and Safe Abortion was initiated in January 2006. It envisions a society that ensures maternal-neonatal health care and safe abortion for all, and especially for the poor, in India. The Mission of the Coalition is

- To raise visibility about the unacceptably high numbers of preventable mortality and morbidity among mothers and newborns, and the lack of access to safe abortion, especially among the disadvantaged.
- To mobilise advocates from different constituencies who will collectively generate pressure in a deliberate, organised and systematic effort to
 - a. ensure effective implementation of relevant policies and programmes
 - b. develop new policies and change existing ones when needed
 - c. bring about change within communities, health care providers, researchers, administrators, elected representatives and the media.

The strategies of the Coalition are to

- Bring together individuals and organisations who share our vision across various states and from diverse backgrounds and areas of expertise
- Create a space for members to
 - a. enhance their knowledge and skills by sharing different kinds of expertise and sustaining peer review mechanisms
 - b. provide solidarity to bolster ingenuity, creativity and persistence for effective advocacy.
- Identify priority areas and pool together ideas, knowledge and skills to develop and implement key advocacy interventions (with the actors and levels mentioned above)

The short course on ‘Advocacy for sexual and reproductive health and rights’ was developed and organised in response to a need expressed by members of the Coalition for enhancement of advocacy capacity as one of the first activities of the Coalition.

2. The Course

2.1 Objectives

1. Building conceptual clarity on
 - rights-based advocacy on sexual and reproductive health, with a focus on maternal-neonatal health and safe abortion; and

- the need for such advocacy
- 2. Getting an in-depth understanding of the present scenario in sexual and reproductive health and rights: policies, evidence and debates.
- 3. Understanding the process of social change: what factors/actors are involved to change opinions, practices, policies
- 4. Providing an orientation on essential advocacy skills:
 - analysing the political, economic, social context
 - identifying problems/advocacy issues/rights violations
 - doing stake-holder analysis
 - mobilization, organization-building, networking, alliance building
 - communication, negotiation, conflict-resolution
 - campaign planning, influencing specific groups of opinion makers, working with media
 - using available evidence and building evidence, developing information and advocacy materials
- 5. Applying the above in developing/refining strategic advocacy plans including identifying process indicators and intermediate outcomes

2.2 Design, contents and methodology

The Course design, content and methodology was developed by a team constituted of Abhijit Das, Director of the Centre for Health and Social Justice, New Delhi, Jashodhara, Sahayog, Lucknow; Renu Khanna, Trustee of SAHAJ Society for Health Alternatives, Vadodara; Vijaya Nidadovolu of the Population Council; T K Sundari Ravindran, Honorary Professor, Achutha Menon Centre for Health Sciences, Trivandrum; and Aleyamma Vijayan, Director, Sakhi Women's Resource Centre, Trivandrum.

The Course consisted of three modules. The first module introduced concepts of human rights, sexual and reproductive health and rights, and concepts related to social change, advocacy, and what is meant by a 'human-rights' and evidence-based approach. This module also introduced tools for situational analysis of contextual factors, actors and processes that influence sexual and reproductive health and rights, as the basis on which evidence and rights-based advocacy initiatives are to be developed.

The second module focused on specific advocacy skills and strategies. It skilfully combined experience-sharing by activists and advocates with theoretical inputs and application exercises. The specific advocacy skills that were introduced were: conceptualising and developing communication strategies and materials; using evidence; lobbying; working with the media; and community mobilisation. Specific advocacy skills were drawn out through discussions and reflections, from a number of case studies presented by a fascinating range of activists and advocates who worked at different levels and used different strategies, along a wide spectrum of issues related to health and wellbeing – from prevention of pre-natal sex-selection to

movements such as the “*Narmada Bachao Andolan*” for people-centred development paradigms.

The third was application module in which participants learnt about steps involved in planning for an advocacy intervention, and then spent about a day working in small groups to develop their own advocacy plans, with inputs from resource persons and peers.

The course used a variety of teaching and learning methods, such as simulation and other participatory exercises, group work on specific advocacy skills (e.g. preparation of press releases, developing a communication strategy), interactive lectures by resource persons, sharing of case studies on advocacy by advocates, readings, discussions and presentations by participants and mentoring for developing advocacy plans.

2.3 Core faculty and participants

The course was co-ordinated by Abhijit Das and Renu Khanna. Vijaya Nidadovolu and T K Sundari Ravindran were other core faculty members.

There were in all, 25 participants, 16 women and 9 men. They included members of the Coalition for Maternal-Neonatal Health and Safe Abortion, and others working in the field of sexual and reproductive health and rights as researchers, programme managers in the non-governmental and government sectors, activists or service providers. There was a good mix of disciplines: medical doctors, public health specialists, sociologists and social workers. They were drawn from a large number of Indian states: seven participants were from Jharkhand, three each from Bihar and Gujarat, two each from Delhi, Rajasthan, and West Bengal, and one each from Andhra Pradesh, Chattisgarh, Kerala, Karnataka, Madhya Pradesh and Uttar Pradesh.

2.4 Monitoring and evaluation

The course employed several assessment strategies. One was to evaluate the learning gains of participants. This was done through a pre and post test. The second was concurrent feedback by participants on the course. At the end of each day, participants gave in their ‘feedback-slips’ to be discussed by faculty and an appointed subgroup of participants. This process helped make changes in teaching and scheduling even as the course was being implemented. There was also an end-of-course evaluation by participants on the relevance and quality of course content, design and methodology, and on the logistics.

In addition, Asha George, Consultant, Indian Institute of Management, Bangalore acted as reviewer for the course. She was present throughout the ten days of the course observing the sessions and interacting with participants and resource persons. Her review of the course content and methodology will guide revision and refinement of the curriculum. This is available as a separate report and not described below.

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This report is divided into three sections. Following this first and introductory section, section two presents a description of what transpired in the various sessions of the course, highlighting main the learning points. Section three is the annexure, which includes the course time-table; list of participants; and the list of reading materials provided during the course.

II. Course content

Module 1: Building conceptual clarity

1. Welcome and introduction

The course started with an introduction to the Coalition for maternal-neonatal health and safe abortion by Asha George, a member of the Coalition's Steering Committee. This was followed by a brief overview of work of the David and Lucile Packard Foundation's work in India by Lester Cutinho.

An ice-breaker game helped participants feel at ease and get to know each other. Each participant was given a piece of paper with a picture on it, which they pinned to their backs. Each picture had a pair: for example, lock and key, water and mug, cup and saucer, and participants had to find their 'partners' without talking to each other. Each pair then introduced themselves to each other, and each participant was introduced in the larger group by his/her partner.

After this light-hearted exercise, participants were given cards and requested to write their expectations from the course. Expectations from participants fell into three broad categories: acquiring information on specific technical areas in sexual and reproductive health and rights; learning advocacy concepts and skills; and networking with other participants.

The objectives of the course were then presented by course co-ordinators Renu Khanna and Abhijit Das.

The highlight of the welcome and introduction session was a key note address by Dr Prakasamma, a well-known researcher and midwife working in the area of maternal health and safe abortion. She spoke about the need for advocacy for sexual and reproductive health rights, drawing on her own experiences. Advocacy was for her an effort at influencing the influential. It is dynamic, constantly evolving, and need to be planned and systematic.

Advocacy efforts have to be undertaken at multiple levels, from policy-making to programme management and service delivery, and community mobilisation for demand creation. Collaboration with actors working at different levels is often the best way to achieve this. Prakasamma spoke about the several networks advocating for different dimensions of sexual and reproductive health and rights: maternal health, safe abortion, neonatal health, contraceptive choices and so on, and highlighted the need for joining forces with each other on broad themes even while focusing on specific issues. Touching on some challenges and problems encountered in advocacy efforts, she said that advocates need to know when to quit: when the advocacy effort succeeds, or turns counter-productive, or becomes a lost-cause. Dr Prakasamma's address proved to be an inspiring beginning to the course.

2. Human Rights, Right to Health and the ‘Rights Approach’

2.1 Rights and inequalities

Introduction to the concept of rights was through a game conducted out in the open lawn. Participants were each given a card of one of two colours: red and blue. The game was a modified version of musical chairs. There were large paper squares laid out on the lawn, and there was one less square than the number of participants. Participants had to move around to music and as soon as the music stopped, each person had to find a square to land on. Each time the music stopped, one person would therefore be left out, or lose.

Participants were not all equal. Restrictions on movement was progressively imposed on the ‘blues’: at first, they could not run but had to hop; then they had to hop and hold their hands behind; and then they had to hop, hold their hands behind and close their eyes, while they competed for a square to land on with the ‘reds’ who had no restriction on their movement.

The game was an opportunity for participants to get into the shoes of those who start-off with disadvantages related to their caste, class, gender or other identities, and experience the feeling of discrimination. Interestingly, while the ‘blues’ felt discriminated, the ‘reds’ who lost also felt that they were disadvantaged in some ways: the blues had hogged the squares for too long, there was too much sympathy for the blues. The parallel with arguments made by those who are on the wrong side of affirmative action policies (e.g. reservation policy for disadvantaged caste groups) was striking.

Having debriefed the feelings of the participants (blue and red) the facilitator drew parallels in society where certain groups are systemically disadvantaged. In some situations even those who have social advantages feel they have been unfairly treated. In such a situation how is it possible to judge or arbitrate about what is ‘fair’, and what could be the parameters for doing so? Rights, either customary or legal are often used as the framework for judging this ‘fairness’. In today’s context the Constitution-with its set of fundamental rights and the Universal Declaration of Human Rights and the International Bill of Human Rights forms the framework for defining rights.

2.2 Human Rights

The game was followed by a power-point presentation on Human Rights. Human rights may be regarded as inherent and inalienable entitlements to live a life of dignity, which is vested in every individual just by virtue of being human.

Throughout history, people have struggled for their entitlements. For example, the French revolution was a struggle by peasants against feudalism and monarchy; there have been numerous struggles by workers for better working conditions and fair remuneration for work. Women have struggled for political participation, equal wages with men for equal work, equal rights within the marriage and the family, and for gaining greater control over their sexuality and reproduction.

The modern human rights movement was created in the aftermath of World War II and focused on key abuses identified at the root of that conflict. The key human rights document is the *Universal Declaration of Human Rights* (UDHR). It represents the shared aspirations of governments about what rights are, and why they should exist for all people everywhere. The two covenants, the *International Covenant on Economic, Social and Cultural Rights* and the *International Covenant on Civil and Political Rights*, further clarify the rights set out in the UDHR.

In the decades starting the 1970s, a series of UN Conventions have emerged, which elaborate on and in some cases move beyond these three. They concern themselves with the collective rights of entire groups: for example, Children (Convention on the Rights of the Child), Women (Convention on the Elimination of All Forms of Discrimination Against Women).

Human rights as envisaged in International Human Rights treaties

- Belong to all (irrespective of race, religious or political beliefs, legal status, economic status, language, colour, national origin, gender, ethnicity) and are not privileges
- Are based on generally accepted principles of equality and justice
- Regulate relationships between the state and individuals or groups. The individuals have *claims* and the state has *obligations*
- Are interrelated, interdependent, and indivisible

UN Conventions (except the UDHR) are legally binding documents on those countries which ratify them. Every UN human rights treaty has a treaty monitoring body called a committee, which monitors the compliance of the states that have ratified the convention.

Whether and to what extent a government is in compliance with its obligations under a particular treaty is monitored through a system of regular reporting by the government to the Committee concerned.

Treaty bodies also issue “General Comments” and “General Recommendations”, which can help to further elaborate their interpretation of rights contained in the treaty. For example the treaty body that monitors the Women’s Convention has elaborated recommendations on violence against women; and the Committee that monitors Economic and Social and Cultural Rights has elaborated on the Right to Health.

All ratifying governments have three levels of obligations: to respect, protect and fulfil rights. To respect a right means not to directly violate it. To protect the right means enacting laws setting up mechanisms to prevent violation of the right by non-state actors. To fulfil the right means to take active steps to put in place institutions and procedures, including resource allocation, which will enable people to enjoy the right.

2.3. A Rights Approach to health advocacy

The next part of the presentation explained what was meant by a rights approach to health advocacy. Such an approach frames health issues in human rights terms, and attempts to apply international human rights treaties and norms and national law to hold governments accountable for their obligations under the treaties.

The Actors involved in a rights approach are:

- Rights holders – women and men in the community, vulnerable and marginalised groups and individuals. When they are conscious of their rights they become rights claimants
- Duty Bearers – Government institutions and officials responsible for planning, implementing and monitoring policies and programmes – including policy makers and providers
- Guardianship Institutions – Courts, Commissions, ombudsman organisations
- Human rights advocates – Activists, NGOs, advocacy groups, human rights organizations

As duty bearers, the role of governments is to create national legal frameworks that are in consonance with international human rights treaties, and formulating policies and programmes towards fulfilling rights. Another important role is to create redressal mechanisms for violations of rights. Human rights advocates need to be involved in identifying rights violations, and advocating, training policy makers and/or mobilizing the community to demand redressal. Developing new programme models that adopt a rights-based approach is another contribution that they can make.

Adopting a rights approach to advocacy is fraught with numerous challenges. In some instances, the laws of the country have not been reformed in keeping with international human rights treaties and the advocacy has to first be aimed at legal reform. For example, the criminalisation of homosexuality in India violates the right to non-discrimination on grounds of sexual orientation. There is also often a tendency to dismiss human rights as a western concept which is a luxury for low-income countries. Contradictions may also arise between upholding individual rights versus protecting the collective rights of disadvantaged sections of society: for example, land reform may violate the right to property of some individuals in an attempt to address the needs of landless sections of the population.

2.4 The Right to health

Introduction to the concept of human rights and the rights approach was followed by an interactive presentation on the Right to Health.

The right of every human being to enjoyment of the highest attainable standard of physical and mental health is enshrined in article 12 of the *International Covenant on Economic, Social and Cultural Rights*.

Countries that have ratified this Covenant are obliged to take steps for the full realisation of the right to health. The right includes both health care and the right to

have equal opportunities or access to resources and conditions necessary for being healthy: for example, potable water, adequate and safe food, sanitation and housing, healthy occupational and environmental conditions, access to health information and health education.

The Right to Health includes the right to control one's health and body, sexual and reproductive freedom, and freedom from torture, non-consensual medical treatment and experimentation.

A recently elaborated general comment on the Right to Health spells out details of the state's responsibilities concern the Right to health care of its citizens. These include ensuring

- *Availability*. Functioning public health and health-care facilities, programmes,.
- *Accessibility*. Health facilities, goods and services have to be accessible to everyone without discrimination,
- *Acceptability*. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate,
- *Quality*. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate

Ensuring the progressive realisation of the right to health care would require countries to invest in favour of poor and disadvantaged sections of society, including on diseases and medical conditions that disproportionately burden these populations, such as malaria, tuberculosis and HIV/AIDS.

Special attention would need to be paid to under-resourced geographical regions, and primary care. Ensuring people's right to health care would also mean prioritising reproductive, maternal (pre-natal as well as post-natal) and child health care; and ensuring that all services are respectful of the culture of all individuals, groups, minorities and peoples, and are gender-sensitive.

The following are some major milestones in the evolution of the concept of the right to health:

- 1948 – WHO charter includes 'right to healthcare'
- 1967 - Right to Health included in International Covenant on Economic, Social and Cultural Rights
- 1968 – Tehran Human Rights Conference acknowledges reproductive rights of “couples”
- 1978 – Alma Ata Conference – “Health for All by 2000” is the new goal.
- Convention on the Elimination of Discrimination against women and Child Rights Convention acknowledge right to health of women and children
- International Conference on Population and Development (1994) and Fourth World Conference on Women (1995) reinforce reproductive rights of individuals

The Indian Constitution does not guarantee Right to Health, and therefore in the Indian context, Right to health is interpreted within constitutionally guaranteed Right to Life. There have been some positive developments starting 1999, in organizing people to demand their right to health. The *Jan Swasthya Abhyan* has played a lead role in this movement, and has organized a series of public hearings on violations of individuals' right to health. A more recent development is the acknowledgement of the right to health by the National Rural Health Mission.

Mention was made of the need to balance client's rights with providers' needs, and participants were given examples of Patients' Rights Charters.

The participants were shown a film "Citizen's without rights" which depicted women's experiences of accessing health care services. The blue group (from the earlier game) were asked to note the factors shown in the film which affect the health status of the persons whose stories are narrated. The red group was asked to identify human rights violations that they see in the film. At the conclusion it was pointed out that many things that may be deficiencies of the health care system actually translate into gross human rights violations for clients of health care services.

3. Sexual and reproductive health and rights

The next set of concepts to be introduced were sexual health, reproductive health, sexual rights and reproductive rights.

Participants were given four cards, one at a time, and asked to write what they understood by:

Sexual rights
Reproductive rights
Sexual health, and
Reproductive health.

Participants found it challenging to unpack these concepts. Responses varied from very narrow to very broad definitions. For example, sexual health was defined by many as the absence of sexually transmitted infections, while some defined it broadly as fulfilled and satisfactory expression of sexuality. Overall, there appeared to be difficulty in delineating points of intersection and divergence of these concepts. The facilitator, Renu Khanna then presented the definitions of these concepts.

3.1 Sexual rights

Sexual rights have been defined as follows:

"Sexual rights are a fundamental element of human rights. They encompass the rights to experience a pleasurable sexuality, which is essential in and of itself, and, at the same time, is a fundamental vehicle of communication and love between people."

Sexual rights include the rights to liberty and autonomy in the responsible exercise of sexuality”¹

Sexual rights include:

- The right to sexual pleasure without fear of infection, disease, unwanted pregnancy, or harm.
- The right to sexual expression and to make sexual decisions that are consistent with one’s personal, ethical and social values.
- The right to bodily integrity and to choose, if, when, and with whom to be sexually active and engage in sexual relations with full consent.
- The right to enter relationships, including marriage, with full and free consent and without coercion.
- The right to privacy and confidentiality while seeking sexual and reproductive health care services.
- The right to express one’s sexuality without discrimination and independent of reproduction.

Sexual rights are based on certain ethical principles. The first of these is the principle of bodily integrity, or the right to security in and control over one’s body. This means that all women and men have a right to not only be protected from harm to the body but also to enjoy the full potential of the body.

The second ethical principle of sexual rights is that of personhood and the right to self-determination for all women and men. The third is the principle of equality, which acknowledges that all people are equal and should be recognised as such without discrimination based on age, caste, class, ethnicity, gender, physical ability, religious or their beliefs, sexual preference, or other such factors. The fourth ethical principle is diversity, implying respect for difference. Diversity in terms of people’s sexuality and other aspects of their lives should not be a basis for discrimination. The principle of diversity should not be misused to violate any of the previous three ethical principles.¹

3.2 Reproductive rights

The Programme of Action of the International Conference on Population and Development defines reproductive rights as follows:

“...reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right 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

¹ HERA statement, from TARSHI, **Common Ground; Sexuality - principles of working on Sexuality**, New Delhi, 2001.

*concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.*²

Most reproductive rights are premised on human rights recognized by several international human rights treaties, including for example:

- The Right to Life, Liberty, and Security
- The Right to Health, Reproductive Health, and Family Planning
- The Right to Decide the Number and Spacing of Children
- The Right to Consent to Marriage and to Equality in Marriage
- The Right to Privacy
- The Right to be Free From Discrimination on Specified Grounds
- The Right to be Free From Practices that Harm Women and Girls
- The Right to Not be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment
- The Right to be Free From Sexual Violence
- The Right to Enjoy Scientific Progress and to consent to Experimentation

Sexual and reproductive rights are not the same. There are non-reproductive sexual rights like those related to non-procreative, non-heterosexual sexual activities

3.3 Reproductive health²

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system.

It implies

- A satisfying and safe sex life
- The capability to reproduce, and right to decide if, when and how often
- To be informed and to have access to safe, effective, affordable and acceptable methods of family planning
- Safe pregnancy, child birth, and a healthy infant
- Methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems
- Sexual health which is not merely related to care and counseling but the enhancement of life and personal relationships
- A life cycle approach

3.4 Sexual health

Sexual health has been defined in the ICPD Programme of Action as

*“the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases”*²

² ICPD programme of Action

The presentation was followed by a lively discussion that touched upon a number of issues: the relevance of sexual rights in the Indian context; the role of the state in guaranteeing sexual rights; and on the right to abortion versus campaigns to prevent abortion of the female foetus following pre-natal sex selection. According to participants' feedback on this session, although they had been using these concepts for many years, the exercise and discussion helped them to deconstruct the concepts in their own minds and achieve greater clarity.

4. History of sexual and reproductive health and rights:

International scenario

This session started with a short documentary on the history of International Women and Health Meetings from 1978 through 2005. The film highlighted the women's movement's struggle for sexual and reproductive health and rights.

This was followed by a presentation that outlined the global history of the evolution of the recognition of sexual and reproductive health and rights as important components of human rights and entitlements of women and men. It was the international women's health movement that led this struggle in the second half of the twentieth century.

Starting mid 1960s, women's movements worldwide began to examine patriarchal values, institutions and ideologies in creating and reinforcing women's poor health. They engaged with concerns of sexuality, power and sexual violence, and brought 'domestic' violence out of the private sphere into the arena of public debate. Women's right to safe abortion was one of the key issues around which mobilization took place in many Northern countries.

Another major concern of the various women's health movements was the medicalisation of women's bodies. Women's health advocates sought to demystify and reclaim knowledge about their bodies and about healing.

The 1980s may be seen as marking the emergence of an 'international' women's health movement which integrated the agendas of the Northern as well as Southern countries. Linkages were drawn between structural adjustment, debts and declining health of people and women. Population control policies were challenged, and a clear distinction was made between women's right to control their fertility and state-imposed 'population control'.

During the 1990s, the international women's health movement began to engage with and influence major conferences of the United Nations. The Declaration that emerged from the UN Conference on Environment and Development held in Rio de Janeiro in

1992 (Rio Declaration) stressed the centrality of women to the twin issues of environment and development. It called for women's participation in environmental management, economic and political decision-making; and for equality to women, especially in access to natural resources.

The World Conference on Human Rights, Vienna, 1993 endorsed that "Women's Rights are Human Rights". It affirmed the universality of women's human rights, and against arguments of cultural relativism, whereby discrimination against women are often upheld under the guise of preserving culture and tradition.

The International Conference on Population and Development (ICPD), 1994, is the most significant landmark in the history of sexual and reproductive health and rights. The ICPD Programme of Action firmly established the language of reproductive health and rights. It emphasised the centrality of gender equality and women's empowerment if reproductive health and rights were to be achieved by the vast majority of the world's women.

The Fourth World Conference on Women, held in Beijing in 1995 reaffirmed the declarations made in earlier conferences. The Beijing Platform for Action once again affirmed that governments irrespective of their political, economic and cultural systems were responsible for the promotion and protection of women's human rights.

The Millennium Development Goals (MDGs) that were set out by the UN's Millennium Declaration in 2000 may be seen as a setback in the struggle for sexual and reproductive health and rights. Sexual and reproductive health or rights do not feature among these goals. However, there have been attempts to redress this major gap in the reports of some of the MDG task forces, by identifying sexual and reproductive rights as central to the achievement of goals related to gender equality and safe maternity.

Advocates for sexual and reproductive health and rights are faced with a number of challenges in the current time period. These include the rise of right wing political parties and growing fundamentalism; targeting women's sexuality and fertility in inter-religious conflicts (e.g. in Gujarat) and treating women's bodies as markers of dominance. The Indian State has failed to meet its core obligations towards guaranteeing people's right to health, evidenced for example in its failure to reduce levels of maternal mortality, and the introduction of fees for services in government health facilities. Several states of India have population policies that are in direct violation of reproductive rights, through enforcing the two-child norm and disqualifying those with more than two children from contesting in elections to the local government.

5. History of sexual and reproductive health and rights - India

AR Nanda was the resource person for this session, and he provided a comprehensive history of the evolution of sexual and reproductive health and rights issues in India.

His presentation outlined the pre-independence antecedents of the Indian Family Planning Programme, and showed how in India birth control and eugenics converged under the rubric of “family planning”. It then went over major milestones in the Government of India’s Family Planning Programme, starting 1952. The presentation ended with explaining how the National Rural Health Mission (NRHM) offers a window of opportunity to realize the goals of the National Population Policy of 2000, which would result in achieving the ‘reproductive health approach’ visualized in ICPD’s Programme of Action.

Concern about the large size of India’s population had been expressed as early as in 1870s with the very first census of India. Beginning in the 1920s and 1930s, eugenics associations began to spring up in India, under middle class and elite leadership. These societies called for limiting the fertility of the poor in order to protect population quality. These eugenics societies eventually merged with family planning associations by 1949, when the Family Planning Association of India was formed.

The famous Bhore Committee Report which laid the foundation of India’s post-independence health strategy did not prioritise family planning. Instead, its emphasis was on raising the age at marriage for girls; improvement in the standard of living and controlling fertility through self restraint.

The Government of India’s Family Planning Programme was launched in 1951-52. In its initial decade, this programme adopted a clinic-based approach with equal emphasis on natural method like rhythm as on some contraceptives. The Family Planning programme was integrated with maternal and child health during the Fourth Plan (1969-74); and further with health and nutrition in the Fifth Plan (1974-79) with creation of multi-purpose workers. The approach shifted to mass motivational efforts and population education, and the primary objective was to achieve targets of male and female sterilization imposed from above. The compulsory and coercive nature of the programme during 1975 and 1976 made India’s family planning programme highly unpopular. The Programme was also discredited for other reasons, such as slow progress made towards fertility limitation in the early decades, and opposition from the feminist movement because of the way the Programme treated women.

Against this backdrop, the paradigm shift that came about in population programmes worldwide following the ICPD in 1994 led to the abolition of the system of targets. A “target-free” reproductive and child health care approach was accepted from 1996-97 onwards. Family Planning Programme interventions have now become an integral part of the Reproductive and Child Health in India, and this shift in thinking is reflected in the National Population Policy of 2000. The NPP includes indicators of

quality of care, gender-sensitivity, and reproductive rights, rather than the sole indicator of contraceptive prevalence and narrow demographic targets. Unfortunately, several Indian states have implemented State population policies which deviate from and distort the basic values of the ICPD Programme of Action and the National Population Policy. National and State Human Rights and Women's Commissions have to play an important role in advocating against such distortions. Advocacy efforts need to be firmly rooted in evidence, to be effective.

The National Rural Health Mission (NRHM) is a bold attempt to bring about architectural changes in the basic health care delivery system in the backward regions of the country. The concept believes in decentralization of health and family planning management. It reaffirms faith in community participation and ownership of public health. NRHM appears to have brought back the primacy of Alma Ata declaration and comprehensive Primary Health Care. All of these have a potential to contribute towards achieving socio-demographic goals of the NPP.

However, in order to ensure that this potential is indeed realized, there is need for active participation and involvement of community at every stage. There is need to create a *Movement* by building a critical mass of those already involved in rights – based work, community mobilization and dialogue.

*“No major change is possible without organized involvement of people.
If people are organized and mobilized no change is impossible ...”*

6. Concept of advocacy

It was time now for introduction to advocacy concepts. The session started with a brainstorming exercise on what is advocacy by Renu Khanna, session facilitator.

Various definitions of advocacy were shared. In its broadest sense, advocacy is to ensure that the cause or idea one feels concerned about dominates public consciousness. It may also be defined as an organised, sustained campaign by a section of civil society to get their interest represented and addressed by power centres.

Not all acts of persuasion count as advocacy. When we talk of advocacy as social activists, we usually mean public advocacy, or efforts directed towards the benefits of the public at large, or large groups of individuals. Public advocacy promotes the larger good of the people and social justice, attempts to bring about social change so that weaker sections of society get greater access to political power and economic resources.

Advocacy needs to be distinguished also from one-off events and adhoc efforts at against public policy, and is deliberate, organized and systematic. Advocacy is a **process** and not an **event**. It is a ‘long distance race’, and therefore planning for advocacy needs to factor in resources, skills and systems to sustain the effort.

Advocacy is not the same as Information-Education-Communication (IEC) or Behaviour Change Communication (BCC). IEC and BCC or mass mobilisation are discrete strategies, which can be combined in deliberate and strategic ways to become part of an advocacy effort.

Advocacy involves dealing with the system at different levels: Central, State, District, Taluka, Gram panchayat. It seeks to do so through collaboration and cooperation across those working at these levels: for example, those involved in community mobilisation for change, researchers who are studying the issues and policy advocates at the macro-level. Advocacy in principle tries to avoid the divisiveness of conventional (non-advocacy) political mobilisation.

Advocacy work usually tends to focus on using the space available for change within the existing power structure, and to push the boundaries back gradually so that eventually there is a shift in power equations.

Advocacy as visualized in this course is, in addition to the above attributes, founded/erected on three major pillars: Rights-approach, Ethics and Evidence-base. These three have overlapping attributes, and are not mutually exclusive.

Rights based – The advocacy issue must be based on fulfillment of rights or for preventing the violation of rights or for providing the necessary (enabling) conditions for enjoying the rights.

Evidence based – There must be evidence that these rights are being denied or violated. This could be individual stories (case studies) or aggregate information. The evidence must be specific about how and which rights are being denied or violated.

Ethical – The advocacy approaches and actions must be ethical.

6.1. Rights-based advocacy

- Frames advocacy issues in terms of rights-violation or promotion and actors as rights claimants and duty bearers
- Aims to bring about a positive change towards fulfilling, respecting, protecting and promoting human rights of marginalised individuals and groups
- Adopts processes which make a deliberate attempt at 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.

The *ethical norms and values* underlying rights-based advocacy efforts include:

- Being ideological and not instrumental: it does not 'use' either its collaborators or the affected people in order to make quick gains, does not adopt unethical means to achieve a justifiable end

- Constructive approach: proposing viable alternatives not just opposition to existing situation
- Open declaration of ideological positions, principles and biases
- Transparency and willingness to be accountable
- Belief in equality, cooperation, justice
- Participatory and decentralized decision-making
- Non-dogmatic, learning approach, open to modifying positions based on evidence
- Scientific enquiry and fact based work: no exaggeration, scientific enquiry

These last two: learning approach and fact-based work are also attributes of *Evidence-based advocacy*. Other attributes include:

- Developing an information culture: dissemination of systematically organised information
- Based on a situational analysis of the problem or issues, identifying factors and actors influencing it at various levels: from the household and community through to international
- Clearly defines who is to be influenced and what is the expected outcome
- Integrates an ongoing process of assessment of the advocacy process, with clearly spelt-out indicators and scope for refining and revising the advocacy effort based on the assessment as well as on new evidence (implying an ongoing effort to update one's knowledge and understanding of the issues)
- (As an off-shoot of the above) Creates new knowledge about what kind of advocacy works in what contexts.

The session ended with challenges facing advocates for changes in public policy. As advocates, we need to think beyond our own areas of expertise and action, and be able to forge relationships with other sectors. Advocacy is a tight rope walk, advocates have to work closely with those in power to be able to influence them, without ourselves being co-opted into these structures. Also, being close to those who wield power can result in backlashes when the old order changes and a new one takes its place.

Another concern is regarding 'professionalised' advocacy, devoid of ideological content or commitment. Such an approach treats advocacy like a bag of tricks, from which one learns to pull out the right strategy or tactic to suit every occasion. Such an approach is more often than not, far-removed from the approach grounded on rights and ethics described above; and may at times results in further exploitation of the affected people.

7. Using evidence to identify advocacy issues in SRHR

The next session was about using evidence to identify advocacy issues in sexual and reproductive health and rights. Four groups had each been given a set of reading materials on one of the following issues:

- Abortion
- Maternal and child health
- Adolescent sexual and
- Neonatal health

Their task was to read the articles in depth, and pick out some key issues which they think are issues for advocacy. They had then to provide supporting evidence on why it was important to address the range of issues they had identified. These had then to be presented in the plenary by representatives from each group.

Each group identified a wide range of priority issues. For example, advocacy issues for abortion ranged from improving provider credibility and simplifying site-certification processes, to promoting manual vacuum aspiration and medical abortion. In maternal health, ensuring 24-hour access to emergency obstetric care was identified as a major advocacy issue by a part of the group, while other members of the same group felt that accountability of providers and the service-delivery system was the most important issue, because without ensuring accountability, there was no point introducing new programmes (which may gain be poorly implemented). The group on neonatal health identified working with the community and family to improve birthing practices as an important issue alongside working to change the curriculum of skilled birth attendants to enhance their role in obstetric and neonatal care.

The group working on adolescent sexual and reproductive health issues decided to advocate for

- introducing adolescent sexual and reproductive health as a subject in school curriculum (class 6 onwards)
- ensuring services
- representation of adolescents in formulation of village plans
- appropriate policies and earmarked budget for adolescent SRH

The discussion following these presentations identified some key issues. One was on how to read evidence: it was important to identify not only what is present, but also what is left unsaid. For example, a number of policy documents on adolescents' sexual and reproductive health remain silent on making appropriate budgetary allocations for the same. Budgetary allocation can become an advocacy issue, so that it finds a place on the agenda.

A second issue concerned what counts as evidence. Evidence is not just statistical data or research studies. It is important to include qualitative information which gives an in-depth understanding of the issue identified. More importantly, we need evidence on the issue/problem from the perspective of those affected, whether quantitative or qualitative.

Advocacy issues identified on the basis of evidence need not only be for policy change. Finding the information/evidence that identifies loop holes in implementation and advocating for these to be addressed is equally important.

The need to identify one or two central advocacy issues from a range of issues emerging from available evidence was another area of discussion. Prioritising would depend on factors such as the larger political/historical context within which advocacy is to take place; feasibility of addressing the issue by those involved in the advocacy, etc. For example, when advocacy issues in neonatal health were discussed, it was observed that the community perceived neonatal deaths very casually, there was no sense of urgency and they did not see this as a ‘problem’. In such a situation, it would be important to advocate with the community to recognise neonatal deaths as a problem, before or at the same time as advocating with other constituencies involved.

Another important issue was that different people reading the same evidence-base, may identify different sets of advocacy issues. These variations may emerge from differences in professional training, work experience, or differences in how we see and understand the world. Building consensus across constituencies would thus be important, but also a major challenge.

The next few sessions of the course were to address themselves to these issues, among others.

8. Using the Right to Information Act for advocacy

This session introduced the Right to Information Act and shared experiences of using this effectively for mobilising the affected people to demand change.

The session started with a short film “*Janne ka hak*” (The Right to Know). The film depicted through a song and visuals the reasons why it was important for people to know why there was poverty, hunger and unemployment and discrimination in this country.

This was followed by a talk by Arudhati Dhuru, a social activist involved in the *Narmada bachao Andolan* (Save Narmada struggle) who has also been a major actor involved in the realisation of the Right to Information Act. Arundhati traced the trajectory of the sequence of efforts and events towards formalisation of a legal framework for the Right to Information.

8.1. Background and highlights of the RTI Act

The Right to Information Act had its beginnings in 1979, when in a case of Raj Narain vs Government of Uttar Pradesh, the Supreme Court said that the citizenry have *the right to know*. In Rajasthan the “*Hisaab do*” movement started asking for accounts from villages more than ten years ago, and this gradually spread to nine Indian states by 2002. In 2001-02 there was a movement to enshrine this in

the constitution. The election of the United Progressive Alliance to power in 2004 created a window of opportunity for the leaders of the movement to advocate for it to be legislated as an Act. The Right to Information Act came into force in October 2005.

According to this Act, all citizens of this country have the right to access all information with the public authorities except those related to security concerns. Citizens have the right to know everything in government records including file notings, whether in electronic or written form.

The Act covers all Public Authorities – for example, all hospitals including private hospitals that have received substantial grants/subsidies from government. NGOs are covered by this Act. A fully private institution can be approached through the relevant government department. In Maharashtra all private schools have also been brought under the purview of this act, through a recent decision.

Highlights of the provisions of this Act include:

- Principle of transparency
- Accountability of government to make information available
- Penalty to government officials for non-adherence to rules and non-compliance to requests.

The detailed structure and channel for seeking information both at the state and the central level were discussed. The role of the Public Information officer, appellate authorities and information commissioner were clarified.

The process of seeking information under this Act is as follows. There is a Public Information Officer at every level of administration. A simple handwritten application has to be given and within 30 days the Public Information Officer of the concerned department is obliged to provide information on this. For those who cannot write, the concerned officer has to help the person write it. They charge about Rs 10/- (Haryana Rs 50/-) for this.

The boss of the Public Information Officer is the first appellate authority, and if you don't get the information, you can appeal to him/her. S/he also has 30 days to give satisfactory information. The next appellate authority is State Information Commission constituted of a Chief information commissioner and 10 commissioners. The Information Commission's role is to ensure that the information you have asked for is satisfactorily given to you. They have to call the concerned officer; they can penalise the officer and even suspend him/her in extreme cases. There is also a Central Information Commission with 10 commissioners, who are responsible for departments that come under the Central Government.

The person seeking information is not obliged to give any reason. Any citizen can use this Act, irrespective of whether s/he is a local resident, and whether or not s/he has been directly affected by the issue.²

8.2. Using the RTI Act for advocacy

A case study of how the RTI Act was used to highlight anomalies in the water privatisation scheme of Delhi government funded by World Bank. The project was finally stalled.

A small column in the Indian Express announcing the Delhi government's intention to introduce a 24x7 water project was the beginning of this mobilisation effort. Application under the RTI Act was made three times, to get details about this project.

A scrutiny of files and documents revealed a World Bank scheme for privatisation of water supply in Delhi, for which a loan of 10 crores was being granted to the Delhi government. The World Bank seemed to undue influence on the decision making process concerning which companies were to be selected for supplying water, despite the fact that the bids made by these companies were rather high. This would have increased the cost of water supply 500 times, and slum dwellers would be left without access to water supply. This was made public and eventually, the project was dropped.

Another case example was of the work by a Delhi-based NGO, *Parivartan* to make the government accountable to its people. The NGO used the RTI Act to secure the financial accounts related to development work undertaken by the municipality in two slums: Sundernagari and Seemapuri. This information was given to the people residing in these areas. On 14 December 2002 there was a *Jan Sunwaayee* or people's tribunal in Sundarnagri. A panel headed by Justice Sawant guided the process. People gave testimonies about whether or not a specific development project had been implemented in their neighbourhood. This process exposed losses to the extent of 70 lakh rupees by the municipality.

The presentation of these case studies led to further discussion on the kind of health-related advocacy issues for which it would be possible to use the RTI Act. One example was challenging the increase in user fees in public hospitals. The RTI Act may be used to requisition the minutes of the meeting where such decision was taken. This was done recently when the All India Institute for Medical Sciences (AIIMS) increased user fees. The AIIMS eventually revoked the increase in fees.

² For further information on the Right to Information Act, log on to www.rti.gov.in or www.rti.nic.in;

9. Understanding Social Change

This session tried to create an understanding of how the process of social change happens, and how to use this understanding to plan our advocacy. The session started with an exercise. Participants were given the following tasks:

Task 1: Write in your notebook any significant social change that has happened during the last century.

Task 2: Write in your notebook any significant movement for social change that you know of during the last century

Task 3: Write in your note book any individual luminary who has been at the forefront of social change movement

Participants' responses were entered into a table, as follows (Table 1):

Table 1: Participants' responses on significant social change, movements and individual luminaries

Social Change	Movement	Individual luminaries
<ul style="list-style-type: none"> - Women's Political Participation - Inheritance and Property rights for women - Removal of Untouchability - Equal pay for equal work - Widow Remarriage - Abolition of Sati - Education of Construction workers' children - Recognition to sex workers 	<ul style="list-style-type: none"> - Suffragette - Anti liquor - Narmada Bachao Andolan - Quit India - Jana Swasthya Abhyan - Chipko - Sarva Shiksha Abhyan - Civil Disobedience - Sampoorana Kranti - International Women's movement 	<ul style="list-style-type: none"> - Aruna Roy - Nelson Mandela - Anil Agarwal - Ila Bhatt - Jai Prakash - Medha Patkar - Emily Pankhurst - Gandhi - Ram Mohan Roy - Arundhati Dhuru

Participants were asked whether all the changes listed in column one qualified to be classified as social change. In the ensuing discussion, various attributes of social change were identified. Society is dynamic and there is always change happening even without any specific effort by any individual or groups to make change happen. Some of these changes are in response to changing social circumstances. Others occur as a means of resolving conflicts within society. A number of contemporary and

historical factors interact to bring about social change. Social change may be spontaneous or deliberate.

When there is a deliberate attempt to bring about change in society, guided by a desire for improvement of the human condition, this is a 'movement' for social change. Movements for social change have a common goal. There is interest and investment in a particular kind of change. People join voluntarily, with understanding and conviction.

A movement need not have an individual leader, it could have collective leadership. A movement may be successful or unsuccessful, i.e. need not have resulted in a tangible change.

We sometimes think that a movement is spontaneous, but before the spark there is usually a lot of ground work that goes into preparing the ground. In different parts of the world, a number of activities for fostering change may be ongoing for a long time. Things come together at a particular point of time and a critical mass gets involved, and it becomes a movement.

Movements for social change differ in their characteristics. One way of classifying movements for social change is as follows:

- Reformist – rapid, does not question fundamental hierarchies; partial improvement of gross anomalies in power and oppression
- Revolutionary- new power relationships introduced over short span of time
- Reactionary – seek to restore earlier systems of power relationships (may be mythical)
- Collective Action- Through empowerment and claiming and fulfillment of human rights

The nature of the issue in which change is sought makes a difference to how easy or difficult the process of change is likely to be. There are certain changes which are desired by a large number of people: for example, increased economic status, improved literacy. There other changes which may not be desired but may be acceptable if advocated for effectively: for example, women working outside the home or delayed marriage for women. Changes that significantly challenge power hierarchies within society and disturb the status quo meet with greater resistance. Some examples of this are same sex relationships, and contraception outside marriage.

The session ended with a 'tool' consisting of a set of questions that would help identify advocacy issues for social change. This built directly on the question raised in a previous session about how one would identify a priority issues from a list of issues emerging when analysing evidence. The questions to be asked are:

- Is the issue within the domain of 'issues of concern' ?

- Is the issue important from a rights perspective, i.e. does it address a rights violation or fulfill/promote a right ?
- Are marginalised groups aware of the issue and their rights?
- Are the duty bearers and guardianship institutions concerned?
- Are there already any leaders and champions?
- Does this issue constitute a ‘desirable’ change ?
- Is change in this issue feasible? Who and how strong is the opposition?

10. Case studies in advocacy for social change

Two case studies were presented in this session. The first was a case study of advocacy by the Lawyers’ Collective for the enactment of the “*Protection of Women from Domestic Violence*” Act, and the second, a case study of the ‘*Narmada bachao Andolan*’, a major movement for social change to make development people-friendly.

10.1. Advocacy to enact a civil law to protect women affected by domestic violence

The talk by Asmita Basu described the efforts by the Women’s Rights Initiative of the Lawyers’ Collective to engage in a pro-active legislation to address problems faced by women experiencing domestic violence.

The Women’s Rights Initiative of the Lawyers’ Collective started in 1996, to encourage young lawyers take up social action litigation for women’s rights. Helping women affected by domestic violence soon became a major activity of the Women’s Rights Initiative.

Their experiences soon brought home the fact that while there were a number of criminal laws under which complaints can be lodged against the perpetrator and criminal action taken, the affected woman had no **right** to stay in her natal or marital home. She could easily be thrown out if she filed a criminal complaint. Women’s right to a violence free space is something that didn’t exist. Also, the law did not address issues pertaining to women who are not in ‘legal’ marriages.

The Lawyers’ Collective believed that a woman affected by violence should have a right to a home and a right to compensation. It started looking at Civil law options, because putting the man behind bars may be is not always the best solution; and even when needed, there should also be positive implications for the affected woman. They worked on a civil law which defined domestic violence in all its dimensions, and secure the right of the woman within her home.

There was concerted collective effort at various levels through partnerships with the women’s movement to take the cause forward. In 1999, a draft bill of a Civil Law was prepared and 1999-2001 was spent consulting with a range of others working on domestic violence. In 2001, the NDA government introduced the Bill in parliament, but with many distortions to the extent that the very purpose of the new law would be defeated. There was successful protest to withdraw this bill, and this was then referred

to the Standing Parliamentary Committee in 2002. Submissions were made before the Committee. The Indian women's movement was united on this and spoke with one voice. During 2002-2004 no action was taken. In 2004 when the government changed, the Women and Child development department accepted the draft bill. The draft bill was circulated within different departments of the government and statutory offices up to June 2005. On 22 August 2005, the bill was unanimously passed in Lok Sabha and on 24 August, passed unanimously in Rajya Sabha. On September 13, 2005, the bill received presidential assent and was adopted as an Act of Parliament.

Under the provisions of this Act, a Protection Officer is appointed by the court to liaise between the woman and court processes; and also facilitate access to various support services. If an NGO is registered under the law then they can record the domestic incident report and pass it on to Protection officers for action.

Legal Aid services have to be strengthened in order to make this Act actually work. There has been an amendment to Court fees act which exempted women facing violence and discrimination. The Protection Officer is supposed to inform women of free legal aid services. Much work is also needed to increase awareness among all women on the provisions of this Act.

10.2. The “Narmada Bachao” Andolan

Arundhati Dhuru described the history and strategies of this movement which has been ongoing for more than two decades, since its beginning in 1984. The *Narmada Bachao Andolan* is a movement against big dams, and specifically against the dam on Narmada which passes through Madhya Pradesh, Maharashtra and Gujarat. This is the biggest river valley dams project in India, and dates back to 1962. The issues were human cost-benefit analysis, displacement; geographical region; environment and social justice.

People were nowhere in the scene when the plans were made. Seismologically, the Sardar Sarovar, the biggest dam of this project, is located in a dangerous zone for earth quakes. There was actually no official clearance for the dam; there was a conditional clearance saying studies had to be carried out. However, construction of the dam nevertheless began and continued.

Many of the people displaced by this construction are those belonging to the scheduled tribes who did not have documentary evidence of residence. In one tehsil of Maharashtra, there was not a single revenue record because of dense forests; but there are people who have lived there for generations, with no proof.

For all these reasons, those organising against the dam refused to restrict themselves to demanding resettlement, and declared total opposition for the dam. The NBA believes in the Constitution of India and in non-violence for organising. Extensive lobbying was done with the Japanese government, which withdrew funding for the project. German bilateral donors withdrew of their own accord. It was not impossible to take on the mighty World Bank. Advocacy at the global level drew a lot of negative

attention for the World Bank, which had to appoint a committee. The committee gave negative report and World Bank voted against the dam. This was a big victory for the movement. For the first time resettlement of the displaced was accepted as an issue. Internationally, World Bank had to change its policies related to large dams.

What are the strengths of the movement? There are many. One is its work at multiple levels simultaneously, from hamlets to international level.

The movement uses information very effectively. Activists spend a lot of time reading thoroughly about all the actors involved. For example, they studied US laws to argue why their laws and constitution were against the large dams. Arguments have to be based on sound evidence to be effective.

Although the NBA was focused on opposing the dam on Narmada, it always considered this a part of a larger struggle to challenge the development paradigms. The movement is grounded in a rights perspective. It never believed in casting the displaced tribals as victims who needed help. The movement is built on the power of tribals; and they have a strong sense of entitlement. They participate actively in all aspects of the struggle.

Among NBA's effective strategies has been linking the "dam affected" to the "dam beneficiaries". On being informed about how little the benefits to them is likely to be, the "beneficiaries" have joined hands with the affected in many places.

The NBA has chosen not to be dependent on donor funding. It has 40 support groups all over India, and also receives contributions from individuals and local people. Money is limited, but this has never been a barrier to effective organising.

Among the weaknesses of the movement are: heterogeneity of the people affected, in terms of class and caste. This means that bringing all of them together to speak with one voice is extremely difficult. Another weakness is that gender issues are not always addressed.

The NBA is clear that there are no short-cuts and easy victories in this struggle. It has already been two decades, and those involved are ready for a long haul.

Both these case studies depicted different strategies and actors engaged in movements for social changes. The lawyers' collective was a group of professionals who used their professional skills for advocating for a legislative change. This was an example of change within the system. They skilfully invoked the participation of large sections of the women's movement to do so. The NBA on the other hand represents a process of social mobilisation for a comprehensive struggle questioning the development paradigm. It is a sustained long-term effort, working with those affected and giving voice to the marginalised.

11. Power and how it affects advocacy

This session consisted of a series of role-plays followed by discussion, on how power operates in different settings. Participants were divided into three groups and each group was given a script for a role-play. There were also some participants who were observers.

All three skits were located in the same district, and depicted three different scenarios.

11.1. Skits depicting power dynamics across different settings

Skit 1

The setting for first skit was a district hospital. The obstetrician-gynaecologist is in her clinic. There is a dalit woman patient waiting to be examined by the doctor, she is pregnant and she and her husband are distressed because there has been no movement of the baby in the stomach for the past few days.

The doctor is busy talking over the phone, she receives many phone calls and the topic of preoccupation is the forthcoming FOGSI elections for which she is contesting. She is irritated by the pleading of the *dalit* woman and her husband for the woman to be examined. She asks them to leave the room.

A medical representative who has been waiting gets priority to see the doctor. He is marketing a new fertility enhancing drug and is making promises of lucrative incentives. The next patient is called even while the medical representative is still in the doctor's consulting room. This is a young girl who says she has stomach ache but is actually suffering from a reproductive tract infection. She is sent off because she does not explain her problem.

We also see the doctor's interaction with the nurse and a male clerk. She is rude to the nurse, while the male clerk appears to wield relatively more power.

Skit 2

The setting is a Non-governmental organisation (NGO) providing reproductive health services. The project manager receives a phone call from his boss about an important project on male participation, in which vasectomy has to be promoted and targets met. The project manager orders the project officer to implement this project successfully and establish his credibility. The project officer is subservient, and does not question this order.

In turn, the project officer tells his field workers that there is a big project on male participation and that field workers can expect an increased payment if targets are met, but increment will be cut if targets are not met. He talks down to them on how they should approach the villagers to convince them. Field workers are not convinced, but they do not share their misgivings with the project officer.

Field workers visit some couples in the community to promote vasectomy. In the first household the woman is working in the kitchen and the man is seated in the front room. The man answers all questions posed to his wife. The female field worker advises the wife not to have too many children. The male field worker brings up the topic of vasectomy with the husband, which he flatly refuses. In the second household where the couple have only one child, the man refuses to use condoms.

The field workers get shouted at by the project officer for not getting any cases. They go back to the first couple and explain that this is a matter of their jobs, they will be fired if they did not get 'cases'. They make a deal with the husband that he will get some money and will be counted as a case even without undergoing vasectomy. Thus they now have one case.

The project manager reports to his boss that the project is progressing well, and that they can manage to get 50 cases within the first month.

Skit 3

The setting is the Chief Medical officer's office in the district headquarters. The World Bank representative has come to see the project 'herself'. She asks the CMO why the district, even though smaller, is not able to perform as well as other districts.

CMO agrees that the project is slightly delayed but that they will do well. The consultant suggests the name of a consultant for helping the CMO with the project. The CMO asks her about a Delhi meeting. She seems to use the possibility of his attending this meeting as a bait to make him perform, but tells him he will not find the Delhi meeting useful; The CMO is really keen to go.

In the meanwhile, there are various happenings outside the CMO's office. A media person comes to find out about an encephalitis case which died. CMO says they can't help, with monsoon there will be mosquitoes and disease. The department was doing its best. A pharmacist who does not want to be transferred meets him next. She has the MLA's recommendation. An NGO leader arrives requesting for a certificate. Two women self-help group leaders are waiting to meet the CMO. They are not shown in by the PA. The CMO gets a phone call and goes off for a meeting, the people waiting don't get to meet the CMO.

11.2 Discussion

Those who acted as community members in the skit were asked to share how they felt. The *dalit* woman in the clinic setting felt a lot of helplessness in the face of inhuman treatment. She felt as if she had done something wrong by becoming pregnant. No one was listening to them and there was no space for expressing herself. The second patient also felt neglected. She was blamed for not talking to the doctor about her reproductive tract infection. The doctor did not realise that a young girl would not talk about it with a man –the medical representative- present.

In the second skit, the couples felt that there was a lack of sensitivity on the part of field workers, in asking them directly about the number of children they had and about contraception. They felt a sense of disrespect and intrusion into their private affairs.

In the third skit the women leaders from self-help groups felt that they were being treated like beggars. The PA was obstructing their access to the CMO. As SHG leaders they had nothing to offer the CMO, so he didn't bother with us. The CMO and World bank consultant were talking about community's problems without consulting community members.

Overall, those who played the role of community members felt that the skits were life-like. Community members are often not treated like human beings. Officials and decision-makers are not interested in them, there is no ground for communication. They felt a lack of control over their lives. Their problems and solutions were discussed over their heads, they had no identity, no self-determination. The skits depicted a wide range of power relationships. Between the doctor and patients, between the CMO and World Bank Consultant, between field workers of an Ngo and community members.

In every social situation that we seek to intervene, there is a web of power hierarchies. As rights-based advocates, we are constantly assessing power inequalities in society and striving to alter the situation of community disempowerment. We need to identify and map these in our conceptual framework, to be able to identify what we have to contend with.

An equally important issue concerning power hierarchies is that as advocates we need to constantly assess the power hierarchies that we are ourselves a part of, and seek to ensure that we do not contribute to inequalities in the various roles we play. The concept of ethical advocacy introduced earlier includes such sustained self-assessment.

12. Situational analysis

12.1. Factors and actors influencing sexual and reproductive health and rights

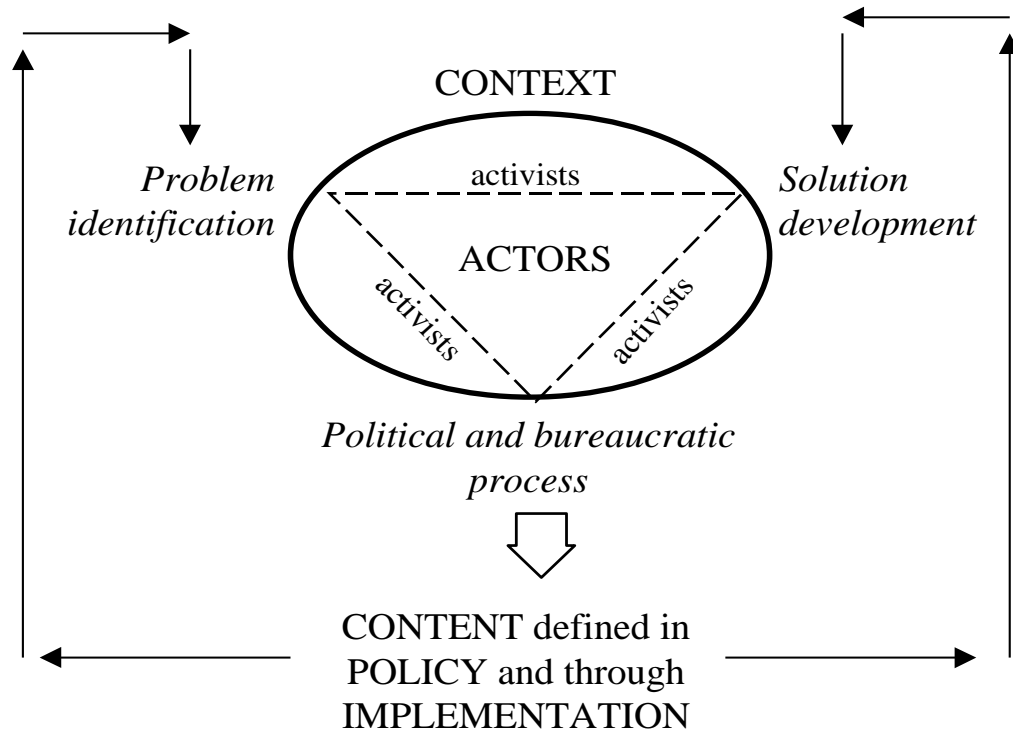
This was a continuation of the session on power and how it affects advocacy. The session consisted of two activities. The first was a power-point presentation on how to carry out a situational analysis to identify what to advocate for, with whom, and at which level(s) to focus advocacy activities.

The presentation started with introducing a framework for situation analysis. There are three major aspects to keep in mind:

- Process of problem-identification and solution-development
- Context (or contextual ‘factors’)
- Actors

It then illustrated these aspects drawing on the example of the Anti-Arrack movement, on which the participants had watched a film the previous evening.

Figure 1. A framework for situational analysis



As seen in the session on identifying advocacy issues based on available evidence, different people identify different issues as problems when examining a situation. This is dependent on the expertise of those involved in problem-identification, and more importantly, on their world view. How we define the problem determines what the solution we seek for it is; in other words, what we advocate for depends on problem-definition and the solution-development that ensues. In the example of the Anti-arrack movement, the problem underlying or causing widespread poverty was defined as alcoholism and the availability of alcohol in the village. There were a number of other factors present, such as mechanisation of agriculture and the shift to commercial crops, large scale rural unemployment and loss of wages. But these were not identified as the major issue to be addressed. Is the development paradigm the problem, or is it state policy to earn revenue from sale of liquor? The latter was identified by this movement.

The solution developed was therefore banning arrack shops from operating in their villages. The struggle stopped where it did – with prohibition by the second-time come-back NTR government, because this is what the movement aimed for.

The context was one of increasing poverty and hunger, with women folk in dire straits because they were unable to find food for their families. The last straw was the death of a woman because of violence by her drunken husband. One of the major facilitating factors in the context was the literacy movement which gave women the tool: reading skills enabling information gathering from newspapers; and an opposition party newspaper which saw news value in this story. The struggle lasted several years, till a change in context in the form of forthcoming state-assembly elections offered political space. The Telugu Desam Party saw in the Anti-Arrack movement a sizeable vote-bank and rode to power on the plank of prohibition. (This victory was short-lived, and prohibition is no longer enforced in the state).

A wide range of actors got together to make change happen. The women from villages, an NGO working on literacy; young men of the village who were against alcoholism; and eventually, political parties and trade unions. But the agenda was set by village women.

12.2. Multi-level framework

There are various levels of contextual factors and actors:

- Global
- National
- Community
- Household

Some examples of various levels of actors influencing sexual and reproductive health and rights include:

- Donors
- International NGOs and consultants
- The World Bank
- The medical profession : various levels

- Other health providers: various levels
- The research community: various levels
- Local, state level and national bureaucracy
- Political leaders: various levels
- Civil society organisations: various levels
- The women's (health) movement: various levels

The following are examples of factors influencing sexual and reproductive health and rights:

Table 2. Factors at different levels influencing sexual and reproductive health and rights

Global	National	Community	Household
<ul style="list-style-type: none"> ➤ International conferences and policy decisions (e.g. MDGs, ICPD; IWHM) ➤ Emergence of new very large private donors ➤ Health sector reforms affecting availability of funding for the health sector and other social sectors ➤ Changes in global power balance following the collapse of the socialist block ➤ A strong ideological shift in favour of privatisation in health ➤ Increase in world oil prices and consequent balance of payment crises in developing countries 	<ul style="list-style-type: none"> ➤ A new party in power ➤ Whether going through structural adjustment programme ➤ Health system factors: e.g. to what extent is government funding SRH services? ➤ Type of development policies pursued 	<ul style="list-style-type: none"> ➤ Location and status within the national context ➤ Resource base: material, social and cultural ➤ Distribution of resources across population groups ➤ Intra-community distribution of social prestige and power ➤ Gender relations ➤ Health resources and beliefs 	<ul style="list-style-type: none"> ➤ Status within the community ➤ Resource base: material, social and cultural ➤ Intra-household allocation of resources and power ➤ Gender power relations within the household ➤ Health practices and beliefs

Underlying many of the factors at the individual and household levels are larger political and economic forces. If we do not see the linkages between the micro factors that are easily discernable and the structural factors operating at the macro-level, we may not be able to plan effectively for making change happen.

This presentation was followed by a group activity. Two groups each had to identify factors and actors at the global, national, community and household levels, which influence one of the following problems

- incidence of sex selective abortions

- rural women's access to emergency obstetric care

Due to time limitations, only one of the above issues: pre-natal sex selection - could be presented and discussed at length.

Four column headings were put up on a blank wall, marked "household", "community", "national" and "global". Members of the two groups that worked on pre-natal sex selection took turns to display below the column headings cards with "factors" and "actors" at each level.

Factors at the household and community level were identified as: son preference, gender discrimination, dowry, values. At the national level, negative and positive factors contributing to the problem of pre-natal sex selection identified were the collusion of health providers; existence of a law; to prevent pre-natal sex selection; limitations in its implementation; and confusion over sex-selective abortion and MTP Act. At the global level, international: research funding and multinational companies supplying diagnostic equipments made effective prevention of pre-natal sex-selection difficult. On the other hand, pressure from donors against sex-selective abortion, highlighting of issues by the research community contributed towards making the problem visible.

Actors involved in pre-natal sex selection include doctors, lawyers; demographers; media persons; women's movement; the PNMT Act movement (women's movement); policy-makers and international organisations.

A link was made between factors and actors across different levels in an attempt to prioritise which issue should be tackled from a strategic perspective (these could then be put to test for their 'rights' content and ability to mobilise marginalised groups). For each of the issues identified, an attempt was made to identify the relevant actors who will be able to impact on that issue. The main question was "Can we identify the most strategic issue and level at which to act, which will enable/facilitate action at all other levels? *Which is the master switch which can switch on several lights at the same time?*"

With this, the first module of the course, "Building conceptual clarity" came to an end. The next module focused on introducing specific advocacy actions and skills through case studies on advocacy.

Module 2. Essential advocacy actions and skills

13. Case studies of advocacy on women's health and SRHR issues

The second module with a panel consisting of three speakers, each of whom presented a case study of advocacy. The first of these was on advocacy against sex-selective abortion; the second on advocacy for the rights of HIV positive women and sex workers, and the third case study was on advocacy against coercive population policies and for upholding women's reproductive rights.

13.1. Where have all the little girls gone?

Dr Puneet Bedi shared his experiences as an advocate against pre-natal sex-selection. He defined sex-selective abortion of the female child as genocide, not merely a social evil. He shared data from South Delhi clinics on the extent of pre-natal sex-selection and abortion of the female child. Although strong son-preference has existed in Indian society for centuries, it is the easy availability of technology for sex-selection and the willingness of doctors to carry out sex-specific abortion that had led to the development of a well-organised multi-million-rupee industry. According to Dr Bedi, .The number of ultra sound machines per square kilometre is directly related to skewed sex ratio.

The PNDT Act, meant to prevent the use of diagnostic technology for pre-natal sex-selection is not being implemented with seriousness in any part of the country. Moreover, the law lacks teeth since it does not provide for penalisation of the medical practitioners involved. The Act is not equipped to deal with this 'organised crime'.

To prevent further deterioration of female sex ratio, we need to treat pre-natal sex selection as a major human rights violation akin to genocide. We cannot afford to treat it like other social problems. There are many vested interests, and there is denial of the problem among some senior medical professionals. The PNDT Act should be implemented stringently, and audit of clinics carried out regularly. Culprits should be taken to court and the licenses of medical practitioners involved, revoked.

In the discussion that followed his talk, misgivings were expressed by some participants about the use of the term foeticide when referring to abortion of the female foetus. They felt that by using such terminology, we could be strengthening the anti-abortion lobby. Dr Bedi responded that the term was used by him because it is also used in the PNDT Act, and moreover, he did not think that there was any danger of a conflict of interest arising between the movement against sex-selective abortion and support for women's right to abortion.

Dr Bedi's was an example of a committed individual's advocacy efforts. He does not belong to any organisation, nor has affiliations with any networks. He did not believe in the politics of 'engagement' if it meant collaborating with those who are largely responsible for creating the problem in the first place.

13.2. Sex-workers organising to prevent HIV/AIDS – the experience of Veshya Anyay Mukti Parishad (VAMP)

The next speaker was Meena Seshu, who shared her experiences in working through VAMP which organises sex-workers for HIV prevention in Sangli district of Maharashtra.

Meena started working with HIV among sex workers in Sangli 14 years ago, through a peer education programme. Her task was to train a group of sex workers in 'client negotiation strategies', and they were then to be peer educators for other sex workers. She soon realised that she knew nothing about sex work and the life of women involved in it, but was 'telling' them what to do. This led to making fundamental changes in the peer education programme, and learning from sex workers about what such a peer education programme should do.

Women in prostitution and sex work are mainly portrayed and treated in public discourses and policies as vessels of moral hazard, vectors of disease and objects of pity. They are socially excluded as their presence 'might' trigger moral panic in communities.

Working together in creating an alternative approach to HIV prevention gave rise to the formation of the VAMP (Veshya Anyay Mukti Parishad or Freedom from injustice) Collective in 1996. The name was intended as reference to the social stigma they face and was also an attempt to reclaim the term 'veshya'. VAMP now works in six districts in Western Maharashtra and two districts in North Karnataka with more than 5000 women in prostitution through 60 peer educators.

VAMP's HIV prevention programme is peer-focused, with the 'educators' and the 'educated' living in similar circumstances where they can understand each others' experiences. It is women-centered, based on the needs, perceptions and experiences of women in prostitution rather than what the intervention thinks the women need.

The peer education programme works to empower sex workers and to foster a collective identity as an end in itself. It views HIV within the totality of the lives of sex workers, and links HIV vulnerability to other vulnerabilities, such as violence, discrimination, gender and human rights violations. It necessarily addresses issues of exploitation, oppression and human rights abuses that women face. Women are trained on issues such as law, inheritance, property rights and other gendered issues related to HIV. In other words, the 'problem-definition' here is informed by a framework of gender, sexuality and rights.

Over the years, VAMP has gained recognition as a collective that has prevented HIV while ensuring that women in prostitution are treated as human beings, with the same rights and dignities as others.

VAMP as a model of bottom-up advocacy

Speaking of VAMP's work in the context of an advocacy approach, Meena identified her work as a model of advocacy from bottom-up. The goal was for ensuring that HIV/AIDS interventions relating to sex work adopt as core values human rights, dignity and empowerment of vulnerable groups.

The sex workers she worked with were not a community, since there was tremendous competition among them. One of the big challenges was to advocate with sex workers themselves, to build a concept of the community among them and to make them feel entitled to human rights.

The group looked at advocacy from the ground. It identified the key players and power hubs. Small issues were taken up. For example, they had to advocate with the civil hospital; the timings of the STD clinic in the civil hospital were changed to 10 a.m to 3 p.m, from the previous 8 a.m to 1 p.m. This advocacy was done by the women themselves. Another issue they confronted was the *hafta* system. They started with negotiations, both with those collecting *hafta* and with the police. They succeeded in getting everyone to stand together to negotiate. Another victory was getting agreement that the Co-ordinator of the HIV programme would be a sex worker. The small victories mattered a great deal.

Meena then talked about some factors and actors affecting advocacy for HIV/AIDS interventions relating to sex work to adopt as core values human rights, dignity and empowerment of vulnerable groups.

There had been an alarming shift recently against policy and programmatic support for interventions (though proven effective) concerned with the rights and health of people in sex work. In part, this was due to the power of the anti-trafficking lobby in the U.S., which had ensured the denial of funds by the US government for any activities that are deemed to promote prostitution or sex trafficking, or organizations that do not have an explicit policy against them. This has resulted in a resource crunch.

Secondly, those working for anti-trafficking are being pitched against those working for the rights of sex workers.

Thirdly, attempts to forge alliances with the women's movement and with the dalit movement have met with difficulties because of the stigma attached to sex workers. Human Rights workers are against sex workers because they think they are against sexual exploitation. If we want to do something it has to be done in a structured manner. There has to be strategic alliances at times, but this also has to be planned.

A challenge to collectivisation of sex workers is that the most vulnerable group of sex workers are those who have been trafficked and/or are illegal migrants. Many of them are violated, controlled and abused in situations where they are engaging in sex work as trafficked persons or 'illegal' migrants.

Meena believes in a strategy of 'engagement' with the powers that-be in order to bring about changes, even as they use confrontation at the local level when the situation demanded it; and further, that there was need to engage and protest at various levels, even though their focus was at the community-level.

13.3. Advocating for women's health and rights and against coercive population policies: Experiences of Health Watch, Uttar Pradesh

Abhijit Das was the next speaker. He shared his experiences as an advocate for women's health and rights and against coercive population policies in Uttar Pradesh during 2000-2006.

Context

UP has the highest population among Indian States (170 million), and is characterized by high levels of poverty and low literacy. Fertility levels in the state are among the highest in India. The state has poor health infrastructure, and the little there is is focused entirely on family planning. Sterilisation operations are often forced on women, and the State Population Policy promotes disincentives and targets. The number of maternal deaths is as high as 40,000/year. Quality of care in family planning is abysmal. There is high failure rate among sterilization operations performed in 'camps', and death and disability levels are unacceptable.

On the other hand, numerous programmes, policies and national laws and standards provide an opportunity to claim justice and rights. Some examples of these are the Target Free Approach in Family Planning Programmes, the RCH programme and the NRHM, the National Population Policy, as well as Consumer Protection Act, Medical Negligence Act and Constitutional provisions in support of the right to health. International agreements and treaties also give us a mechanism to hold the government accountable.

Advocacy issues/demands

The demands being advocated for were better policy, improved programme implementation, new programme components, stopping proposed coercive population control laws. Acknowledgement by authorities of culpability where gross violations of rights had occurred, provision for compensation, and appointment of an ombudsman to adjudicate cases of violations were also important issues being advocated for.

Approach

Health Watch UP began with defining health problems in human rights terms. The 'Rights' framework guided their approach. They chose to work with the community to generate awareness and enable them to claim their rights and demand justice.

Creating an evidence-base

They set about creating an evidence-base on the poor quality of care and coercive methods in UP's family planning programme. They documented rights violations, prepared case studies of maternal deaths, reviewed existing literature and data, and also carried out direct observation of sterilization camps. Health Watch UP also organized an opinion poll across the state about population policy. This information was used effectively in creating awareness and claiming rights.

Constituencies and activities

They worked at various levels: with members of the community, with other NGOs, activists and academics and the media. Advocacy activities undertaken by them included widespread dissemination of evidence through meetings and press-kits, public hearings, media advocacy, advocacy training, and programme and policy analysis and feedback to the government.

Strategies

Both direct and indirect routes to advocacy were adopted. Negotiation with Government of UP authorities, Public Interest Litigations, Public hearings under the auspices of the National Human Rights Commission and postcard campaigns were the direct methods used. Indirect pressure was applied through media stories and through lobbying with the Law commission, politicians, legislators, and experts

Abhijit spoke at some length about their media advocacy efforts, and their impact. As a result of a sustained media advocacy effort, issues like poor quality of services, and medical negligence are highlighted in the media, reporting of medical negligence has increased dramatically and in-depth reports, opinions and editorials on issues related to rights violations in Family planning programmes are regularly published.

Health Watch UP actively networks and collaborates with those involved in similar issues at various levels, starting from community-based organizations to international NGOs. Effective networking is a time-consuming process, and involved keeping everyone informed, and actively seeking their participation. At the same time, one had to accept that not everyone will remain interested consistently, because people's interest levels rise and fall. In working with others, one has to constantly negotiate when it is important to take initiative and lead, and when it is appropriate to function as one among several collaborators. Modalities of functioning and expectations from each other need to be clarified constantly among collaborators.

Impact

- There has been some increase in rights consciousness among communities, NGOs and media
- Age at marriage bill and UP Population Control bill were stopped
- Parliamentary committee investigation and report
- Gujarat population control bill was modified

- National Human Rights Commission has issued a show-cause notice to the Government of UP for violations of rights
- There is a Public Interest Litigation filed in the Supreme Court demanding a Family Planning Insurance Scheme

Challenges

Major challenges still remain, many of these related to the use of litigation :

- A majority of those affected by rights violations tend to accept these as 'normal' because they have never seen any different.
- The PIL does not serve individual interests as the prayer and the directions are aimed at a systemic solution. Thus individuals who have suffered any form of injustice do not get compensated.
- If cases are filed under the criminal justice system then there is possibility of the cases dragging on for years. The individual interest is subsumed as the crime then is against the 'state', and has to be proved beyond doubt. The current Supreme Court orders relating to filing FIRs in cases of medical negligence makes it extremely difficult to even register a case.
- Civil 'tort' laws are not well developed in India. The COPRA or consumer protection act has provisions for dealing with health / medical service deficiencies.
- A further challenge is that when systems themselves are so deeply 'unfair' and discriminatory it is difficult to ensure system improvement through redressal of individual cases.

More needed to be done about working with *panchayati raj* organisations and professional groups. Sustaining common interest of all members of Health watch UP without any formal platform was a major challenge in itself.

13.4. Advocacy for promotion of maternal health and reproductive rights: Health watch UP-Bihar

Sandhya of Health watch UP-Bihar shared the experiences of her organisation, which was a part of Women's Health and Rights Advocacy Partnership (WHRAP), in giving visibility to issues of high maternal mortality and morbidity and poor quality of health care during the past four years.

Sandhya worked in Mirzapur district of UP. The district had a sizeable population of adivasi and dalit communities. Men, women and children work for private contractors who lease land for mining. Monsoon months are unemployment months, so they take loans from contractors and then are bonded to them to work for the remaining months. Her organisation was first working on its own, but was now a part of WHRAP, which covered seven districts. Since they started working with WHRAP, they had several capacity building programmes, and their understanding expanded.

WHRAP did a health assessment of Uttar Pradesh. The assessment found that there were 80% more maternal deaths as compared to national average. Family Planning programme in our state was more of population control, the auxiliary nurse midwife focused on sterilisation targets. They are not able to give attention to maternal health.

Mirzapur is backward, hilly and covered with jungles. Illiteracy among women is very high. The district has become a naxalite hot spot. So government services have become even more unavailable. Subcentres are located far away from the villages, women have to lose her day's wages in order to go there. There were no transport facilities. Even if they reached hospitals, especially government hospitals, they are treated badly by government, especially if they were poor and dalit. Services are said to be free but they are made to pay. For delivery, the hospital staff take money even before the delivery is conducted. Otherwise they don't get service. High maternal mortality is an expected consequence.

Women used to think that maternal death is fate; god's will. Sandhya's organisation felt that it is important to work on this. They carried out a needs assessment in five villages to find out what are the services that they were not getting. They found that girls were getting married between 12-15 years. Women were not getting ANC during pregnancy. Delivery was conducted by unskilled birth attendants, usually relatives not even *dais*.

Women knew only about sterilisation as a family planning method, not about anything else. They suffered a lot of problems following sterilisation. They had no knowledge about reproductive health and it was also considered inappropriate to discuss this in open meetings. Each WHRAP partner put together five case studies of maternal deaths as evidence, and prepared a compilation of 50 case studies of maternal deaths.

Case study of a maternal death in Mirzapur

A dalit woman agricultural labourer died several days following her third delivery. She had delivered at home. On the seventh day after her delivery she developed oedema. She was given IV solution and taken to the local PHC in a broken down old Jeep. The doctor did not come out for a long time. He did not bother to find out the condition of the patient or even direct them to another place. He just said he cannot deal with this case, it was beyond his capacity. The family went to a private doctor, where she was given more IV solution. At 3 a.m the doctor asked that she be taken elsewhere. She was taken elsewhere, and again given IV solution, and then referred to the district hospital. The doctor there asked for a certain amount of money, so the family went to a relative's house, planned to put together the money the next morning, but she died in the meanwhile.

They took their case studies documenting maternal deaths to government officials from the district to state level. They also started talking about this with people's representatives. This began to act as a pressure. In Gorakhpur – adolescents decided that they will not get married below 18 years. ANMs have started visiting the villages

regularly. There is pressure from women of all communities for their regular visit. As long as the women leaders do not sign that ANM has come, then their salaries will not be given; the medical officer said this. When panchayat elections came in Gorakhpur, the people demanded that safe motherhood should be on their agenda. Only then they will vote. The organisation has had dialogue and representation with CMO and district officers about medical negligence leading to maternal death. This was done in every district. A signature campaign for safe motherhood was carried out in all districts. In 17 districts of UP there was a movement using varied media such as skits, rallies, CDs with films, posters and songs. They presented their demands in the capital city as well. Women from the villages were confident, they talked about the issues in any meeting, pressed their demands everywhere and also use the media. The media in UP now projects safe motherhood and services related issues everywhere.

A large number of women from the villages came to Delhi, presented their situations and their demands: e.g. the Right to PHC, blood bank, female doctor, and spoke out in front of the media and ministries. They went to MoHFW and Planning Commission, to the National Commission of Women and the State Commission of Women – we represented there as well.

Her organisation continues with carrying out awareness and advocacy on maternal health/maternal death. They work with adolescents and with men, conduct workshops for different groups on RH and safe motherhood, with a focus on **rights** – what these are, how to claim these. They identify adolescents who have leadership potential, and develop them further.

They face many challenges. These include getting men involved to the same extent as women; getting district officials' time; getting information from health sector; being branded as naxalites when they speak rights-based language; goondas and gangs raj that threaten the safety of women.

The discussant following this case study summarised the skills in developing effective community-based advocacy demonstrated by this case study. One was evidence gathering through systematic documentation, by collecting case studies that were sufficiently large in number to make an impact. The second was mobilising and leadership-development skills. Efforts were made to build the confidence of women, to inform women, and to enable their agency to represent their demands at the level of legislators including at the national level, and also other major actors. The third skill was in alliance building and collaborating with other organisations. Sustainability had been ensured by systematically building the advocacy and organising capacity of the partners in WHRAP. One of the major assets of the group was its staying power and perseverance in a hostile environment against many adverse odds.

13.5. Advocacy for rational therapeutics

S.Srinivasan of LOCOST made a presentation about his involvement in the movement for rational therapeutics and access to drugs in India, a movement dating back to the 1980s. He used this case study to highlight skills required for advocacy.

The movement was part of a larger struggle for the Right to Health Care. It emerged out of the realisation that drugs played a crucial role in access to health care and that drug companies were not telling the complete story about the risks and side effects when marketing their drugs, and that the prices of drugs were fixed way above

Box 1. An overview of the drug situation in India

Irrational and unnecessary drugs hike up health care costs

The drug situation in India is one of poverty amidst plenty. Drug costs are about 40 percent of health care costs, and health care is the second most common reason for rural indebtedness. There is practically no health insurance in the country, and the public health system is decaying and non-functional in most rural settings.

There are more than 20,000 drug formulations available in the Indian market. A great many are irrational and unscientific. There are numerous combination drugs. Further, 62 percent of the top-selling 300 drugs are not in the National Essential Medicine List. There is poor regulation by drug authorities, and corruption and inefficiency are endemic.

Over-pricing
One of the major concerns related to drugs is the unbelievable levels of overpricing of drugs. Profit margins can be up to 4000 percent. There are many “players” in the industry but competition has not brought down the prices of drugs. The same drug is sold at different prices by different companies. Even more interesting is the fact that the same drug is sold at different prices by the SAME company too! Drug prices are fixed according to what the perceived target market for the brand can take. Markets are distorted by unfair and unethical marketing practices of drug companies

The huge profit margins of pharmaceutical companies becomes evident when we compare government tender prices for drugs with retail prices. For example, when we compare tender prices for Tamil Nadu Medical Supplies Corporation (TNMSC) with retail prices, we find that tender prices of many drugs are less than 5 per cent of market prices. For example the tender price of Albendazole are less than 2 per cent of market prices ! (See www.tnmisc.com for tender prices of a good, transparent government procurement agency. See also: *Srinivasan, S. “How Many Aspirins to the Rupee? Runaway Drug Prices”, Economic and Political Weekly*, February 27-March 5, 1999).

Need for price controls and regulation of the pharmaceutical industry
The following characteristics of drugs make it a commodity like no other:

- The consumer may have no knowledge about the goods he/she is purchasing, Goods can be purchased only on the written recommendation of a third party (who may charge you heavily for doing so), and where the goods are purchased in such distress, Result of non-purchase of the goods may be death or disability. Expensive gifts and heavy discounts are offered to those recommending and stocking a particular good and none offered to those who purchase them.
- A particular company making a particular product can have exclusive rights over marketing and manufacture for a period of 20 years.

Price controls operate for many commodities
Some examples of price controls include telephone rates, which are determined by Telecom Regulatory Authority of India (TRAI); insurance premium, controlled by Insurance Regulatory & Development Authority (IRDA); electricity tariff, decided by the state-level Electricity Regulatory Commissions such as DERC in Delhi; Interest rates are decided upon by the Reserve Bank of India (RBI). Medicines are not less important than telephones call charges or insurance premia. So why should the state not ensure that they are available at fair, affordable prices? In addition, food for export, cooking gas, urban transport (rail and road), electricity, IITs and IIMs and AIIMS all enjoy heavy subsidy from the government. It is not inappropriate then, to expect the government to subsidise at least essential drugs.

Price control by governments

Prices of drugs in India are controlled by the National Pharmaceutical Pricing Authority, under the Drug Price Control Order 1978. But the number of drugs subjected to price control – the ‘price control basket’ - has come down over the years: from 350 in 1978 to less than 74 now. It is worth pointing out

that there is no free market pricing in drugs even in the so-called free market economy countries, except in the USA, where drugs are costliest!

In the UK, there is the Pharmaceutical Price Regulation Scheme (PPRS) (See <http://www.doh.gov.uk/pprs/index.htm>). In Canada, prices are regulated by the Patented Medicines Prices Review Board. In France, the Transparency Commission and the Economic Committee on Medicines are responsible for regulating drug prices. In Egypt, all drugs are under price control. In Italy, price control is restricted to wholesale margins. Some system of price monitoring and price regulation prevails in Japan, Germany, Netherlands, China, Indonesia, Colombia and so on. In some of these countries drug pricing is tied with national health system reimbursements and/or insurance schemes.

Will price regulation cause pharmaceutical industries to run-away from India?

It is usually argued that price control and regulation could lead to an exodus of pharmaceutical industries away from India. This is unlikely. The medicine market is growing and rationalisation and regulation can only be a win-win solution. India offers unique advantages to the pharma industry. Low costs of production and the advantage of an English speaking and scientifically trained human power (with low salaries compared to other countries) is not to be found easily elsewhere as in India. A look at the share prices shows that Indian pharmaceutical companies are the most profitable business in India : for example, for every Rs. 1000 invested by promoters/family members in Sun Pharma in 1994, the value was Rs. 4,93,200 in 2004!

Regulation will help the growth of the Indian pharmaceutical industry. About a fifth of the world medicine market – products worth over US \$ 80 billions will go out of patent during the next 2-3 years (2006-2009). These will all be available to Indian companies for production. Indian entrepreneurs can compete with the best of foreign MNCs given the right type of domestic support such as supportive Patent Laws and Compulsory licensing if necessary. Indian drug companies will become more efficient as overpricing (which is itself an escape route for inefficient companies) will be curbed and the fittest will survive in what will be truly knowledge based industry.

Bangladesh is a good example of a country with very good regulation and price stabilisation over the last 22 years, and no drug company has withdrawn from the country because of this.

Is WTO against price control? TRIPS is silent on Price Control. Doha Declaration and Art 7 (Objectives) and Art 8 (Principles) of TRIPS assert members right to protect public health.

“Each member has the right to grant Compulsory License and freedom to determine grounds upon which such licenses are granted.” (Doha Declaration)

It is acknowledged internationally that trade cannot be given primacy in comparison to health and human rights.

reasonable profit margins. The effect of irrational prescriptions and high prices of drugs relative to people's incomes meant impoverishment of the poor who sought health care. Srinivasan presented a comprehensive overview of the drug situation in India (Box 1) and also provided evidence to challenge a number of arguments put forth by the pharmaceutical industry in support of removal of price controls and liberalisation of the industry. This provided the backdrop against which the advocacy issues and strategies of the movement for rational therapeutics could be understood.

The principal actors in the movement for rational therapeutics were health activists, organisations like the All India Drug Action Network and Medico Friends Circle; NGOs working on health and feminist organisations like SAHELI. It was greatly strengthened by the presence of doctors, some FDA commissioners, health economists and low cost drug producers.

Advocacy issues

The main advocacy issues were

- Unaffordable prices of many drugs
- Overpricing and the need for price control
- Abundance of irrational, banned and bannable drugs
- Unscientific prescription costs
- Lack of essential drugs
- Poor health/medicine budgets in governments
- Patents, TRIPS, access issues
- Unethical practices of companies including in clinical trials, and lack of transparency

Advocacy skills used

There are many different skills needed for advocacy: People-skills, Doing skills, knowledge-related skills; and systemic/ecological skills. Many of these different skills were leveraged by the movement during the quarter of a century spanning 1980-2006. One of the main pillars of the movement was to develop knowledge-related skills. The many talented people who were a part of this movement carried out documentation and research on a number of issues related to pharmaceuticals. The movement played an important role in deconstruction of official reports, and in general, demystification of the politics and economics of pharmaceuticals. Members of the movement became knowledgeable about drug pricing practices and could use this in challenging overpricing.

The movement also used media advocacy and litigations among its strategies for advocacy. It questioned and challenged the accepted wisdom of economics and industry, and provided evidence to the contrary. Members of the movement used every opportunity to represent in govt forums.

There have been a number of publications from the movement, including writing in local, national and academic media, critiquing government policies, and using the government's own reports: (e.g. Lentin Commission, Standing Committee Reports of

Parliament, Pronab Sen Report (2005) to advocate for access to and affordability of drugs. Some of the recent publications include “*Banned and Bannable Drugs*”, “*Lay Person’s Guide to Medicines*”, and “*Impoverishing the Poor*”- this last one was on drug overpricing. Publications in local languages has been limited except in Malayalam. Members of the movement are in regular contact with the media and contribute articles to newspapers regularly.

The movement’s own understanding of drug pricing issues has evolved over the years. There is no doubt now that the economics of drug pricing is politics; that competition in health does not reduce prices; that price regulation is a common feature in health in capitalist economies ; that regulation and liberalisation go together. We have also understood clearly the flawed nature of health services in the US where the health and pharmaceutical sector is not adequately regulated. Mainstream economic: Akerlof (asymmetry of information), Sen, et al. as well as several international commissions support our averments

Achievements

There is now a much greater acceptance that all is not well with the pharma industry. Pharma industry’s anomalies arising from the asymmetry of information in health, and drug overpricing are now acknowledged as issues.

The movement has also successfully advocated for banning some bannable drugs, though a lot more remain. Many states and hospitals now have an Essential Drugs List.

An important achievement is that the movement has become a force to reckon with, and cannot be ignored by policy makers when making drug policies.

Facilitating and discouraging factors

In terms of contextual factors, one of the important facilitating factors has been the discourse on access to drugs that has emerged from the AIDS crisis. Generic competition and social activism has driven down the price of AIDS drugs in Africa, and also created international support for the need to regulate drug prices in the interest of public health. There is now an international network of concerned NGOs and activists including Health Action International (HAI) and *Medicines sans Frontier*(MSF), and ACT UP. In India, the recent change in patent laws has promoted public awareness about drug over pricing issues.

The movement’s own strength includes the fact that most drug activists are also health activists, and can therefore analyse issues holistically. Their ability to be at it, and keep going has been one of their greatest strengths.

Against these facilitating factors are stacked a huge number of discouraging factors or barriers. To begin with, the issues are very politically sensitive, because much (in terms of profits) is at stake for pharmaceuticals. They wield a great deal of money power, influence policy and are a formidable adversary to take on. The two faced

nature of pharmaceutical industries: MNCS and “national”- makes organising against these more complex. The growing dominance of market- orientation and opposition for any form of market regulation is another major obstacle.

An important constituency – the medical professionals- are not a major part of the movement, and most medical associations are indifferent to issues of rational therapeutics. Unfortunately, not many young people are joining up either.

In the discussion that followed, the discussant highlighted the fact that this is a movement that is not community-based. Concerned professionals could also be engaged in advocacy from wherever they are located, using their many skills. What is important is to recognise themselves as part of a much larger movement, in which



**I did take the tonic, Sir !
But had to starve for days to buy it.**

they play a small part. Of the many skills highlighted by the presentation, one of the most important seemed to be the skill of understanding the *context* very clearly, and using suitable tools to put forth their points at every opportunity. This movement had skills of engaging with the judiciary. The actors used their skills in gathering and making sense of evidence very effectively to influence public opinion as well as policy contents.

13.6. Advocacy with policy makers

This was a presentation on advocacy with policy makers, by Ena Singh of the United Nations Population Fund (UNFPA). Ena has a track record of several decades of collaboration with sexual and reproductive health and rights activists.

She presented her own experiences in advocating with policy makers, and illustrated advocacy at this level with the example of advocacy against sex-selective abortion of the female foetus.

She began by saying that the participants' experiences on advocacy and hers may come at issues at different angles, because she works in a different space as compared to those directly engaged with the community. Her location gives her the advantage of access to policy makers; but this also imposes the need to be diplomatic. Their approach is one of partnering and collaborating with the government to change things. This style had helped her to learn a lot about how to work even with the 'enemy'

The issues

The consequences of a serious deficit of women

Ena took us through photographs of women whose lives had been affected negatively by the severely skewed societal preference for boys. The images were all from northern part of India, but from rural areas. Not because it is predominantly a rural problem, but because no one from the urban middle class was willing to speak out. Slide after slide showed what the consequence of the deficit of girls in a society could be. Men from such societies went to the poorer regions of India such as Orissa, and especially to the socially disadvantaged communities, in search of women to marry. There were several young women who had been bought for a few thousand rupees, married to old men who wanted a son even after their wives were menopausal, women who, after being bought and married in this way, went back to their communities to find brides for other men.

How serious is the problem

Nationally, there had been a steady decline in child (0-6 years) sex ratio: from 962 girls per 1000 boys in 1981 to 945 in 1991 and 927 in 2001. The decline and the levels are much lower in urban (from 931 in 1981 to 903 in 2001) than in rural areas (963 in 1981 to 934 in 2001). The deficit of women estimated by census has increased from 4 million in 1901 to 35 million in 2001.

Who does it?

Overall, the problem is one of the educated, urban rich and aspiring middle class, and this is what makes changing the trend of adverse sex ratios so difficult. Economic progress has not necessarily changes traditions of gender discrimination. Where there is rapid fertility decline, with son preference and access to technology, there is sex

selection. The degree of son preference and the potency of the available technology combine to bring about sex selective abortions.

Advocacy against sex-selective abortions

Dilemmas

There were many dilemmas in deciding whether or not UNFPA should get involved in some was in advocacy against sex-selective abortions. One was that UNFPA does not do advocacy per se. A more tricky issue was the global politics around abortion. They had to tread a careful line between advocating against sex-selective abortion and at the same time being pro-abortion in the same breath. They had to be careful that right to life groups did not take advantage of the messages in the campaign against sex-selective abortion. Yet again was the issue of whether it was alright for public money and effort to be spent on middle class issues. Should not the money be spent on other priorities?

What should the message be? The one thing that got people thinking was that sons will not be able to find wives. But would it not perpetuate stereotypes of women as wives, if they used this message?

Another dilemma is how to decide on where to pitch one's work, given that the problem is at various levels. By focusing on only a few areas based on one's own skills and resources, would one not be leaving out certain essential areas?

The most important thing to remember is that advocates have to make choice and decisions with limited information almost on an everyday basis. There are no simple answers, no rehearsals for real life problems. One has to learn to live with uncertainties and personal dilemmas.

UNFPA's strategy:

UNFPA evolved a three-pronged strategy to address the issue of sex-selective abortions and declining sex ratios..

One: Because of who they were, they have to work with the government, to increase awareness and improve capacity in implementing the law; to integrate this in all government programmes that are relevant.

Two: Research. There is need for good evidence, not only data on sufficiently large scale, but also case studies that are able to tap on emotions. One of the first efforts was to initiate with the Registrar General of India's office a study on the causes and consequences of declining sex ratio. Besides this, they decided to synthesise the research already available and disseminate this widely and effectively.

Three: Advocacy; with medical professionals, with media; religious leaders; celebrities; and with young people. Of these, medical professionals are a very

important group to focus on, because that is the interface at which the act of sex-selective abortions can be stopped.;

Guiding principles

- Just do it by doing it
- Talk to anyone who will talk to you (religious leaders, television academy, schools, army's education wing, schools, NIIT) Find out who is worth meeting from this process
- Then people who are willing to work with you move towards you
- People rely on reason and emotion; use both. People first make decisions on the basis of emotion.
- Balance – the 'right' message, participation of people, with what appeals to the listener and what works. What are the benefits, what are the risks.
- Materials: don't get hung up on it; they are important, but not the central piece. Good material takes a long time to make. Use newspaper clippings: for various groups.

Dealing with one's own dilemmas:

- Uncertainty; anything can go wrong, but this is dynamite. When things go wrong, one does not know how many people will stand by you. Always to listen, and make your own best judgement. Listening is really the only way in which you can be prepared for big mistakes.
- Temptation to keep changing; flexibility is okay, but reasonably steady course, a mind map, where you are going who you want to work with , what are your bottom-lines.
- You can become a lightning rod for resentment when you say things that people don't agree with. Careful what you say, where, how you say it.
- No matter how you communicate your message, in the end what is most important is your own integrity, credibility is paramount.

Group work on policy advocacy

Participants were then divided into four groups, each group addressing one of the following target audiences:

- Medical community
- Religious leaders
- Role models and endorsing celebrities
- Panchayati Raj Institution members.

Each group had to address the following questions:

- How do you articulate the problem to this group?
- What are the three or four things that this constituency can do to further the cause?
- What are the three or four things that this constituency can do to hurt the cause by inaction or action?

- What are the problems/risks and resistance that members of this group are likely to face if they came on board?
- What kind of road map would you make to work with this group over one year?

Group 1: Advocacy with medical professionals

The scenario was three doctors in a train compartment. The advocate takes a news item in the Times Of India, and uses this as a means to start conversation. The message to them is that they have to advocate with other medical professionals, because they can make the difference between whether or not sex-selective abortions are actually carried out. This constituency can hurt the cause through negative propaganda. However, if they decide to come onboard, they could face professional ostracism, cold shouldering and loss of practice.

He feedback to this group was that their message was not very clear, it was very general. It was suggested that going through a forum will help more than just addressing three doctors. However, having personal communication can help the advocate to feel out what the group thinks; and get a sense from them how they will react to the issue. This will us anticipate the reactions of the constituency when preparing to meet a larger group or forum.

Group 2: Advocacy with religious leaders

The scenario is again encounter with a priest in a train. The message to the priest would be that **“It is a sin. The family is going to collapse.”**

What can they do to further the cause? They can use the opportunity of preaching in the community, to bring up this issue. We would like them to become a part of the larger community. What can they do to hurt the cause? Many religions sanction dowry, and son/men-centred rituals. If they support these, they can strengthen son preference. They risk isolation and reprimand.

The plan was to gather evidence – e.g. where there are no girls any more. Positive case studies of where religion has had a role to play against sex-selective abortion would also be collected. For one year, one-to-one advocacy will be carried out with religious leaders. At the end of one year, a meeting of all religious leaders will be held.

The feedback to this group raised the appropriateness of using the language of ‘sin’ – whether this would not prove counter productive.

Ena talk about UNFPA’s advocacy with religious leadersat the Chinmaya mission and with Sree Sree Ravishankar. They also organised a meeting of religious leaders representing different religions, and also invited NGO leaders.

The meeting seemed to be going astray when some religious leaders started talking against abortion. The NGO participants protested against this. However, more than the protest, a suggestion from one NGO person that religious leaders should not give blessings that in any way demean women, and that they should preach about women's right to perform last rites really resonated well with some religious leaders. Sree Sree now talks about sex selection being bad;

Ena emphasised that when addressing religious leaders, it was important to work in collaboration with NGOs and activists to ensure that the issue does not take a different turn (e.g. anti-abortion).

Group 3: Advocacy with Celebrities

This group presented a scenario wherein they approach Sushmita Sen and talk to her about gender discrimination; sex selective abortion, and present her with some information which they can leave behind with her. Her potential is that she can do: if she can talk to people within her sphere of influence. If not on our side, she could become negative advocate. Also she may just project her glamour, the message may be forgotten. The risk she faces is that her commercial interests may suffer; she may start getting judged.

The road map was that they will invite the celebrity to some forums and groups; educate her on these topics so that she can speak about these effectively. They will also seek her help in featuring in a spot film on the issue.

Sushmita has an adopted daughter. The group will appeal to her emotion – “you have adopted a daughter, but many girls do not come into the world”.

In the discussion following this presentation, one participant shared her experience of working with celebrities. They had invited two celebrities for advocacy on safe motherhood, and this was a mistake. One of them wanted talking points right away, and these were not ready. She then spoke about HIV/AIDS instead of safe motherhood. A lot of money and energy goes into organising celebrity events and if everything is not meticulously planned, the returns to investment may be very poor. On the other hand, if a celebrity is touched by an issue, this could prove a great boon. People are looking for issues.

Ena spoke about their experience in working with Rabi Shergill, who they had wanted to write a song about missing girls. The pamphlet in Punjabi caught his emotion. He wrote a song, which was not as strong as she would have wanted it, but they had won a committed advocate.

Group 4: Advocacy with members of Panchayati Raj Institutions

This group planned to go meet members of PRI in a village. They would go to the village and give evidence about the dwindling number of girl children in a village nearby, and what the consequences are. PRI members will be posed with the problem of what they can do to change the situation.

The PRI can play a role in stopping service availability, and enforcing social sanctions against erring families. However, if not all villages co-operate, then services can just shift. Another problem can be that they can cause a division between families having sons and those not having sons. The latter may resent the whole thing, and feel that their rights are being curbed. The risk the PRI members face is that their popularity may wane and re-election may be threatened.

The group's road map for one year was to collect evidence and real life stories. They would develop alliances with other local groups also concerned with the same issues, e.g. community-based organisations. Regular meetings will be held with PRIs. A monitoring system will be put in place to find out if they are making progress in curtailing availability of services.

14. 'Media'ing advocacy

The next part of the course focused on media and communications strategies and skills for advocacy. There were three major sessions: one on communication strategies, a second on effective use of the print and television media; and a third on methods and materials for advocacy at the community level.

14.1 Using strategic communications for advocacy

This session was facilitated by Vijaya Nidaduvolu. The session started with a presentation by Vijaya on strategic communication. Vijaya began by explaining that using the media is a process of negotiation. The way we construct a message is informed by our world-view. There is no one right way of doing this, each one does it according to their ideological position.

Effective communication may be used in advocacy in various ways: for example,

- To lobby with policy makers so that research/learning from interventions can be used for formulation of policy
- To create added pressure from the mainstream media
- To inform the general public so that they demand better services, information and rights
- To communicate research findings to a wider community of actors so that a significant body of evidence is built

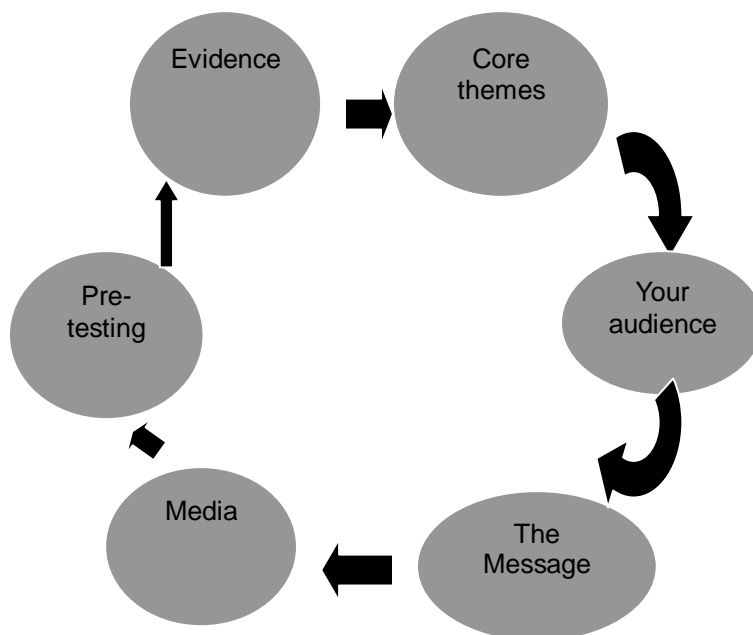
These four different groups: Policy makers; media; general public and community – usually constitute our audience for advocacy in sexual and reproductive health and rights. The tools and technologies to be used with each group will have to be different. For example, one would use briefings, presentations and public hearings with policy makers; Press releases, media briefings and media trainings with the general media; Mass media to interpersonal media channels (Broad cast to narrow

cast) in order to reach the general public; and meetings, networks, reports, e-mail listserves, websites for other research and/or implementing bodies.

Using popular media to communicate your message in a strategic manner is a major challenge. For example, mass media may not give as much space as community media and it would mean working within a specific structure of entertainment. Also, when using popular media one has to achieve a balance between entertaining and educating (people do not like ‘preaching’).

Developing communication materials is an iterative process. Starting with the large mass of evidence at hand, one has to identify the most important or core themes around which messages are to be developed. The next step is message development, which depends on the media/technology chosen for communication. The message is pre-tested and revised; the learning from this feeds into the evidence again (Figure x).

Figure 2. The Process of developing communication materials



The message has to be kept simple. The language used should also be simple and jargon-free, and absolutely to the point. Involving those affected in message development would be important in ensuring its relevance and appropriateness. The message needs to focus on the positives rather than reiterating the problem. Endorsements by community leaders or celebrities may be used to draw attention to the message or to add credibility. It is important to remember that both images and language are open to interpretation by the audience, and hence field testing and revision become an important component of message and material development.

Using local resources/media would ensure maximum impact, entertainment and sustainability.

There are a number of ethical issues to consider in using media, and effective communication without compromising on ethics is a major challenge. There are more questions than answers. For example, do we use only one side of the story? Or do we give both sides of the picture? Giving both sides of the picture could dilute the message. Is it alright to use images to titillate, shock, question? Is it acceptable to use good-looking women in television spots on domestic violence, or would we be reiterating stereotypes?

When using or projecting human images, for example when projecting HIV positive people, should we block out faces of HIV positive persons in order to protect their right to privacy, or would we, in doing so, perpetuate secrecy around HIV status? Informed consent has to be obtained from those who are being projected. But informed consent alone is not adequate. One has to take responsibility for the possible consequences of projecting images of people: can they deal with the aftermath of such media exposure?

Vijaya shared examples of some communication materials that she had been involved in developing. A study she carried out on what information materials on abortion were available in Rajasthan showed that there were no materials on abortion either on billboards, wall paintings, or in television spots. However, there was a lot of information being projected through multiple media, on sex-selective abortions. Many talked openly about '*Jaanch*' – which meant sex selection in Rajasthan. Women in the community believed that abortion is illegal, because of all the images used for sex selective abortion campaigns. Even service providers from the government were really confused about the legal status of abortion. Vijaya developed a 'story-chart': shaped like a flower, each petal opened out to one specific illustrated story of a woman's abortion experience. The stories were women's own stories and the illustrations were drawn by the women. The chart was tested in different states and the pictures were universally understood. The story-chart came with a mini-sized resource booklet for facilitators and also contained space for including information on safe abortion service providers in each area. Vijaya felt that it was important for communication materials to include information on/scope for follow-up or actionable avenues. For example, a pamphlet on domestic violence should contain information on a help-line or shelter.

Another example was comic strips and posters on masculinity and domestic violence. The posters had positive images of men who stood up against violence against women. (Figures A and B below). These proved very effective. Even so, uncomfortable questions remain: the poster depicts a short woman and a tall man with his arms around the woman. Is it reiterating stereotypes?



सब्जू पति-पत्नी के बीच मारपीट को
रोकना अपनी जिम्मेदारी समझता है



ऐसा होता है!

और यह आपकी भी जिम्मेदारी है

सोच सही मर्द वही

YARI-DOSTI Project: CORO For Literacy; Population Council/Horizons;
Instituto PROMUNDO; Durex & Macarthur Foundation

Assessing impact of communication efforts for advocacy is very important but is rarely carried out. Process and outcome indicators need to be developed to assess whether the intended effect is being achieved and the campaign is on the right track.

Participants wanted to know how social change communication which she was talking about differed from Information, Education and Communication (IEC) and/or Behaviour Change Communication (BCC). Vijaya explained that IEC assumes that the audience is passive, not that they are mediating the message, and are interpreting it in the context of their past experiences. Likewise, BCC does not give people the agency, and does not take into account the systemic issues, the social relations within which a behaviour is happening. Several studies are cited to show that the changes in behaviour are significant. But; one needs to be careful about not using BCC as a panacea, as the solution. It can only be a trigger, a powerful means of kindling interest. No matter how good or effective the communication campaign is, achieving behaviour change or social change does not happen merely because of such a campaign. There are no magic bullets; social change does not work like that. Unless systemic, social relations problems are addressed, nothing changes.

14.2. Example of an advocacy campaign: TV Spots on Domestic Violence

Participants were then shown a series of TV spots on domestic violence developed by International Centre for Research on Women (ICRW), following a study covering several Indian states. Each of the spots focused on one woman's story, gave a short glimpse of her encounter with violence and finished with a positive image of the woman as survivor who was in charge of her life. The spots were only one minute each, and within this short span, communicated the idea that women can speak out against violence.

The spots were telecast on NDTV and on STAR News. The telecast was well timed. These were the days immediately following the communal violence in Gujarat, and many people were tuned on to these channels. The spots therefore got a lot of exposure and grabbed public attention.

How did the research study help in designing the campaign? One important finding from the study was prevalence of domestic violence across class and social groups. This gave the 'LOOK' of the campaign, which portrayed women from different social classes as survivors of domestic violence. From the vast data gathered by the study, a few main messages had to be identified. Given the extent of denial around the issue of violence, the campaign decided to focus on physical abuse as the ONE fact that it wanted people to be aware of, although the research had gathered evidence also on psychological and sexual violence. Case studies gathered as part of the study showed that support from fathers and from the police made the crucial difference as to whether the women could sever the abusive relationship and leave. The campaign therefore decided to make some spots focusing on the role of fathers and of the police. These spots conveyed an alternative scenario where the natal homes supported the women to come back home.

Some of the spots depicted men on the road being asked if they thought that domestic violence was a problem. Many men denied that this was an important problem. The spot then projects the statistics on prevalence of domestic violence. This makes a big impact.

One important communication message addressed men, and said “Real men do not hit their women”. This spot makes a good impact, the average corporate guy who hits his wife may stop and think. However, here again was an instance of using the stereotype of ‘real guys’. A question that one has to constantly confront when doing media advocacy is whether it is possible to be (and whether it is necessary to be) politically correct all the time, or can we make compromises in the interest of making an impact?

In the discussion that followed, some of the participants wanted to know why only one single solution was projected: the police and parents ask the abused women to leave their husbands. Vijaya explained that to her it just gives an end to the story, the positive end. Also, all women featured in the spots except one had left their husbands. Only those who had walked out were willing to appear on camera. Also, the campaign could not possibly explore all avenues, why women continue to live in abusive situations within the limited 60 seconds.

Groups working with women affected by domestic violence in India owned the ICRW spots as their own and used them widely. The spots were translated into many Indian languages and used by many women’s groups including those at the grassroots level.

Each of the TV spots ended with contact details of ICRW for those who wanted further information. They got a large number of requests for action in their post box, especially from bigger cities. ICRW put each one of them in contact with an organisation closest to them. But we did not sustain it after the project wound up. The impact of this campaign has not yet been evaluated.

14.3. Developing communications campaigns

As part of the session on communication strategies, participants were given an exercise on developing communication campaigns.

Participants were brain-stormed on issues for communications campaigns, and from the large list of issues identified, the following four themes were selected:

- Maternal mortality and community audits
- Panchayati Raj Institutions and health
- Adolescent sexual and reproductive health in the school curriculum
- Safe abortion

Participants worked in groups and presented their communications campaign strategies.

Group 1: Maternal mortality and community audits:

The target audience identified for this campaign was the entire community. The community was to be divided into different groups and if necessary, different communication methods will be used with different groups.

At first, a maternal death audit will be conducted in the community. The audit will be done against a framework of entitlement to services. A team of community members will be trained to carry out the audits - not to identify medical causes of death but the processes leading eventually to the maternal death.

The message will be: *Every pregnancy carries risks; community should be aware of this.*

The principal communication method was to be a role play. The role play was to be participatory: the project team would present a role play of something which would create an emotional trigger. The content of the role play was to come from the maternal death audit, so the role play will present the problem. The community has to replay the skit and depict ideal behaviour.

After the first part of the play, there will be a discussion with the audience : *Ye mouth kyon huyi?* around the many reasons that led to the maternal death.

Using the play as communication method would facilitate one-to-one interaction with community members. Also, by involving the community in depicting the solution to the problem, the community is made to take responsibility for each maternal death, taking the onus away from the family.

While involving the community in role-playing is the desired method, an alternative was also to be field-tested, where the project team projects the negative, and also does the positive. Using a positive example also from the same village/area, juxtaposed against a negative one could help create good discussion on what were the factors that varied between these two settings.

Group 2: Safe abortion- campaign or *Surakshit Garbhpath Abhiyan*.

This was a campaign that would run in 10 states of India, safe abortion. The main tool or method used in the campaign would be a poster or wall painting which depicts two women, one with a baby and one without, both shown to be sympathetic to each other.

The main messages are:

Safe abortion is our right
and

Safe abortion is available in government and private health facilities

The target audience intended was the general public.

In the discussion that followed, it was pointed out to this group that this strategy does not meet the needs of illiterate audience and may not be appropriate in states with a high level of illiteracy, especially among women. Also, the message is not customised to meet the differential needs across states, where the reason for non-availability of safe abortion services may vary.

Group 3: Panchayati Raj Institutions (PRIs) and sexual and reproductive health.

The objectives of this campaign were

- Sensitization of PRI so that SRH becomes the priority in their agenda
- To ensure regular meetings by PRI members and SRH issues coming upfront
- Budgetary allocations of SRH services are at par with other allocations

Several potential target groups were identified, including the Gram Sabha; elected PRI representatives; community-based organisation/NGOs; and the PRI department at the state level. The campaign would start with elected PRI representatives.

Communications strategies used will include thematic workshops; training programmes; IEC/BCC.

The feedback to the group was that this seemed more like a programme for awareness raising among PRI representatives, and was not a communication strategy. There had been no thinking through what the specific message was, what the communication tool or method would be and why; and why and how the message was expected to appeal to the target audience – i.e. PRI members.

Group 4: Strategic communication for advocacy on incorporating adolescent SRH in school curriculum

This communication campaign would draw on evidence from

- Research Findings
- Case Studies
- Newspaper Articles
- Organizational Reports
- Television clippings

The audience will be at 3 levels:

- System Level: Ministry of Human Resource Development, Ministry of Health and Family Welfare, Women and Child Development, Department of Education.
- Institution Level: Counsellors, Teachers' associations, Principals associations, Federation of Obstetricians and Gynaecologists' Societies of India, Indian Medical Association, Hospitals
- Community: Family members, Religious leaders, ICDS functionaries, school children, panchayat members, community volunteers.

Message development is based on identifying one crucial issue that is blocking the inclusion of SRH issues in the school curriculum. For example, parents worry about SRH education leading to promiscuity. This is addressed through the message by challenging them to be proactive.

The messages to the community will be:

"Apne bache kee suraksha badhayiye; life skills education kejiye"

"Apne Bachchon ko zimmedar banane ke liye aage aaye"

We believe that this will encourage buy-in from the parents.

Messages at the system level will be: *"Life Skills Education Based school curriculum"* *"UDAAN: Towards a Better Future"*, and at the institutional level, : *"Support the adolescents for building up Responsible Reproductive and Sexual Health Behaviours"*

The methods used will vary according to the audience. At the system and institutional levels, research reports, meetings, newspaper articles, case studies, and model curriculum will be used. At the community level, there will be a campaign through posters, leaflets, street plays, meetings, films.

The feedback to this group was that they should try to address one specific audience at a time, and break down the campaign to its nitty-gritty details, for example the message for system level had not been thought through. The barrier to be addressed and changed through the communication campaign had been well identified at the community level but not at the system level.

15. Using the print media

This session was run by Usha Rai, a well known journalist with more than 27 years of experience in Times Of India and then with Indian Express, and then with the Press Institute of India. Usha Rai's session began with a sharing of her experiences with advocacy on gender and reproductive health.

15.1. Experiences in advocacy with and through print media

While with the Press Institute of India, she had worked with media advocacy on gender and reproductive health. The project was funded by the UNFPA and the Government of India. The project had four major activities: production of a newsletter, running workshops for journalists; offering travel grants, and producing a directory of development journalists.

Two newsletters: "*People*" and "*Hum Log*" were produced to brief the media on issues of gender, population and reproductive health. The two child norm was very much in the news then, and a part of her media advocacy was to enlighten the media that this was against women, against human rights. The bureaucracy did not like criticism of government policy, but the newsletter continued nevertheless. Starting out with 8 pages, the newsletter soon progressed to having 16 pages. The major problem was distribution of the newsletter, so they had most of the stories on the web: www.reportingpeople.org.

As part of the Press Institute's project she also ran workshops with journalists mainly from smaller towns, largely in the Hindi belt. They got journalists for three days at a stretch; paid a small stipend; presented controversial issues such as the impact of the two child policy on women. Every workshop included a field visit. For example, a lot of them had never been to a health centre, and a visit to one was part of one of the workshops. Journalists like a news peg and these visits gave them the opportunity to find new stories. One day during the workshop was a media lab. This was to test out how much they had absorbed, they would be asked to do poster campaigns; skits; radio discussions. There was an amazing amount of talent among them. There was a lot of interaction and people loved it. At least one editor of a newspaper would be on the jury for evaluating these; and prizes were given out.

They had one interesting workshop with editors of newspapers who are responsible for making space for news stories. City editors and resident editors came for a day-long workshop in which the Secretary to the Government of India was also present. They were shown films and given crisp presentations on the new paradigm of reproductive health and rights. The editors did not know about the issue. They believed that population is a problem. There has to be ongoing advocacy on this issue.

The project provided travel grants for journalists to go to different places to cover stories. Those getting a travel grant had to produce at least one or two stories for

People and Hum Log. At the end of three years all the journalists were brought together and they made a presentation of the stories they had published.

A directory of development journalists was published periodically. Journalists in the directory got to network, got access to stories, and got invited to international conferences.

A website has been launched to provide information for journalists who want to write of reproductive health and rights issues. The launch of the website was a media event. The billionth baby came and opened the website along with Mr Nanda, then Registrar General.

After five years with the project, Usha Rai quit the Press Institute and has been working on media advocacy independently. She has been running journalists' workshops which combine information on gender and sexual and reproductive health and rights with actual writing skills.

Her current project is to look at HIV coverage in television and newspapers to see how they dealt with stigmatising. The use of language can add to the stigma and discrimination. Very negative stories create fear and panic. She was preparing a style book for editors and changing press council guidelines on how to report on HIV/AIDS. An ongoing attempt at advocacy was to sensitise news editors, copy editors and desk editors so that headlines do not use stigmatising language;;

15.2. Points to bear in mind when doing media advocacy

Usha Rai made a number of points related to how to engage with media advocacy:

- You cannot do media advocacy in 6 months and 1 year. You have to cultivate the media – various people across various papers – over a period of time. There has to be lobbying within the media for spaces within columns for: development, rural issues and health. You have to work with journalists who have been in it long enough to be able to carve out this space.
- Breaks in funding or closure of a project should not cause breaks in your contact with the media. You have to keep up connections. Call, meet, invite them to your events.
- Every journalist wants an exclusive story. Organise a press conference only if it is a news event. If it is an incident, share it with a national newspaper in your state and one local language major newspaper. Exclusives make it to first pages.
- Run workshops for news editors of local papers, they may be able to come only for a half day or less, but make an important difference to what news gets included and what kind of space it gets.

Box 2. Who is who in newspapers

City editor: City reporters with different beats: crime beat, municipal corporations, functions and events, education.

Special correspondents: cover parliament, central ministries (different ones); political parties, PMO

Assistant editors, editor: They decide on what goes into the edit page and opposite edit page.

Newseditor: Final say for all the news.

Every newspaper has a central room, desk; people sit around and edit and give headlines to all the news. All editors meet every evening to decide which stories go into the front page; the editorial page and opposite-editorial (op-ed) page.

15.3. Group work: Preparing press releases and writing letters to the editor

As part of the session on using the print media advocacy, participants were given two group tasks. One was to prepare a press release of 500 words or less on an issue concerning a teacher not willing to teach two chapters on sex education. The other was to write a letter to the editor about a report in a newspaper that child immunisation rates had declined in India in 2005. After each group presented its work, it was given detailed feedback on what was good and what needed to be changed.

Boxes 3 and 4 present examples of group work.

Box 3. Press release

Silence in the class, shame in the field

On Friday 13th at 4 pm 13 year old Lajo Kumari (name changed) in Maripura was happily returning home, looking forward to the weekend free of studies. Little did she know that the fields that she had played in since childhood would today witness a **violent end to her innocence**. She was forcibly stripped by four boys who were deaf to her cries and pleas.

For these boys not much older than Lajo herself, she was merely flesh to be seen and felt. The young boys were aroused, excited and curious after spending a couple of hours watching porn sites in a local cyber café. They had decided what the teacher did not teach in the classroom, they would discover themselves.

Ironically it was only this year that sex education had been introduced in the school curriculum. But it seems that there is widespread resistance to teaching this part of the curriculum. The school that these boys studied in is no exception. Even near the end of the term the chapters on sex education were conveniently skipped by the concerned teacher. The boys in the class had repeatedly requested the teacher and the principal to cover the syllabus, but were rebuffed. Some had even requested their parents to intervene; but they too refused passing the buck back to the school.

These young boys finding no avenue to satisfy their curiosity decided to find out on their own.

Following the incident the principal of the school **conveniently thrashed** the boys and rusticated them, turning a blind eye to their own responsibility to provide sex education in a healthy environment to these young boys.

Comments:

“Violence ending her innocence” suggests rape. This should be written more clearly. Also, Teacher “conveniently” thrashed is a comment. Cut out the “conveniently” and stick to facts. :...that’s your comment...not the event. End the story with a potential follow-up lead. For example, what is the story in other schools? What happens in the school, to the teacher? Is an FIR filed? These are the ways in which you encourage follow up and continued reporting. E.g. Six months no action on teacher and still school is not teaching sex ed. Set up a debate: Should sex ed be taught in schools? How should it be taught?

Letter to the Editor

Dear Editor,

This is to draw your **kind** attention to two news items dated May 16 and May 23, 2006 published in your **esteemed** newspaper regarding the initiatives of the state government of Madhya Pradesh to address maternal and child health.

Doling out economic incentives to dead mothers does not aid those alive. Providing women Rs 1000 for institutional deliveries ignores the complete inability of the state government to provide such institutions. The loud claim of reduction in proportion of malnourished children does not state the time period during which this reduction was achieved. The state should stop treating its people as poor subjects waiting for its prescriptions and money. It is time that the state understands the complex reality of people's lives and performs its role of creating the infrastructure and conditions that improve the survival chances of the mother and her child.

Comments: Cut out 'kind' (attention) and 'esteemed' (newspaper) in the opening sentence and go straight to your points. Also, cut out the commentary, make it more crisp and to the point..

15.4. Points to bear in mind when writing for newspapers

Preparing a press release

- Not very sensational headline
- Headline has to be information (news)
- Potential for a few stories from the main story
- Give contact information for additional information (for journalists to get in touch)
- Ring journalists, meet them
- The press release should be as comprehensive and complete as possible for printing
- News items should be limited to event and fact, comments should be minimum (or none)
- No questions in a press release
- Change names protect identity
- Careful use of words: molest can mean rape etc. loss of innocence can mean rape

Writing a letter to the editor

- Start with an affirmation of the article
- Make your main point in the beginning
- Don't run down an article
- Use opportunity to plug gaps, provide information
- Don't end with questions
- Avoid jargon
- Keep it to the point (word limit 100-200)

15.5. Can the print media make a difference?

The session ended with a power point presentation by Usha Rai with stories of how media had made a difference to changing situations that affected the health of women and men.

There are several examples to illustrate the positive impact of media coverage of socially relevant stories. Four such stories were included in the presentation.

Use of bicycle pumps in sterilisation camps:

Journalist Sreelata Menon wrote a news story about Bimla, a 28 year old woman from Ferozabad, who underwent laparoscopic sterilisation in a camp. She felt miserable for weeks. Her two sides were swollen. In the Usayini camp where she underwent surgery, cycle pumps were used to push in air into the stomach of women so that doctors could get a clearer view of their insides to do the ligation. Air is pumped into the woman's insides after she is given an injection of local anaesthesia.

Sreelata's story was not accepted by the Indian Express, but was published in the Press Institute of India's publications *People* and *Hum Log*. Rashme Saxena of *The Week* saw the story and did it for the Malayala Manorama group of publications. Many more people saw the story and reacted to it. The case was taken up *suo moto* by the National Human Rights Commission after the case was raised in Parliament. Sreelata went back to Usayini several months later and saw that they were no longer using cycle pumps.

Media and women's groups ensure ban on quinacrine sterilisation

Quinacrine, the anti-malarial drug, was being used in West Bengal as a method of non-surgical sterilisation. Seven quinacrine pellets were placed deep in the uterus with the help of an intra-uterine inserter. Quinacrine is a sclerosing agent and forms scabs in the uterine lining and blocks the inner ends of the fallopian tube preventing fertilisation.

In 1994, the World Health Organization had advised that quinacrine sterilisation be stopped immediately because it had not been approved by any national drug regulatory authority in the world. Quinacrine sterilisation could trigger off cancer and health hazards such as ectopic pregnancy.

Dr Biral Mullick had used quinacrine sterilisation with 10,000 women in West Bengal. Women and health activists opposed these illegal and unethical trials. The media in West Bengal, including *The Telegraph* kicked up a furore in West Bengal. A public interest litigation was filed by the All India democratic Women's Association and the Centre of Social Medicine and Community Health. In August 1998 the Drug Controller of India banned Quinacrine Sterilisation under section 26A of the Drugs and Cosmetics Act, as he found the method likely to 'involve risk to human beings'. Within three months of the Indian ban, the USFDA issued strictures

that the malarial drug should not be imported, manufactured or exported for female sterilisation.

Sex-selection portrayed on television

In May 2002 a popular tele-serial “*Kyunki Saas Bhi Kabhi Bahu Thi*” broadcast an episode in which a couple conduct a pre-natal diagnostic test to determine the sex of the foetus. The doctor says “*Congratulations, it is a boy!*” A complaint on the blatant manner in which sex selection for a male child was being portrayed by Balaji Telefilms was made by two NGOs – MAUM and CEHAT – to the Maharashtra State Commission for Women. The Commission issued a contempt notice to the producer of Balaji telefilms and the CEO of Star TV which telecasts the serial. They were asked to apologise for the error by telecasting a social message depicting the consequences of the misuse of these tests for five consecutive days.

Rat faeces and hair in food samples from godowns

The Prevention of Food Adulteration Act 1954 and Rules 1955 allow pulses and cereals to contain five pieces of rat droppings and hair per kg. When Kalpana Jain of the Times of India was investigating this story, officials in the Union Ministry of Health tried to justify it saying “*if we do not allow a few droppings, all samples will fail*”. When members of the Central Committee of Food Standards tried to intervene, they were told that removing the garbage would lead to enormous problems. All the Committee was able to do was to disallow the rule from being extended to other food items

The story was reported in the *Times of India* and had an immediate impact on all those for whom wheat was the staple diet. The media furore caused the Union Ministry’s Committee on Food Standards to amend the rules to make it explicit that wheat flour and wheat products had to be free of rodent contaminants. Food Inspectors were supposed to inspect food to ensure that standards were met.

The media covers and should cover socially relevant stories for two reasons. First, they are good stories. They speak for the common man/woman and attack the powerful. If well written they help build up a reputation for responsible reporting.

Second, the media should report socially relevant stories because they matter enormously. A very important role of the press is the defence of ordinary people against abuse, neglect and exploitation from those in authority.

Stories of abuse and exploitation, which shame us as a nation, emerge because dedicated reporters seek them out. Activists bring them to light, but they depend on journalists for publicity, which might persuade errant authorities to mend their ways. Journalists must be the conscience of the nation.

16. Developing and using communication tools for community mobilisation and advocacy

This session was facilitated by Lakshmi Murthy from Udaipur, Rajasthan. Lakshmi is a graduate of the famed National Institute of Design, and a communications and designs expert by training. The session introduced participants to examples of a range of communication materials that Lakshmi has developed, and through a discussion of the features of these materials, led them to understand essential principles in developing communication tools for community mobilisation and advocacy.

16.1. Myth of the universal symbol

Lakshmi started the session with an exercise : all participants were given a sheet of paper. On one side were pictures, and participants had to write below these pictures what the picture meant to them. On the other side of the paper were words, and each person had to draw something that depicts that word. The results showed how differently different people perceived the same things, or depicted the same things.

Lakshmi then shared how she discovered the myth of the universal symbol through her attempts to develop communication materials for rural people in Rajasthan. She found that many of her drawings were not working for people in the community. This inspired her to listen and learn from the local women and men about symbolic representation, and to involve them in developing communication materials.

For example, when developing a poster about the need to cover one's water pot, she had depicted one open pot with a cross, and beside it a closed one with a tick. But women thought the cross was a wooden stand to put your water pot on it. In another poster communicating gender equality, a boy and a girl are shown running and there is a balance beside them. Viewers thought that the boy and girl were running to the grocer's shop. In another instance, a talking bubble was interpreted as a tree. Lakshmi soon learnt that reading from left to right and from top to bottom are a literate society's constructs.

16.2. Examples of communication materials that educate as well as empower

Lakshmi shared examples of several communication materials that she had developed. There were included audio-dramas on adolescent sexuality and on men's sexual health (night emissions in men) which were to be used as discussion starters. There were a number of visual aids and tools for working with young people about sexual and reproductive health. Two characters of a young man and a woman, *Sundar* and *Sundari* had been created. There was a body booklet showing different body systems including the reproductive system and outlines of male and female bodies in different sizes which were to be filled in by young people in workshop or classroom settings. They start with eyes, nose, and come to yoni and ling, they hesitate and then get used to saying it. This empowers young people to talk about their sexual and reproductive health problems normally, and overcome shame about their bodies.

There were story boards and cartoons on abortion, conception, menstruation, various contraceptive methods and so on, developed for different audiences in local languages. All had drawings developed by local people and used local forms of visual representation, and were attractively produced.

16.3. Principles of communication

A great deal of thought has to go behind developing a communication message for the community. Consumer goods companies invest a lot of money and resources on research to sell their products to people who haven't tried their product for 15 years but are motivated to do so. Similar effort is needed also to develop social messages.

There are five *mantras* for communication

- *maidan*: research and understand the context
- *dhyaan* and *kaan*: pay attention to audience, keep ear to the ground
- *pechchan*: identify the strategy that would be best
- *jaan*: put passion into planning
- *Abhiyan*: design the campaign

There has to be research about the context, clarity on who the message is for; understanding of the characteristics of target audience; a suitable communication strategy; passion and conviction in the messages, and systematic dissemination of the message through a campaign. The purpose of such communication would be not only to educate, but also to inspire and empower. By involving the users in content and design of the materials, the audience is empowered.

Ensuring effective communication

Communication often fails because of assumptions such as

- One size fits all –. The trend is generally to have a single communication material for several states. There are practical problems such as cost and time involved, and we have to strike a balance between the need to be specific, and to also have timely and cost-limited material.
- There is disconnect between the urban-educated designers of materials and the receivers of the messages who are rural, often illiterate villagers.
- Lack of participation of users: The designers of communication materials and/or programme managers should take on the role of facilitators who encourage people's own visual expression, finding common visual languages and finally producing visuals that are responsive to the needs of the target audience.

To communicate effectively, it is important to

- Have an audience-centred strategy
- Keep visual literacy in the centre
- Integrate the community's contribution into media design

Based on these principles, the following are some steps in the design process:

- a) Field test existing communication products
- b) Discuss with target audiences and find solutions to resolve any communication gaps
- c) Conduct drawing sessions with the target audience to develop a pictorial dictionary of visual representations
- d) Integrate rural images into media design
- e) Field test integrated designs with target audiences
- f) Revise as needed
- g) Repeat field visits and revisions as needed
- h) Final prototype is developed

16.4. Where does development of communication materials fit into the advocacy process?

All advocacy efforts include message development. This where development of a strategy and materials and tools for communication to communicate the message most effectively comes in.

The same tool can be used just an educational tool in one setting and a powerful advocacy tool in another setting. It is the process of using the material or tool, and the audiences and purposes for which it is used that makes it an advocacy tool.

For example, the communication materials on sexual and reproductive health – may have been used only to give information. But the process designed is one of involving adolescents in self-discovery and helping them articulate their questions and concerns. Through this, you are able to influence them positively. Two, by involving parents in the process of designing the materials you break the barriers with the parents. Three, you make the matter “discussable” in the community; and influence school teachers to think that teaching about sexuality is not impossible but do-able. You can convince policy makers that we can carry out sex education in an acceptable way.

To give another example: how the making of low-cost sanitary pads fits into an effort of advocacy. If you just gave information, it would be Information Education Communication. If the girls start using the pads, it is Behaviour Change Communication. If this is used to make the point that girls need sanitary protection and that it is possible to do so at low costs and acceptable means, and get government or UNICEF to provide it as part of its programme, that becomes advocacy. If the same material is used to mobilise the community to demand action on the part of government, then we have used the communication tool for community mobilisation, or in other words, advocacy at the community level.

The following are some *principles of communication for community mobilisation*.

Format

- Communication tools should allow for two-way communication and interaction
- Words used should be carefully chosen, and for illiterate population, there should be no words at all
- It is important to give practical stories
- Field-testing of all materials prepared is a must.
- Pictures drawn need to take into account the community's ways of visual representation of the subject
- The physical product should be compact and not consist of too many loose pieces.
- Materials need to be well thought-through, and based on formative research carried out in the community

Content

- Materials should seek to inspire, empower and convince (and not focus only on convincing people or changing behaviour)
- Communication materials intended to be used for advocacy need to address power centres in the community (PRI leaders, men etc.)
- The content should not be prescriptive, but give its audience information that will enable them to make their own decisions
- Materials should seek to increase awareness of the affected groups by
 - discussing barriers to change
 - helping them identify various factors and actors involved, and
 - informing them of their entitlements

16.5. Group work: Designing a product to advocate for Emergency Obstetric Care at the Community Level

Participants were then given a group task to design a product that would help in advocating for emergency obstetric care at the community level. The profile of participants was as follows: The men in the community and husbands of pregnant women had an average eight years of schooling, the mothers, mothers-in-law and the traditional birth attendant were illiterate, and the women themselves had an average of five years of schooling. Members of Panchayati Raj institutions were mostly high school graduates.

Group 1: Addressing leaders of Panchayati Raj Institutions (PRI) and community leaders

This group had developed a product with the objective of getting PRI and community leaders to become aware of the kind of delays that women experience in getting emergency transportation.

The group designed a “snakes and ladders” board game.

Ladder 1: Dai says to husband bring vehicle

Ladder 2: Husband arranges for money

Ladder 3: Driver is ready

Ladder 4: Driver knows the way to government hospital

Ladder 5: The bridge en route has been kept in good repair, and they can go.

Snake 1: The vehicle is in disrepair/ is not available for use

Snake 2: Driver is drunk

Snake 3: Driver asks for too much money

Snake 4: There is no diesel in the vehicle

Snake 5: The road is damaged, can't move forward

The panchayat president can ensure that a vehicle is available; keep the roads in good repair; ensure that services are available. They can also talk about emergency obstetric care in village meetings.

Comments: The product has potential for starting discussion on the role of PRIs in emergency transportation. The board game has to be part of a larger campaign or effort to ensure that action follows awareness. Getting adult men and women to play a board game and ensuring that there is detailed discussion of what to do about the “snakes” – the many barriers to quick emergency transportation- would need good facilitation skills.



Group 2: Addressing the pregnant woman

This group worked on developing a product for interpersonal communication with the pregnant woman. The product was chart shaped like an envelope which opened out on four sides. A danger signal in pregnancy was depicted on the outer side, and when it was opened out, there were the following messages:

- Go to the hospital immediately
- Make a birth plan
- Put money aside
- Make sure your husband or someone is there to accompany you
- Identify an ambulance service;



When presenting its product, the group role played a health worker speaking to a pregnant woman one-on-one.

Comments: The product is excellent, but was used for one-way communication. This was not the best use of the material. There was no scope for discussion, and to find out the reasons why the woman may be unable to access emergency obstetric care. Power hierarchy between women and the health worker is reiterated. Advocacy is making sure that there is increased demand, that it is their right to access; her lack of agency and voice is a problem. Probably the use of this material with a group of women would be useful to discuss how they may be able to birth planning, putting money aside etc. as a group of women or as a community.

Group 3: Addressing men and specifically partners of pregnant women

A set of flash cards to generate discussion among a group of men was the product made by this group. The product was intended to help men find solutions themselves at the end of the discussion.

The flash cards depicted: a man taking responsibility for finding emergency obstetric care for this wife; a man feeling helpless and drinking, running away from the problem; a man playing cards and not taking responsibility; and the absence of the pregnant woman's husband because he was a migrant labourer.

The discussion would encourage them to think how they would plan for the possibility of emergency obstetric care, how they would take matters into their hands through prior planning. For example, to plan for where to access emergency transportation; arranging for child care; for money, and so on. The discussion would also want to convey that community members can help, it is also their responsibility.

Comments: These cards are useful as discussion starters. It may be good to have other written material that one can leave behind: pamphlets on danger signals, or those with contact details of institutions where EmOC may be accessed, and so on. It is important to involve women; but we need to think through how to do this without disempowering women and handing over all control to men.

Group 4: Addressing traditional birth attendants (TBAs)

The product designed by this group was a poster with three pockets. Each pocket contained flash cards. The product was meant to be used in meetings with TBAs. Its aim was to highlight TBAs' role in emergency obstetric care.

The three pockets in the poster were labelled: Preparing for birth; identifying danger signals in delivery; and avoiding three "delays" in emergency obstetric care.

The pocket labelled "preparing for birth" contained cards portraying Putting aside money needed; identifying referral institutions in case of emergency; motivating the woman and/or her family to prepare a safe delivery kit; and ensuring that the woman will have someone at home during the days when delivery is expected, and identifying suitable means of emergency transportation.

Danger signals depicted in cards included absence of foetal heartbeat; convulsions; prolonged labour; antepartum hemorrhage and abnormal presentations.

The three delays pocket had cards depicting delay in decision to seek care; delay in reaching the appropriate level of medical care; delay within health institutions in initiating definitive treatment.

Comments: The product is attractive and would stimulate discussion. However, the design of the product, with several cards in pockets, is not very appropriate for community-based use. The cards could get lost, there are too many things to manage.



Some of the participants felt that the product also talked down to the dai, upholding only scientific obstetric knowledge and not validating the dais own knowledge. Also the message that the dai should refer early to avoid delay does not take into account the fact that no hospital respects the dai's referral and may even blame her for any problems. The messages should be developed take into account dais' perspectives, addressing the barriers that prevent her from doing her job effectively, and finding solutions.

Group 5: Addressing mothers and mothers-in-law

This was a poster to start discussion with mothers and mothers-in-law. Its messages were that mothers and mothers-in-law – women in the community- should get organised to demand that health facilities function well, and enable effective emergency obstetric care. The poster also depicted the pregnant woman being relieved of her work load by the mother-in-law.

Comments

Given the earlier session on there being no universal visual symbols, such posters could be interpreted in a wide variety of ways by the audience. To develop a poster on the role of mothers and mothers-in-law, one might work with a group of community women who are themselves mothers with married daughters and mothers-in-law, develop the messages to be communicated and also get these same women to come up with the visuals that convey the message. Material developed in this way may be pretested and then used in other villages as well.

Module 3. Planning for Strategic advocacy

The last two days of the course were dedicated to consolidating the learning during the previous week and applying it to develop an advocacy plan that participants can implement in their work setting.

17. Consolidating our learning

The second-last day of the course began with a series of presentations consolidating what had been learned about essential steps; communicating for advocacy; and prioritising issues and developing strategies for advocacy.

17.1. Essential advocacy steps

Renu summarised the work done during the past eight days by presenting the “Essential steps for advocacy”.

Step 1: Situational analysis

Situational analysis would consist of two parts, one is assessing the factors affecting the advocacy issues at hand, and the second is to identify the actors who are involved and need to be addressed through the advocacy.

Assessing the contextual factors

- examining the political, economic and social contexts
- looking into the programme and policy context
- collating available evidence in order to identify if we need to invest on gathering essential evidence
- frame issues in terms of rights violations

Identifying stakeholders

- identifying actors likely to support and those likely to oppose the advocacy effort
- assessing the skills and resources necessary and identifying people who will be able to provide these
- identifying people who will be able to help fill in the gaps in resources and skills

Renu used the example of an advocacy effort being planned by SAHAJ in Baroda, which has been working with shelter issues, organising slum dwellers; working on housing and the right to education. The organisation recently began engaging with health issues among slum-dwellers.

Situational analysis shows that there has been rapid urbanisation in Baroda, with increasing in-migration. Thirty per cent of the urban population are poor. There appears to be a nexus between real estate “developers” and politicians, with the poor

being displaced from the centre of the city to give way to the building of malls and multiplexes.

In Baroda 14% of the slum population live without water or sanitation. Health service coverage indicators are worsening. The urban poor are spending a lot of money, not accessing public but only private health facilities most of the time. Not enough is known about how reliance on the private sector affects access to maternal and child health services for the urban poor in Baroda.

The Jawaharlal Nehru urban renewal scheme and RCH-2's component of urban health offer policy opportunities for intervention among the urban poor.

Step 2: Identification of advocacy issues

This includes having clarity on the change one seeks to bring about, and taking the next step towards clearly articulating the advocacy issue. The 'advocacy issue' would depend on the solution or pathway through which the change is planned to be brought about. For example, one may want to prevent adolescent pregnancy; this may be the change one seeks to bring about. However, the 'advocacy issue' may be life skills education for adolescent pregnancy, or enhancing the availability of contraceptive and abortion services for adolescents.

When identifying advocacy issues, it is necessary to think through who the advocacy is aimed at; who are the advocates; and on whose behalf advocacy is being carried out.

In the example of SAHAJ's work in Baroda, the change they are seeking to bring about are:

- a) increased awareness of right to health in the community
- b) putting urban poor's health needs on the policy and programme agenda

They seek to advocate with three groups of people:

- The Municipal Corporation: The Commissioner, the health officer, the corporators;
- The community: Community-development committees, Bal samithis, adolescent peer educators
- Service providers: Doctors and paramedical workers within the public sector and private sector health care providers, formal as well as informal

Advocacy is being carried out on behalf of residents of 15 bastis, with their participation.

Step-3 Planning strategies and activities

This would involve, among other things, refining one's information-base on factors and actors, and beginning to develop communication with those at whom advocacy is

aimed. It would be best to adopt an advocacy strategy that combines a balance of consensus-building, negotiation and confrontation. Decisions will have to be made on which of those involved will adopt each one of these strategies respectively.

Strategising also involves identifying allies and their strengths, and establishing links across various groups including those involved in related issues. For example, those involved in the *Narmada Bachao Andolan* have gone beyond just the one series of dams to form alliances with all struggles of people affected by displacements.

The other requirement is to identify 'potential' allies, figure out what is needed to bring them in, and take necessary steps for doing so. For example, one can carry out advocacy from within the medical profession, and expand spaces within the profession and win a number of new advocates for the cause.

In the SAHAJ example, allies that one can count on include the Preventive and Social Medicine Department of the Baroda Medical College and Women's health Training, Research and Action Centre (WOHTRAC) of the MS University in Baroda. Potential allies may be United Way of Baroda, which is a citizens' group, *Jan Swasthya Abhyan* of Baroda, and People's Union for Civil Liberties. There is a federation against displacements, which is also a potential ally that may help expand the scope of the campaign.

Opposition may be expected from Baroda Municipal Corporation; Health Officers; Private practitioners. However, within each of these categories we have to identify allies. The media and Health Committee of the United Way may be expected to be neutral.

Step-4 Implementing activities and tracking progress

A clear, time-bound plan of activities may be developed with inputs from all concerned, responsibilities allocated and accountability mechanisms put in place. Accountability mechanisms may take the form of regular meetings and reporting to the larger group involved in advocacy, and setting up procedures for consultative and yet timely decision-making.

SAHAJ plans different activities for the different audiences at whom advocacy is targeted. The Community Development Committees and peer educators may be engaged in participatory action research on health facilities. Bal samitis may organise right to health care debates like the right to housing debates they have always done. Peer educators can also do *nataks* on right to health.

WOHTRAC and PSM department are best placed to call a meeting of corporators and Health officers. Three meetings may be organised. In the first meeting we will present evidence on the health situation and especially maternal and child health status in the selected slums based on participatory research and PSM department's research findings. A panel with municipal corporators, PSM department faculty and community development committee members may do this. Based on this meeting, SAHAJ would like to build consensus on what is the one thing that we can do jointly.

The second meeting may be after 7-8 months to review progress, register appreciation for efforts made till then and planning for upscaling. The third meeting could be held after further reviews of the upscale.

Other activities would include lobbying with the mayor and corporators, working with the media to highlight both the problem and the actions being taken to address these problems.

Tools used would include a poster, a generic power point presentation which includes health status of the urban poor in Baroda; media briefs based on studies and stories; Press releases and letters to editors;

Indicators will have to be developed for use at different stages: Input indicators; process indicators and output and impact indicators. Process indicators in the SAHAJ example would be: actions taken by the CMD, community others to make visible the health needs of the urban poor; campaigns launched as a result of study findings; number and kind –diversity and quality- of press coverage. We should be more concerned with results-based monitoring. Outcome indicators would measure: What improvements have come about in terms of access to maternal and child health care? In terms of health outcomes, e.g. decline in proportion of untreated morbidity. What are the kind of changes that have occurred in the quality of care?

Step 5- Evaluating advocacy efforts

Evaluation of the advocacy effort needs to happen around multiple dimensions. Some of the fundamental questions relate to the advocacy process, to answer the question: was it a rights-based process?

Some questions to ask in relation to this would be:

- Was the constituency – the group affected by the issues - part of the advocacy efforts? What was its role during different phases of advocacy?
- Did the effort address specific rights' violations?
- Did power relations change as a result of the advocacy effort?
More specifically, how did the content and process of the advocacy efforts see women and men? Were gender equations within the advocacy efforts, and in the larger society with respect to the issue addressed? Altered?

The next set of issues relate to the extent to which advocacy was grounded in evidence.

- Was adequate research and analysis built into the advocacy?
- Was the campaign sufficiently fine-tuned and proactive with respect to larger changes?
- Was new ground broken, new knowledge created?
- Was the analysis of the original issues reformulated?
- Were advocates able to project themselves as informed, authentic and credible?

Long-term sustainability is another dimension on which evaluation is important.

- Did the advocacy effort create processes for long term sustainability?
- Were horizontal and vertical linkages made across different groups?

17.2. Essential principles of communication for advocacy

Using the same example of SAHAJ's advocacy plans for improving maternal and child health in Baroda's urban slums, Vijaya revisited the principles of communications for advocacy.

After one identifies the target audiences at whom advocacy is aimed, one then begins to think of suitable communication strategies for each of these groups. For example,

- Dept. of urban development of the Baroda Municipal Corporation : One can use policy briefs
- Urban poor : Posters, street theatre, community meetings, debates by Bal samitis
- Fence sitters/opposers: Power point presentations with convincing arguments to win them over
- Media: Press briefings to create wider publicity

One might decide to include only some of these elements for strategic reasons.

Choice of the above communication strategies is based on the following essential principles:

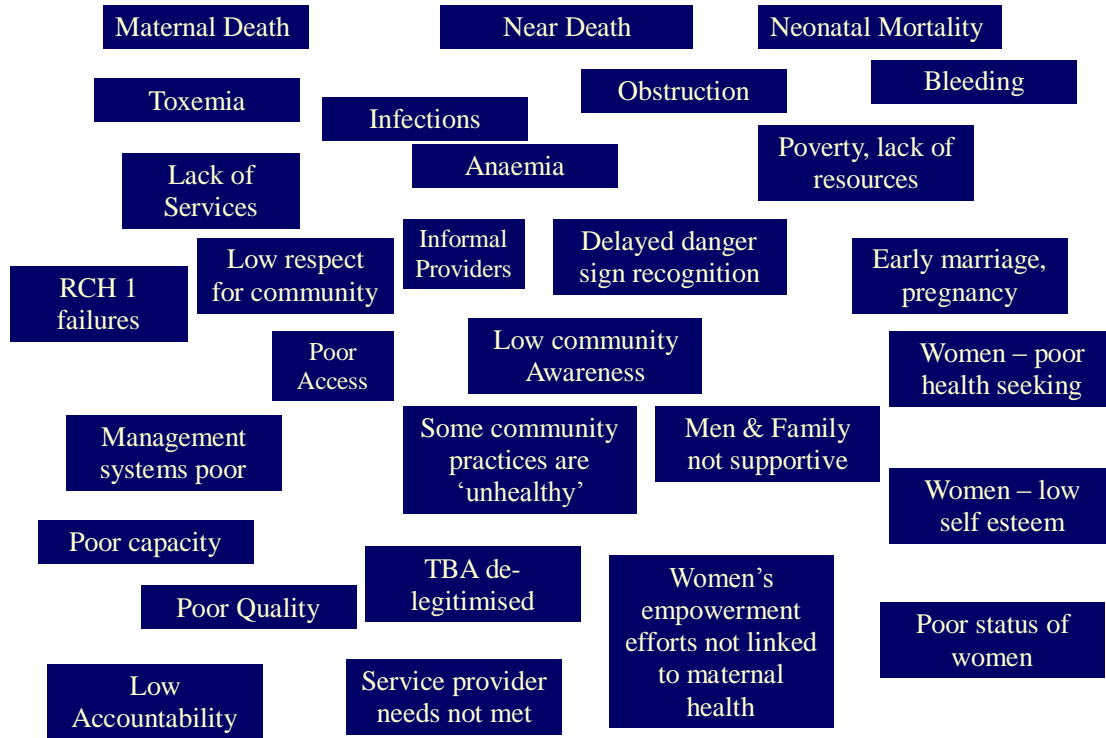
- Characterise your audience (literacy, media habits, age, where do they hang out)
- Find appropriate media
- Use evidence/case studies to illustrate your message
- Identify language/visuals that are appropriate (making one line from a body of research, visually challenging norms)
- Include follow-up action where appropriate: (helpline, referral centres, linking up with government services)
- Assess impact of communication effort (no. of articles, no. of referrals)

17.3. Essential principles for identifying advocacy issues to be addressed

The last part of the consolidation of learning dealt with the complex issue of how one would zero-in on a specific advocacy issue from among several related problems. This helped fill-in details within advocacy steps one, two and three mentioned by Renu in the earlier session.

Abhijit used the example of issues related to maternal death, near misses (of maternal death) and neonatal death to illustrate how this may be done.

Fig. 4 Issue Identification



There are a wide range of factors underlying maternal deaths, and each factor has several related actors. One of the first things an advocate or an advocacy group does is to identify a set of factors which they consider as core issues. These then have to be taken through further analysis.

For example, let us assume that we consider poor status of women; and poor access and quality of health care as the core issues.

Then go through the first advocacy step: what is the nature of change desired? Who are the target audience at whom advocacy needs to be aimed, in order to achieve this? Before taking a decision on whom the target audiences for advocacy will be, a few more steps of analysis are needed. We have to analyse

- Is advocacy possible on this issue?
- Do vulnerable groups benefit?
- Is it possible to involve the affected in advocacy?

(See table 3).

Table 3. Framework for identifying advocacy issues

Issue/Change desired	Criteria		
	Is advocacy possible on this issue?	Do affected groups benefit?	Is it possible to involve affected groups in advocacy?
Community			
Women taking charge of health care decision-making			
Health care delivery system			
ANM makes regular visits and starts staying in the sub-centre			
Law/policy level			
Support for improving TBA skills and including her as part of the health care delivery chain			

After having selected the issue(s) to focus advocacy efforts on, a political analysis of potential allies and sources of opposition would help evolve strategies and activities for advocacy. List all actors involved, and classify them in one of the following categories: Support – high, medium or low; Opposition – high, medium or low; and the unmobilised.

Following the above assessment on the extent of support and opposition, one would opt for issues that are relatively easier to win. If the extent of opposition is high for all issues chosen, would have to contend with for the issues selected, one may want to go back to the drawing board and select issues that may be relatively easier to win.

17.4. Developing rights-based advocacy plans

After the sessions consolidating learning on advocacy, participants were divided into groups according to their regions and interests. Each of them worked individually on developing a plan for rights-based advocacy, which they will be able to implement as part of their work. This was intended to be an exercise in applying what participants had learnt during the course. Each group was assigned at least one resource person with whom participants could bounce off ideas, in addition to inputs and feedback from peers within their group.

The task given to them was as follows. They had to define the problem, carry out a situational analysis and identify actors and factors that they need to take into account. They then had to select three actors who they will direct their advocacy activities at, after carrying out an analysis of support and opposition by different actors. For each actor selected, participants had to develop activities in order to bring about the change you desire, keeping in mind risks and resistances.

Their plan had to describe how they would build and support alliances for the change they wanted to bring about, and identify indicators for assessing progress in their advocacy efforts.

Throughout their plan, they had to keep in mind the following:

- Ensuring that marginalised voices are represented
- Basing their work within a rights framework
- Ensuring adherence to ethics, and integrity in all their activities

18. Concluding session

The concluding session consisted of a number of leave-taking activities. The session started with the 'Back Pack' exercise. Each person had a paper pinned on to his/her back, and everyone in the group had to write one positive comment on the person on this paper. With everyone writing on everyone else's back, the group soon started looking like a human train. Many said that the positive comments from peers received at the end of ten days of staying and working together felt like a valuable 'certificate'.

The back-pack exercise was followed by feedback from facilitators and sharing by participants on what they felt.

18.1. Participants verbal feedback on the course

- *Advocacy is a kind of lever; you have to find out where to put the fulcrum, what level of power to move what weight. Collect background information and decide on these.*
- *I was able to revisit scientific knowledge, question what I am doing. I have gained, more energy, more confidence, more support. I am reaffirming that wherever I am located, is a very powerful position for advocacy. I will advocate within the system.*
- *I came with no knowledge of advocacy; thought I will learn skills. I realised that advocacy is not very easy, there are many big theories around it. Worked out that we will be able to work with NGOs and apply many of these principles. Lot of work has gone into preparing for this training programme. Learning involvement has remained undeterred till the end. Interface with so many resource persons has been a major opportunity. All participants were very co-operative. All were eager to learn.*
- *I liked the environment, especially willingness to change in response to comments from participants. Human interaction was very good, as independent researcher I felt connected with so many people.*
- *Now I have learned a lot on advocacy. We were taught step by step, component by component. We used the term superficially before. We realised why our 'advocacy' efforts were failing! No analysis. Re: participants, we usually go to places with one particular constituency; this one brought people across sectors: doctors, government and corporate, NGOs and researchers. What is the follow-up in future? We have become such a nice group. Our organisers have to think about it. What will be networking in future? They have to tell us. What will happen when we go back? Will we able to implement what we have learned?*
- *I don't know what I have to say. When I was selected for the workshop, I was asked why I wanted to attend. I found that many things I am doing in the field were at least in part advocacy. That I could do this in a more organised way if I came to the course. I see these ten days only as a beginning. We will learn more when we continue to communicate, by e-mail.*
- *I came on my own. Took casual leave. I am thankful to have been converted into a rights-based advocate, in addition to gender-sensitive doctor.*

- *I have a lot to say and nothing to say. I have had a new experience in this workshop. Kept sleeping later and later. There was too much happening in my head. This workshop should have happened 10 years ago. I want to go back from here and do so many things. Resource people were north pole and south pole: very flexible as well as very rigid. I am both of these now.*

Participants then wrote detailed written evaluations of the course, the key findings from which are summarised in below. Certificates were given out, and plans for setting up a listserve were made.

18.2. Summary of participants' written evaluation of the course

Overall, 23 participants submitted written evaluations of the course. Table zz below summarises participants' rating of achievement of course objectives and appropriateness of methods used. Almost all participants (22/23) rated the objectives of the course as having been completely met (9) or mostly met (13/23). Of methods used, discussion were rated as most useful (20/23), followed by group work (18/23) and exercises (15/23). Reading materials and presentations by external resource persons were rated as most useful by 13 of 23 participants.

Table 4: Summary of participant evaluation about content and methods (n=23)

Objective	Met completely	Met mostly	Not met adequately
Build conceptual clarity on rights-based advocacy in sexual and reproductive health and on the need for such advocacy	10	13	0
Get in-depth understanding of the present scenario in sexual and reproductive health and rights: policies, evidence and debates	9	13	1
Understand the process of social change: what factors and actors are involved to change opinions, policies and practices	8	14	1
Orientation on essential advocacy skills:			
▪ Using and building evidence	15	8	
▪ Analysis of the political, economic, social context and identification of problems/stakeholder analysis	10	13	
▪ Communication for advocacy	10	13	

Table 4: Summary of participant evaluation about content and methods
(continued)

Objective	Met completely	Met mostly	Not met adequately
▪ Advocacy approaches with different groups – PRI, media, community etc.	7	16	
Methods used	Very useful	Useful	Not useful
Discussion and presentation	20	3	0
Group work	18	5	0
Exercises	15	8	0
Reading and resource materials	13	9	1
Presentations by external resource persons	13	9	1

A majority of participants found the following sessions most useful: sessions on advocacy concepts, rights-based advocacy and media advocacy, Abhijit's open-discussion sessions, and sessions on analysis of context to identify multi-level factors and actors. The most popular session was that on media advocacy by Usha Rai.

There were a number of suggestions for adding to the content of the course or modifying/improving on sessions that were included in the course. Several participants suggested that policy analysis be added to the content, and that there needed to be a session on ethical issues in advocacy. The need to spend time on finding and evaluating evidence to be used for advocacy were pointed out by some. Other suggestions for topics were leadership skills, group dynamics, specific skills needed for advocating controversial sexual and reproductive health issues, overcoming resistance to advocacy, and introduction to case examples of successful advocacy for sexual and reproductive health and rights at the international level. One participant felt that at least a few sessions needed to focus on the need for advocacy specifically in the area of sexual and reproductive health, and that there should have been a presentation on why the Coalition for maternal-neonatal health and safe abortion had been formed (in terms of its advocacy role). One person pointed out that there was no session on advocacy for neonatal health because the scheduled speaker was unable to come.

More than one participant felt that sexual and reproductive health and rights issues had not been dealt with in depth; that lobbying skills and community mobilisation skills needed separate sessions.

Suggestions for possible sessions or activities were that some films that were not directly relevant be excluded; and that the number of case-studies be cut down; and

that there be a direct link between conceptual sessions and case study presentations by resource persons. Some felt that case-study presenters tended to use one-way communication, which limited attention span although the case studies were in themselves very rich and interesting. Another comment was that sessions on communication skills by Vijaya and developing communication materials by Lakshmi Murthy be combined into one cohesive session. The value of time spent on developing individual advocacy plans was not clear to a few participants.

Time-management and overcrowding of the schedule featured in the evaluation by several persons. Participants noted that some sessions in the first couple of days went way beyond the time allotted, resulting in dropping off other scheduled sessions. Many participants felt that they needed time to reflect on, discuss and clarify concepts; that time needed to be allocated to make clear links between case study presentations and conceptual sessions; and that each day should close with a summing-up of the day's sessions.

All participants stated that they would recommend the course to others, and many suggested that the course be run regularly:

“the course gives conceptual clarity, perspective, sensitivity, and builds confidence. It empowers us (to carry out advocacy)”

... (the course) helps to change mindsets, encourages humility about our own power positions, helps to keep rights and power dynamics central to our work and lives..”

“we need to (continue the course)..build up a cadre of sexual and reproductive health and rights advocates”

“Excellent for making one's efforts for change more effective”

The course ended with a visit from members of the Packard Foundation and their advisory committees. The meeting served as an opportunity to introduce the Coalition for Maternal-Neonatal Health and Safe Abortion to members of the Packard Foundation and their advisors who are active in the field of sexual and reproductive health and rights, and to share with them our plans for capacity building for advocacy at the ground level.

Annexures

Annex 1

Agenda

Date and Time	Session	Objectives	Reading	Resource person
September 14,2006 5.30 – 7.30 p.m.	WELCOME AND INTRODUCTION	<ul style="list-style-type: none"> • Introductions • Orientation to Objectives and Design of the Course • Orientation to Resource Material • Key Note Address <i>Advocating for Sexual and Reproductive Health and Rights</i> 		Renu Khanna Abhijit Das Dr. Prakasamma
September 15,2006 9.00 – 11.00 a.m.	MODULE 1 BUILDING CONCEPTUAL CLARITY			
	Session 1 <ul style="list-style-type: none"> • Concept of Rights 	<ul style="list-style-type: none"> • Different kinds of rights • History of rights discourse 		Abhijit Das
	<ul style="list-style-type: none"> • Sexual and Reproductive Health and Rights 	<ul style="list-style-type: none"> • Sexual Rights • Reproductive Rights • Sexual Health • Reproductive Health 		Renu Khanna
11.30 – 1.00	Session 2 <ul style="list-style-type: none"> • Right to Health 	<ul style="list-style-type: none"> • Right to Health • Right to health care • General Comment 14 • Rights related to Maternal Health 		Abhijit Das Renu Khanna
2.00 – 3.30	Session 3 <ul style="list-style-type: none"> • Concept of Advocacy 	<ul style="list-style-type: none"> • What is Advocacy • Ethics of Advocacy • Effective Advocacy 		Renu Khanna

		<ul style="list-style-type: none"> Skills required 		
4.00 – 5.30	continued	continued		
		film/ Homework Readings		
September 16,2006 9.00 – 11.00 am	Session 4 <ul style="list-style-type: none"> History of SRHR: (International) 	<ul style="list-style-type: none"> History since the 19th century More recent history: Mexico Conference, ICPD, Beijing, MDGs 		Lakshmi Lingam
11.30 – 1.00 pm	Session 5 <ul style="list-style-type: none"> History of SRHR: India 	<ul style="list-style-type: none"> History since early 20 th century, 1952 Family Planning Programme Emergency 80s post ICPD: TFA, RCH I RCH II, NRHM 		A.R. Nanda
2.00 – 3.30 pm	Session 6 <ul style="list-style-type: none"> Identifying Advocacy Issues in SRHR based on evidence 	<ul style="list-style-type: none"> Maternal- neonatal Health Adolescent SRHR Safe abortion HIV-AIDS and maternal health interface 		Lakshmi Lingam
4.00 – 5.30 pm	Session 7 <ul style="list-style-type: none"> Current debates in SRHR 	<ul style="list-style-type: none"> TBAs vs Skilled Birth Attendants Compulsory testing for HIV before marriage Contraceptives and other SRH services for Adolescents Banning Second trimester abortions 		Abhijit Das Lakshmi Lingam
		HOMEWORK READING RCH II, NRHM, NACP3 DOCUMENTS		
September 17,2006 9.00 – 11.00 a.m.	Session 8 <ul style="list-style-type: none"> Analysis of recent policy and programme 	Group work on <ul style="list-style-type: none"> NRHM RCH2 		Renu Khanna

	documents	<ul style="list-style-type: none"> NACP3 		
11.30 – 1.00	Session 9 <ul style="list-style-type: none"> Right to Information Act 	<ul style="list-style-type: none"> Contents of RTI Act Experience with using RTI Act How can it be used for SRHR issues 		Arundhati Dhuru
2.00 – 3.30 p.m.	Session 10 <ul style="list-style-type: none"> Social Charge 	<ul style="list-style-type: none"> Overview of theories of Social Charge Case studies <ul style="list-style-type: none"> Narmada Bachao Andolan Domestic Violence Act 		Arundhati Dhuru Asmita Basu
4.00 – 5.30 p.m.	Session 10 contd	<ul style="list-style-type: none"> Discussion on Rights based approach to Social Change 		
FILM – Anti Arrack Movement				
September 18,2006 9.00 – 11.00 a.m.	Session 11 <ul style="list-style-type: none"> Power and how it affects Advocacy 	<ul style="list-style-type: none"> Axes of Power – International to Local Factors and Actors that operate at different levels affecting SRHR issues 		Abhijit Das
11.30 – 1.00 p.m.	Session 11 contd	<ul style="list-style-type: none"> Strategic advocacy interventions 		Sundari Ravindran
MODULE 2: ESSENTIAL ADVOCACY ACTIONS & SKILLS				
2.00 – 3.30 p.m.	Session 12 <ul style="list-style-type: none"> Essential Advocacy Steps 	<ul style="list-style-type: none"> Panel discussion on Advocacy Cases <ul style="list-style-type: none"> Sex Selective Abortion Right of HIV Positive women and sex workers Target free Approach 		Puneet Bedi Meena Seshu Abhijit Das

4.00 – 5.30 p.m.	Session 12 contd	<ul style="list-style-type: none"> Overview of practical steps in advocacy 		
FIM/ HOME WORK				
September 19,2006 9.00 – 11.00 a.m.	Session 13 <ul style="list-style-type: none"> Developing Advocacy Material 	<ul style="list-style-type: none"> Developing advocacy messages from evidence for varied audiences 		Vijaya Nidadavolu
11.30 – 1.00 p.m.	Session 13 contd	<ul style="list-style-type: none"> Feedback Principles of developing advocacy material 		
2.00 – 3.30 p.m.	Session 14 <ul style="list-style-type: none"> Skills required for Advocacy 	<ul style="list-style-type: none"> Panel Discussion on Advocacy Efforts <ul style="list-style-type: none"> Maternal Health and Reproductive Rights Rational Therapeutics 		Sandhya (HWVPB) Chinu Srinivasan (LOCOST)
4.00 – 5.30 p.m.	Session 14 contd	<ul style="list-style-type: none"> Overview of skills Required 		
FILM – CITIZEN RUTH				
September 20,2006 9.00 10.00 a.m.	Session 15 <ul style="list-style-type: none"> Advocacy for Neonatal Health 	<ul style="list-style-type: none"> Issues in Neonatal Mortality Advocacy Actions taken, Skills used 		Dr. Vinod Paul
10.00 – 11.00 a.m.	Session 16 <ul style="list-style-type: none"> How to do advocacy with policymakers 	<ul style="list-style-type: none"> Principles of Lobbying 		Ena Singh
11.30 – 1.30 p.m.	Session 16 contd	Plenary of Group Outputs		
Post lunch: HALF DAY BREAK				
September 21, 2006 9.00 – 11.00 am	Session 17 <ul style="list-style-type: none"> How to do advocacy with media 	<ul style="list-style-type: none"> Principles of Media Advocacy 		Usha Rai

11.30 – 1.00 p.m.	Session 17 contd	Plenary of Group Outputs		
2.00 – 3.30 p.m.	Session 18 <ul style="list-style-type: none"> How to do advocacy at the Community level 	<ul style="list-style-type: none"> Principles of community mobilisation 		Lakshmi Murthy
4.00 – 5.30 p.m.	Session 18 contd	Plenary of Group Outputs		
September 22, 2006 9.00 – 10.00 a.m.	MODULE 3 PLANNING FOR STRATEGIC ADVOCACY			
	Session 19 <ul style="list-style-type: none"> Planning cycle for Strategic Advocacy 	<ul style="list-style-type: none"> Identifying Advocacy Issues Setting Objectives Indicators for Advocacy 		Renu Khanna
10.00 – 11.00 p.m.	Session 20 <ul style="list-style-type: none"> Participants presentations of their Advocacy Plans 			
11.30 – 1.00 p.m.	Session 20 contd			
2.00 – 3.30 pm	Session 21 <ul style="list-style-type: none"> Working in Groups to Refine Advocacy Plans 	<ul style="list-style-type: none"> Analyzing Context Identifying Advocacy Issues Stakeholder Analysis 		Renu Khanna Sundari Ravindran Vijaya N Abhijit Das Asha George/ Lakshmi Lingam
4.00 – 5.30 p.m.	Session 21 contd.			
September 23, 2006 9.00 -11.00 a.m.	Session 22 <ul style="list-style-type: none"> Working in Groups to Refine Advocacy Plans 	<ul style="list-style-type: none"> Advocacy Planning Cycle <ul style="list-style-type: none"> Goal Strategies Indicators 		Renu Khanna Sundari Ravindran Vijaya N Abhijit Das Asha George/ Lakshmi Lingam
11.30 – 1.00 p.m.	Session 23 Presentation of Refined Advocacy Plans			Renu Khanna Sundari Ravindran Vijaya N

				Abhijit Das Asha George/ Lakshmi Lingam
2.00 – 3.30 p.m.	Session 23 contd			
4.00 – 5.30 p.m.	Session 24 <ul style="list-style-type: none"> ○ Evaluation and Future plans ○ Meeting with guests/donors 			

Annex 2

List of participants

Sl No	Name	Organization	Location	E-Mail
1	Gayatri Giri	Govt of Gujarat	Gujarat	girigayatri@rediffmail.com
2	Aarti Kelkar	Independent Researcher	Trivandrum	aartikhambete@rediffmail.com
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6	Lindsay Barnes	Jan Chetna	Ranchi	Lindsay_india@yahoo.co.uk
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Annex 3

Reading Material for Short Course on Advocating for Sexual and Reproductive Health and Rights

- I. Overview Papers – Advocacy for Reproductive and Sexual Health and Rights
 1. Ensuring Quality of Care in Reproductive Health: An Advocacy Handbook (ORDER FROM ABHIJIT)
 2. Strategic advocacy and maternal mortality: moving targets and the millennium development goals (*Lynn Freedman*)
- II. Sexual and Reproductive Health and Rights
 1. Sexual Rights (*TARSHI*)
 2. Sexual but not Reproductive: exploring the Junction and Disjunction of Sexual and Reproductive Rights (*Alice Miller*)
 3. Swaminathan, Padmini (1997), “Work and Reproductive Health: A Hobson ’s choice for Indian Women?” in *Economic and Political Weekly*, October 25: WS-53-WS-61.
 4. Petchesky, R. 2000. Human rights, reproductive health and economic justice: Why they are indivisible. *Reproductive Health Matters*. Vol. 8, No.15, May Pp.12-17.
- III. Concept of Rights
 1. The Right of the Highest Attainable Standard of Health, General Comment 14
 2. CEDAW General Comment 24
 3. Advancing Safe Motherhood Through Human Rights
 4. A Human Rights-based Approach to Programming for Maternal Mortality Reduction in a South Asian Context. A review of Literature (*UNICEF*)
 5. Developing a human rights-based approach to addressing maternal mortality
 6. Women who die needlessly: maternal mortality as a human rights issue
 7. Do Human Rights have a role in Public Health (*Sofia Gruskin*)
- IV. Concept of Advocacy
 1. Advocacy: A Conceptual Critique (*Renu Khanna*)
 2. Dealing with Advocacy: A Practical guide (*Joke Van Kampen*)
 3. Advocacy: Issues, Skills and Systems (*S. Srinivasan*)
- V. International History of Sexual and Reproductive Health & Rights

1. Dixon-Mueller, Ruth (1993), *Population Policy and Women's Rights. Transforming Reproductive Choice*, (Chapter 1: "Human Rights, Women's Rights and Reproductive Freedom: The Evolution of Ideas"), Westport, Connecticut: Praeger Publishers.
2. Correa, Sonia with Rebecca Reichmann (1994), *Population and Reproductive Rights. Feminist Perspectives from the South*, (Chapter I: Fertility Management Policies: Past, Present and Challenges for the Future, pp.11-55), London & New Jersey: Zed Books Ltd. in association with DAWN.
3. Petchesky, R. 1995. "From Population Control to Reproductive Rights: Feminist Fault Lines." *Reproductive Health Matters*. 6: 152-161.

Indian policy historical background

1. A.R. Nanda

VI. History of Sexual and Reproductive Health & Rights in India

1. Reclaiming the Reproductive Rights Agenda: A Feminist Perspective (*T.K.Sundari Ravindran*)
2. Lingam, Lakshmi (1998), "Sex Determination Tests and Female Foeticide: Discrimination before Birth" in *Understanding Women's Health Issues: A Reader*, (Ed.) Lakshmi Lingam, New Delhi: Kali for Women: (209-218)
3. Jesani, Amar (1998), "Banning Pre-Natal Sex Determination: The Scope and the Limits of the Maharashtra Legislation" in *Understanding Women's Health Issues: A Reader*, (Ed.) Lakshmi Lingam, New Delhi: Kali for Women: 219-228
4. Das Abhijit (2006) Reproductive and Sexual Rights : History and Contemporary Challenges, *Indian Journal of Family Planning*

VII. (a) Maternal Neonatal Health

1. Can skilled attendance at delivery reduce maternal mortality in developing countries?
2. Policy debates in maternal, newborn and child health
3. How can we monitor progress towards improved maternal health?
4. The Challenge of Neonatal-Perinatal Health
5. Newborn and child health in India: Problems and interventions
6. The Executive Summary of the Lancet Neonatal Survival Series
7. Review of women and children's health in India: Focus on safe motherhood

8. Maternal Health Financing – Issues and Options: A Study of Chiranjeevi Yojana in Gujarat, Bhat Ramesh ; Singh Amarjit ; Maheshwari Sunil ; Saha Somen

(b) Adolescent Sexual and Reproductive Health & Rights Issues

1. Mamdani, Masuma (1999), “Adolescent Reproductive Health: Experience of Community-based Programmes” in *Implementing a Reproductive Health Agenda in India*, (Ed.) Saroj Pachauri, New Delhi: Population Council (South and East Asia Regional Office): 261-311.
Garg, Suneela, Nandini Sharma and Ragini Sahay (2001),
2. Barua, Alka and Kathleen Kurz (2001), “Reproductive health-seeking by married adolescent girls in Maharashtra, India” in *Reproductive Health Matters*, Vol.9, No.17, May: 53-62.
3. Sexual Assertiveness and Adolescent Sexual Rights: Patricia East and Joyce Adams (2002).
4. Recognising adolescents evolving capacities to exercise choice in reproductive health care by Rebecca Cook and B.M Dickens from the International Journal of Gyne and Obs ((2000);

(c) HIV/Maternal Health Interface

1. HIV, Pregnancy and Women’s Health

(d) Safe Abortion

1. The Abortion Assessment Project – India: Key Findings and Recommendations
2. Introducing Medical Abortion within the Primary Health System: Comparison with Other Health Interventions and Commodities
3. Elective Abortion as a Primary Health Service in Rural India: Experience with Manual Vacuum Aspiration
4. Poems

VIII. Policy Documents

1. NRHM Mission Document
2. RCH 2 PIP
3. RTI Act

IX. Reference readings

1. Gupta, J. 1993. 'People like you never agree to get it': visit to an Indian family planning clinic. *Reproductive Health Matters*. No. 1, May.Pp.39-43.
2. AK Jayasree. 2004. Searching for Justice for Body and Self in a Coercive Environment: Sex Work in Kerala, India. *Reproductive Health Matters*. Vol. 12, No. 12, May
3. Visaria, Pravin and Vijaylaxmi Chari (1998), "India's Population Policy and Family Planning Programme. Yesterday, Today and Tomorrow" in *Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya and Mexico*, (Ed.) Anrudh Jain, New York: Population Council: 53-112.
4. Greenhalgh, S. 1996. "The Social Construction of Population Science: An Intellectual, Institutional, and Political History of Twentieth-Century Demography." *Comparative Studies in Society and History* 38 (1): 26-66.
5. Presser, H. 1997. "Bringing Gender in: Demography, Feminism, and the Science-Policy Nexus." *Population and Development Review*. Vol. 23. No. 2: 295-331.
6. Dunlop, J., R.Kyte and M.Macdonald. 1996. "Women Redrawing the Map: The World After the Beijing and Cairo Conferences." *SAIS Review* 16 (1): 153-165.
7. Finkle, J.L. and B.B. Craine. 1975. "The Politics of Bucharest: Population, Development and the New International Economic Order". *Population and Development Review*. 1: 87-114. (FIND)
8. Mackintosh, A. and B.B. Crane. 1985. "Ideology and Politics at Mexico City: The United States at the 1984 International Conference on Population". *Population and Development Review*. 11 (1): 1-28.(FIND)
9. "Socio-cultural aspects of menstruation in an urban slum in Delhi, India" in *Reproductive Health Matters*, Vol.9, No.17, May: 16-25. (FIND)
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11. NRHM – PRIs and Health and Family welfare Programme – An Executive Summary

Draft 1

12. NACP 3

13. RTI Act FAQs

Annex 4.

Comparison of Pre Test and Post Test Scores in the Advocacy Training

Statement	Correct Pretest	Correct Post Test
1. Human rights as we know them today were articulated in which of the following documents – Magna Carta / UDHR / Communist Manifesto/ ICPD PoA	12/ 24	19/ 23
2. Human Rights Violations can be brought before the International Court of Justice at the Hague if they are not addressed within the country– Yes / No / Don't Know	1/ 24	12/ 23
3. Right to Health is <u>guaranteed</u> by the Indian Constitution – Yes / No / Don't Know	4/ 24	3/ 23
4. Sexual and Reproductive Rights are basically one and same thing – Yes / No / Don't Know	18/ 24	20/ 23
5. Declining sex ratio and sex – pre-selection is an important <u>reproductive rights</u> issue in India – Yes / No / Don't know	2 / 24	2/ 23
6. Indicate which of the following acts you consider to be part of advocacy action	10/ 24	19/ 24
a. Prepare a programme intervention to inform individual pregnant women about the village health day and the need for Antenatal Care – Advocacy / Not Advocacy		
b. Conduct meetings with Village Health Committees about the provisions of NRHM and health entitlements of the community and roles of the VHC – Advocacy / Not Advocacy	19/ 24	17/ 23
c. Invite the CMO to the inauguration of a Mobile Family Planning Clinic services which have been started by your organization – Advocacy / Not Advocacy	15/ 24	18/ 23
d. Prepare a poster campaign on the advantages and disadvantages of emergency contraceptives - Advocacy / Not Advocacy	10/ 24	12/ 23

e. Prepare media briefs based on state DLHS data and case studies of maternal deaths - Advocacy / Not Advocacy	19/ 24	20/ 23
7. Which of the following terms / phrases <u>best</u> describes 'advocacy' Persuasive Communication / Increasing Voice and Participation / Networking and Negotiation	8/ 24	12/ 23
8. Reproductive rights were first codified in the – Universal Declaration of Human Rights/ Teheran Conference / ICPD (Cairo)	17/ 24	20/ 23
9. The National Population Policy 2000 recommends following a two child norm – Yes / No	6/ 24	12/ 23