The Power to Change

A Training Manual
Building Advocacy Capacity for India’s HIV/AIDS Response
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Acknowledgments

The Power to Change manual has been developed by Julia Cabassi, Consultant, in collaboration with Shaleen Rakesh, National Advocacy Coordinator of the Essential Advocacy Project (EAP), Constella Futures under the supervision of Dr. Subhadra Menon, Project Director, EAP. It has been used successfully to build HIV advocacy capacity in India with the State AIDS Control Societies and their partner NGOs and Avahan partner organizations in the states of Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland. This final manual is the product of a learning process with State AIDS Control Societies and grassroots NGOs from the six states during 2005-2007.

The manual has been adapted from the draft A Squared (A²) Advocacy Curriculum. A² is a joint project being implemented by Constella Futures, the East-West Center, and Family Health International (FHI), with a number of national and regional organizations. Modules A through F have been adapted for use in India to address issues central to the work of the EAP’s partner organizations. Module G has been developed specifically for this manual.

We particularly want to acknowledge the contribution of the many people who have actively participated in and provided feedback on the training. Their input has contributed significantly to refining this manual. We would also like to acknowledge the use and in some cases adaptation of material from the toolkit Advocacy in Action: A toolkit to support NGOs and CBOs Responding to HIV/AIDS by the International HIV/AIDS Alliance.

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Support

Support for The Power to Change manual was provided by the Bill & Melinda Gates Foundation through Avahan, it’s India AIDS Initiative. The views expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Bill & Melinda Gates Foundation and Avahan.

First Published

August, 2007
Contents: Training Curriculum

Module A. Introduction to HIV/AIDS Advocacy  8
A.1 Workshop Opening  12
A.2 About the EAP and a Rights-based Approach to Advocacy  18
A.3 What is Advocacy?  20
A.4 Advocacy and Related Concepts  26
A.5 Examples of Advocacy leading to Policy Change  34
A.6 Steps in the Advocacy Process  36

Module B. Introduction to Evidence-based Advocacy  40
B.1 Understanding the epidemic: HIV/AIDS in India  43
B.2 What is Evidence-based Advocacy?  46
B.3 Introduction to Data Analysis  52
B.4 Analyzing Behavioral and Epidemiological Data  64

Module C. Understanding the Policy Process  68
C.1 The Policy Process  70
C.2 Mapping Key Decision Making Processes  76

Module D. Advocating for Change: What change is needed & who to influence  80
D.1 Identifying Advocacy Issues  84
D.2 Advocacy Issue Prioritization  86
D.3 Identifying Policy Solutions  92
D.4 Developing Advocacy Goals and Objectives  96
D.5 Target Audiences: Identifying Opposition and Support  108
D.6 Analyzing Target Audiences  114
Introduction to the manual

About The Essential Advocacy Project

The Essential Advocacy Project (EAP) is a project of Constella Futures.

Despite nearly two decades of effort, HIV/AIDS prevalence remains high in Key Populations (KPs) such as sex workers, high-risk men who have sex with men and injecting drug users. Prevention efforts must be led by these communities to address the structural barriers and social stigma they face on a daily basis.

The EAP is an advocacy capacity building partner of the Āvāhan programme, the India AIDS Initiative of the Bill & Melinda Gates Foundation. Our mandate is to provide the essential advocacy piece within the strategic initiative of Āvāhan.

The goal of the project is to build, enhance and support advocacy efforts for an enabling environment for KPs, including sex workers, injecting drug users and men who have sex with men, to claim their rights. Our objectives are to:

- Strengthen and support Āvāhan partners, stakeholders and KPs to take leadership in the advocacy and policy process
- Reduce HIV-related stigma and discrimination through advocacy
- Improve the effectiveness and equity of resource allocation for HIV/AIDS

The project builds and supports advocacy capacity by:

- Providing HIV/AIDS advocacy training, including using evidence for advocacy
- Conducting Training of Trainers for NGO staff, KPs and key stakeholders like the police
- Galvanizing strategic alliances and strengthening leadership among major stakeholders like the police, political leadership, lawyers and community leaders to identify advocacy issues and action needed to bolster the impact of local advocacy efforts
- Developing and distributing resource material and policy briefs
We work with the following partners and stakeholders in our efforts:

- Avahan and NGOs who work with the Avahan programme
- State AIDS Control Societies and partner NGOs
- KPs including sex workers, injecting drug users and men who have sex with men
- Key stakeholders at the state-level including the police; political leaders and government officials; legal bodies; community leaders and business leaders

About this manual

This manual is designed to build the advocacy capacity of agencies that work with KPs to build an enabling environment for responding to HIV/AIDS in India.

The program approach is participatory, designed to enable participants to arrive at common understanding of key concepts. It also helps to develop skills through exercises that promote dialogue using practical examples. The programme focuses on enabling participants to understand and use data to make the case for policy changes.

The Modules: An Overview

Module A. Introduction to HIV/AIDS Advocacy

Purpose

Introduce participants to the program and build a shared understanding of major concepts: what is advocacy; how advocacy differs from related concepts such as community mobilization; and the key steps in the advocacy process.

Objectives:

By the end of this module, participants will be able to:

- Understand the rights-based approach that is central to advocating for a better HIV/AIDS response
Create a shared understanding about the role that advocacy plays in work with high-risk groups

Define advocacy and distinguish it from related concepts

Be familiar with examples of advocacy leading to policy change

Understand the steps in the advocacy process

Module B. Introduction to Evidence-based Advocacy

Purpose

Familiarize participants with the factors that shape the HIV/AIDS epidemic in India and the role of data in advocacy. Introduce participants to analyzing data and develop understanding about how this data can be used for advocacy.

Objectives:

By the end of this module, participants will:

- Understand the factors shaping the HIV/AIDS epidemic in India
- Understand what the term 'evidence-based advocacy' means
- Understand different types and sources of data (qualitative/soft and quantitative/hard)
- Understand important factors that shape the quality of data
- Be able to analyze existing secondary data to understand what the data shows, how such data may be used for advocacy, the limitations of data and identify data gaps
Module C. Understanding the Policy Process

Purpose

Introduce participants to key aspects of the policy development process, including understanding the various factors and processes involved in policy development and the different types and levels of policy.

Objectives:

By the end of this module, participants will be able to:

- Understand how the policy development process works in India, at national, state and/or district level
- Understand and identify different types and levels of policy that can provide policy solutions for advocacy issues
- Develop a Policy Process Map for a new policy

Module D. Advocating for Change: What change is needed & who to influence

Purpose

Develop participants’ skills in identifying advocacy issues, prioritizing these issues and identifying the kinds of policy solutions required to address these issues developing clear advocacy goals and objectives; identifying and understanding the target audiences that need to be influenced to achieve the advocacy goals

Objectives:

By the end of this unit, participants will be able to:

- Apply a process to prioritize advocacy issues and identify policy solutions
- Develop advocacy goals and objectives specific to priority advocacy issues
Identify the interests of primary and secondary target audiences and analyze how they may support or oppose advocacy issues

**Module E. Implementation - Advocacy Action Plans**

**Purpose**
Familiarize participants with the framework and constituents of an advocacy action plan and develop their skills in developing a plan.

**Objectives:**
By the end of this module participants will:
- Understand the key elements of an advocacy action plan
- Be able to prepare an advocacy action plan

**Module F. Advocacy Messages and Methods**

**Purpose**
Develop participants' understanding about the components of effective advocacy messages for HIV/AIDS and improve their advocacy communication skills.

**Objectives:**
By the end of this module, participants will be able to:
- Identify the factors that influence the effectiveness of advocacy messages
- Understand and apply the elements and characteristics of effective HIV/AIDS advocacy messages
- Develop and deliver effective advocacy messages for the media and during face-to-face communication
- Understand how to develop an effective policy brief
Module G. Evidence for Action: Using Data for Advocacy

Purpose

Develop participants' ability to analyze different kinds of data and use these data in crafting and delivering advocacy messages.

Objectives:

By the end of this module, participants will be able to:

- Analyze and use data to support the case for a specific policy change in the context of a policy brief and through a lobbying meeting
- Practice writing a policy brief and conducting an advocacy meeting using data
Advocacy Issue

A problem that requires a policy action or solution.
Introduction to HIV/AIDS Advocacy

Purpose:
Introduce participants to the program and build a shared understanding of key concepts: what is advocacy; how advocacy differs from related concepts such as community mobilization; and the key steps in the advocacy process.

Sessions:
A.1 Workshop Opening
A.2 About the EAP and a Rights-based Approach to Advocacy
A.3 What is Advocacy?
A.4 Advocacy and Related Concepts
A.5 Examples of Advocacy leading to Policy Change
A.6 Steps in the Advocacy Process
### Objectives:

By the end of this module, participants will be able to:

- Understand the rights-based approach
- Create a shared understanding about the role that advocacy plays in work with high-risk groups
- Define advocacy and distinguish from related concepts
  - Be familiar with examples of advocacy leading to policy change
  - Understand the steps in the advocacy process

### Background Notes

#### What is Advocacy?

**The EAP’s definition of Advocacy**

Advocacy is a method and a process of influencing decision-makers and public perception about an issue of concern, and mobilizing community action to achieve social change and a favorable policy environment to address the concern.

It is important to note that there is no one internationally agreed definition of the term “advocacy”. You will find as many definitions of advocacy as you will find groups, networks, and coalitions advocating. However, each definition shares common language and concepts. Advocacy is also strategic, and targets key stakeholders and decision-makers. Lastly, advocacy is always directed at influencing policy, laws, regulations, programs, or funding decisions made at the upper-most levels of public or private sector institutions.

Advocacy includes both single-issue, time-limited campaigns, as well as ongoing work undertaken around a range of issues. Advocacy activities may be conducted at the national, regional, or local level.
Within the HIV/AIDS policy arena, advocacy efforts might address issues such as police harassment and abuse of key populations or a legal policy recognizing the rights of sex workers. Operational HIV/AIDS policies where specific resource allocation and service delivery guidelines are formulated (for example, targeted programmes for high-risk groups, or interventions to build community led advocacy approaches) are also potential objects for advocacy campaigns.
Workshop Opening

1 hour - 1 hour 15 minutes

Materials: flip-chart, tape, markers, computer, projector, display screen

Materials to be prepared:
- Power Point Presentation (PPT): Agenda
- Flip-chart: Interview topics
- Other: Continuum cards

Objectives:
- To welcome participants to this HIV/AIDS Advocacy Training Workshop
- To introduce participants to the purpose, objectives (desired outcomes) and program for the workshop
Introduction:

Explain that the workshop will get started by taking time to introduce the facilitators and participants. Explain what will happen during the training workshop.

Session Instructions:

1. Greet participants and welcome them to the workshop.

2. Introduce yourself:
   - Name
   - Affiliation
   - Background
   - Why you are here
   - Introduce the rest of the training team.

3. Ask co-facilitators to introduce themselves, sharing similar information. Clarify roles during the training.

4. Note that you would like to learn more about all of them.

5. Display prepared flip-chart with interview topics and ask participants to find someone they don’t know well and then interview each other by sharing the following information:
   - Name
   - Organization/professional background
   - Their highest expectations for the workshop
   - Who is their hero in HIV/AIDS advocacy in India and why?
6. **Note:** Ask them to introduce each other to the larger group, and keep notes

- They will have 5 minutes to conduct both of the interviews
- Start time
- After 5 minutes, call time.

7. Ask for pairs to volunteer to introduce each other to the group. Tell the group that each pair will have 3 minutes for their introductions of both people (*insist on time limit*)

- Facilitator lists each person’s expectation/s on flip-chart
- Thank the participants for sharing their information and
  - Reinforce the wealth of experience in the room, noting the type of work they are involved in and what they bring to the group
  - Confirm that the workshop is designed to be very participatory in order to draw on the experience in the group

**Transition to Purpose**

8. Return to flip-charts with responses for highest expectations of the workshop, explaining that this leads the group to the purpose of the workshop

9. Review/summarize their expressed expectations.

10. Clarify any that may not be clear or are off-target.

11. Request to bring it up one level, and ask ourselves, “So what?”
    Ask: *What is the big picture?*

    “*We want to understand the advocacy process or improve our advocacy skills so that…?*”

12. Ask participants and facilitators to stand up and participate in an activity to see if we can come together on a purpose. Get the three voice cards.
Make a large continuum across the front of the room with cards:

None          Some          A lot

Ask “How much influence do you think evidence has in shaping HIV/AIDS policy development in India?”

13. Repeat and note that it is a complicated and diverse question, which perhaps has no one answer. Explain the following:

- View this continuum, with “no voice” at one end, “some voice” in the middle, and “a very strong voice” at the other end
- Repeat the question
- Stand at the point on the continuum that best represents your opinion

14. After everyone has chosen a spot, debrief the activity by asking the following types of questions:

- What are your observations?
- Why did you place yourself where you did?
- Ask another, perhaps at another end of the spectrum.
- Other observations of the group.
- Are you surprised by any of the participants' choices? If so, why?
- What do you think this is reflective of?
- Ask if there are any with some experience with advocacy, and how this affects where they have placed themselves on the spectrum

PAUSE

- What gives you hope? What trends are happening that you believe could move you up this continuum?
- What is your role in making this change?
- Do you believe this can happen? (enlist the support of the person on the furthest end of the spectrum)

Thank participants and ask that they return to their seats.
Transition to Workshop Purpose and Outcomes

15. Tell participants that next you would like to discuss what will happen during the workshop.

16. Display the flip-chart with the purpose and outcomes for the participants.

17. Transition to Program (Note: Lead facilitator to prepare and include with participants' handouts provided as part of this manual).

   Review program and ask the group if they have any questions, concerns or comments about the purpose, outcomes, and program.

18. Review people's expectations and note which the program is likely to be able to meet, and any that may not be met given the nature of the program.

Transition to Workshop Norms

19. Ask the participants how they want to be together, what type of atmosphere do they want to create for the workshop, to help meet expectations and desired outcomes?

   For example, they may know that giving everyone a chance to speak is important. These and other group rules are called “norms.”

   Ask the group to brainstorm a list of suggested norms for the workshop.

   Clarify any that are vague or unclear.

   List responses and record on flip-chart

20. After the list is developed:

   - Suggest others if not on the list: examples - punctuality; allow for one person to speak at a time; request for clarification

   - Ask what they expect of the facilitators and of themselves in order to maintain norms

Reminder to Facilitator: Post flip-chart of group norms on the wall and keep up throughout the workshop.
About the EAP* and a Rights-based Approach to Advocacy

Objectives:
- To introduce participants to the role of the Essential Advocacy Project (EAP) and a rights-based approach that is central to the EAP’s work
- To create a shared understanding about the role that the EAP plays within Avahan.
- The Essential Advocacy Project

Materials: computer, projector, display screen

Prepared Materials:
- PPT: About the EAP (on CD)

Participants’ Resources: Page 2 (Background Notes)
Note to Facilitator: This introductory session will generally be used by facilitators who are conducting training for the EAP, and who can therefore field any questions about the EAP’s role in the Avahan program as a whole. Note that the session also explores a rights-based approach to Advocacy.

Option: The facilitator may wish to adapt this presentation to provide an overview of a rights-based approach to advocacy. Also see Participants Resources: Human Rights and HIV Advocacy: Background notes.

Session Instructions:

Step 1: Lecturette

45 minutes

1. Introduce session by setting out the objectives:
   - To introduce participants to the role of the Essential Advocacy Project (EAP) and a rights-based approach that is central to the EAP’s work
   - To create a shared understanding about the role that the EAP plays within Avahan

2. Present the PowerPoint on 'About the EAP'. (25 minutes)

3. Invite comments and questions (20 minutes)
20

A.3

What is Advocacy?

1 hour

Materials: markers, pens, ball of yarn/twine

Prepared Materials:

- Flip-chart: Definition of “advocacy”; Instructions for group work

Participants’ Resources: Page 6 (Background Notes, Definitions of Advocacy)

Objectives:

- To explore views on the definition of “advocacy”

Introduction:

- Tell participants that there is no one international definition of the term “advocacy”. They will find as many definitions of advocacy as they will find groups, networks, and coalitions advocating.

- Tell participants that in the session, we want to be able to see how the EAP definition that has been developed so far, sits with their views on the definitions of advocacy.
Activity Instructions:

Step 1: Ice-breaker/ Building a web

20 minutes

1. Tell participants that you would like them to stand up and form a circle in the center of the room, and explain that shall follow a “Word Association Activity.”

2. Show the group the ball of yarn/twine.

3. Explain the following:
   - One person will hold the end of the yarn and throw it to someone else in the circle.
   - Whoever throws the yarn, must say the first word or phrase that comes to mind when they hear the word “advocacy.”
   - The next person holds on to the string and then throws the ball to someone across from them, saying a word or phrase that comes to mind when hearing the word advocacy. Ask them to ensure they hold on to the string before throwing the ball.
   - Ask if the activity is clear to everyone, and start it yourself as an example, if appropriate.
   - Repeat these steps until everyone has had an opportunity to share their first thoughts.
   - Ask participants to hold on to the yarn/string at the end of the activity.

4. As the activity proceeds, record participants’ words on a flip-chart.

5. Thank the participants and ask them to return to their seats. (Note: In most cases, the participants want to “Preserve” the net, so they gently lay it down on the floor before returning to their seats!)
Note to Facilitator: This activity typically elicits the following:

- Defending
- Exposing
- Decision-making
- Attracting attention
- Providing a solution
- Sensitizing
- Communication
- Intervening
- Selling an idea
- Persuading
- Changing
- Influencing
- Lobbying

6. Lead a brief discussion on advocacy, making the following points:

- Advocacy is both a science and an art. From a scientific perspective, while there is no universal formula for effective advocacy, experience has shown that advocacy is most effective when it is planned systematically.

- Networks, coalitions or other groups of advocates must follow and include specific steps when designing and implementing an advocacy campaign; each step requires distinct knowledge and skills.

- Advocacy is also an art. Successful advocates are able to articulate issues in ways that inspire and motivate others to take action. Successful advocates are skilled negotiators and consensus builders who look for opportunities to win modest but strategic policy gain, while creating still other opportunities for larger victories.

- Artful advocates incorporate creativity, style, and even humor into their advocacy events in order to draw public and media attention to their cause.

- The art of advocacy cannot be taught through a training workshop; rather, it emerges from within network members themselves. Advocacy training provides the tools, but participants must add the spark.

Note to Facilitator: The activities in this are designed to teach both the science and the art of designing and implementing an advocacy campaign. The units correspond to the different steps of the advocacy process. Participants will learn how to use advocacy strategies and tools to influence decision makers and bring about more favorable HIV/AIDS policies and programs.
Step 2: Defining Advocacy

40 minutes

1. Divide participants into two groups of four persons for the activity.

2. Make a transition from the first activity, by explaining that the participants further deepen their thinking about advocacy and work in small groups to develop a full definition of advocacy.

3. Instruct each group to draft a definition of advocacy. Encourage the groups to use the words on the flip-chart to prepare their definitions.

4. Ask each group to think about how best the word “advocacy” translates into their own languages. Ask them to write this (these) words(s) on the flip-chart, and to be prepared to explain the translation. Allow 15 minutes.

5. Ask the group to write their definitions and translation on colored paper and post them on the wall, and to select one person who will be prepared to share their group’s definition.

6. After the groups have finished their task, ask each group’s representative to read each definition aloud. Put up definition on the wall.

7. Share the EAP’s definition for consideration. Point out similarities and differences to what they have come up with.

Advocacy is a method and a process of influencing decision-makers and public perceptions about an issue or concern, and mobilizing community action to achieve social change and a favourable policy environment to address the concern.

8. Discuss the different definitions by asking the group to identify the following:

- Similarities among the definitions (i.e., words or phrases that appear in more than one definition). Circle the commonalities with colored marker.
Elements that are unique to a definition (i.e., not repeated in any of the other definitions). Circle the unique words or phrases with a different colored marker.

9. If participants are all from the same country, and/or need a shared definition of advocacy:

Ask participants to decide whether one of the posted definitions should be the agreed-upon definition of advocacy (for the workshop, for the project, or for the group) or whether they want to craft a new definition by using the common elements and ideas represented in their definitions.

Activity Option:

1. The facilitator can work with the group to construct a complete definition. Using clean colored paper, help the group write a definition that reflects the full group's input.

2. Alternatively, the facilitator can ask for a group of volunteers to synthesize the definition and to be prepared to present it to the full group for consensus the following day.

10. Distribute “Sample Definitions of Advocacy” handout and note that several definitions are included. The definitions come from a variety of sources.

11. Tell participants that they may want to review the definitions and identify points that are consistent with their own definition.

Refer to handouts: “Background Notes & Definitions”.
## Objectives:

To enable participants to distinguish between 'advocacy' and related concepts

### Prepared Materials:

- **Flip-chart**: Blank Chart; definition of “activism”

### Participants’ Resources:

Page 8 (Related Concepts Chart)
Introduction:

- After reviewing the various definitions of advocacy, participants should have a clear sense of the meaning of advocacy.
- Nevertheless, advocacy is often confused with other concepts that share common elements, especially BCC (behavior change communication) and community mobilization.
- This activity is designed to compare and contrast advocacy with these related concepts to provide greater clarity about what advocacy is, and is not.

Session Instructions:

Step 1: Completing the Chart

40 minutes

1. Show participants the chart that you have prepared on the flip-chart or write on a large whiteboard.

<table>
<thead>
<tr>
<th>Advocacy and Related Concepts</th>
<th>Behavior Change Communication (BCC)</th>
<th>Community Mobilization</th>
<th>Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How to Measure Success</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Help participants fill in the chart, beginning with BCC. Ask the group the following questions and write responses in the appropriate box on the flip-chart:
Who is the target audience of a BCC campaign? (Possible responses include: at risk population).

What is the objective of a BCC campaign? (Responses include: reducing harmful or risky behaviors through behavior change).

How do you measure the success of a BCC campaign? In other words, what objective indicators of change will tell BCC campaign organizers that their campaign has succeeded? (Responses will vary according to the campaign’s objective, but several examples include: reduction in HIV and STI prevalence, increased use of condoms, change in knowledge, attitudes, and practices.

3. Help the group think about a community mobilization campaign. Repeat the same questions and fill in the answers on the chart. Common answers for the community mobilization campaign include:

<table>
<thead>
<tr>
<th>Target Audience:</th>
<th>Community members and leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective:</td>
<td>Increase the number of actors within a community activity engaged in addressing an issue; build a community's capacity to rank its needs and take action</td>
</tr>
<tr>
<td>Measure of Success:</td>
<td>Increased participation in and ownership of the problem-solving process; increased mobilization of community resources from different actors/levels; a community problem is solved or a need is met.</td>
</tr>
</tbody>
</table>
4. Now, help the group think about an advocacy campaign. Repeat the same questions and fill in the answers on the chart. Common answers for the advocacy questions are as below:

<table>
<thead>
<tr>
<th>Target Audience:</th>
<th>Policy-makers (decision-makers with the authority to bring about institutional change)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective:</td>
<td>To change policies, programs, or the allocation of public resources</td>
</tr>
<tr>
<td>Measure of Success:</td>
<td>Adoption of a new or more favorable policy/program; percent shift in resource allocation; new line item in a public sector budget</td>
</tr>
</tbody>
</table>

Note to Facilitator: If there is a lack of clarity about the terms BCC and community mobilization, you may wish to introduce the definitions and ideas below during the discussion:

**Behavior Change Communication (BCC)** is developing, distributing and promoting tailored health information that enables individuals and communities to take up and sustain changes in their behavior that reduces their risk of HIV infection or transmitting HIV to others. Effective BCC should increase knowledge and stimulate community dialogue. BCC should create a demand for information and services, and should spur action for reducing risk, vulnerability and stigma. It should promote services for prevention, care and support and ensure services are accessible and appropriate for those most affected by HIV/AIDS.

Adapted from Family Health International (www.fhi.org)

**Community mobilization** is a process whereby a group of people become aware of a shared concern or common need, and decides to take action in order to create shared benefits (UNAIDS, 1997). A community that is mobilized is likely to display some or all of the characteristics:
5. Moderate a discussion organized around the following questions:

What characteristics do all three of these approaches share? (Among the range of answers, participants might note that approaches include strategies for promoting change and are most effective when planned systematically).

How does advocacy stand apart from the other approaches?

6. Summarize by noting that advocacy always seeks to change a policy, such as operational polices, guidelines, resource allocations. Advocacy efforts usually raise awareness of key audiences, but advocacy does not stop with awareness-raising. The advocacy process is complete when a policy-maker implements the prescribed policy action. While the general public may be one of the audiences for an advocacy campaign, the public is targeted to engender support and pressure policy-makers. If the group focuses on the objective of its approach, it will be able to distinguish advocacy from related concepts.
Step 2: Discussion of 'Advocacy' and 'Activism'

20 minutes

Options:

1. The facilitator can go through the initial facilitated questions, and then proceed to presenting the definition of activism.

2. Alternatively, the facilitator can go directly to reviewing the definition of activism (#4 below).

1. Explain to participants that there are also sometimes discussions and debates about how advocacy and activism are related. Sometimes the two words are used to mean the same thing, sometimes the terms are used to mean different things.

2. Ask participants: if they have heard the word activism being used. If yes, they should describe when they have used the word, and/or describe groups or examples that come to mind as activism. Take a few responses around the room.

3. Ask participants to then list what they think are some of the defining characteristics of activism. Record participants’ responses on the flip-chart.

4. Once participants have finished brainstorming, show the participants the definition of activism posted on a flip-chart.

5. Point out similarities and differences between their list of characteristics and the definition.

6. Lead a group discussion by asking participants: How are activism and advocacy the same, different, or related?

Activism: “A practice that emphasizes direct vigorous action especially in support of or opposition to one side of a controversial issue”. Merriam Webster Dictionary
7. Conclude by making the following points:

- Activism is a kind of advocacy. It uses specific methods, such as street demonstrations, strikes, letter or email campaigns and the like.

- Activism tends to be associated with groups that have not had a seat at the decision-making table, that is, groups that have not had a voice or influence within a particular formal decision-making process or system, although this is not always the case.

- Direct action, such as street demonstrations or email campaigns, can demonstrate to decision-makers the strength of feeling and level of support that a group has about the issue of concern. Such activism can create community awareness about the issue, increase involvement of people on the issue and place pressure upon decision-makers.

- This can assist in getting access to decision-makers to enter into dialogue and make the case for change more directly.

- Note that, in fact, most efforts to bring about social change, especially for groups that have been excluded, rely on working both outside and within the system. This has been true for many of the advocacy successes associated with HIV/AIDS. This will be illustrated in the next session with a closer look at some examples of advocacy efforts that have led to policy change in India.

The important point is to know the range of strategies one can use and how to select which will be most effective in which circumstances.
Examples of Advocacy leading to Policy Change

1 hour

Materials: computer, projector, display screen

Prepared Materials (CD):
- PPT: Examples of advocacy leading to policy change

Participants’ Resources: Page 10 (PowerPoint handouts)

Objectives:
- To share real examples of how advocacy has led to policy change in India.

Session options: You can choose one of the PowerPoint presentations provided on the accompanying CD for this session. Alternatively, you may wish to invite a guest speaker to present on a successful advocacy initiative. Guest speaker’s notes are provided in the Facilitators’ Resources to assist in briefing a guest speaker for this session.
Session Instructions:

Step 1: Lecturette

30 minutes

1. Introduce the session by explaining that the presentation in this session provides some concrete examples about how advocacy has led to policy change in India.
2. Present the “Examples of Advocacy leading to Policy Change” PowerPoint or introduce the guest speaker.

Note to Facilitator: The PowerPoint presentations provided on the accompanying CD also provide speaker’s notes. You may choose to present one or both of the presentations provided, depending on the time you wish to allocate to this session.

Step 2: Discussion

30 minutes

1. Ask participants if they have any specific questions about the presentations.
2. Lead a facilitated group discussion, using the following questions to prompt discussion:
   - What struck them about these examples?
   - What did they learn about the approaches to advocacy from these examples?
   - Which of these approaches and lessons learned seem applicable to their own situation? Which do not?
3. Conclude by reminding participants that these examples illustrate some of the key steps in the advocacy process. The next session will look in more detail at these steps, so that we can apply these during the training and in our work to take a systematic approach to achieving the necessary changes in policy that can make the HIV response more effective.
Steps in the Advocacy Process

1 hour

Materials: tape, flip-chart, markers

Prepared Materials:
- PPT: Steps in the Advocacy Process (optional)
- Cards: A set of prepared cards for each small group and one for Facilitator; card format in Facilitators’ Resources

Participants’ Resources: Page 12 (Advocacy Process, Steps in the Advocacy Process)

Objectives:
- Identify and understand the key steps in an advocacy process.
Introduction:

- Now that participants have reached consensus on a working definition of advocacy, and considered some real examples of advocacy leading to policy change in India, they will look at the different steps that comprise the Advocacy process.

- Experience shows that advocacy is rarely an orderly, linear process. Some of the most successful advocacy efforts have resulted from rapid responses to needs and/or opportunities and have materialized amid chaotic environments.

- The ability to seize opportunities, however, does not replace the importance of a sound process and careful planning.

- This activity demonstrates that looking at advocacy in a systematic way can help groups plan and implement effective advocacy campaigns.

Session Instructions:

Step 1: Sequencing the Step

1. Divide participants into small groups of 4 to 5 people.

2. Distribute one set of advocacy cards to each group. Be certain that the cards are NOT in any order when you give the sets out.

3. Explain that each card in the set has one step of the advocacy process written on one side and a brief definition/explanation of the step on the other side.

4. Ask each team to read the cards and reach consensus on the order that would be followed to plan and implement an advocacy campaign. Ensure that participants know that their order does not have to be linear, but can take any shape.

Allow 25 minutes.
5. Ask the teams to post their cards on the wall or display them on the floor so they are visible to the full group. If possible, have all sets of cards displayed near one another so that participants can make comparisons.

6. When each team has posted its cards as a ‘gallery walk’, give participants 5 minutes to look at some of the other groups’ arrangements. Ask them to identify similarities and differences.

Step 2: Discussion

30 minutes

1. Refer to each group’s first set of cards and ask each member of the group to reflect on the process of grouping the cards, using the following questions as prompts:
   - Did everyone agree on the final order?
   - Where did group members disagree on the sequence of cards and what were the areas of debate?
   - Which, if any, steps did participants have difficulty understanding?

2. Lead a general discussion structured around the following questions:
   - Did the teams all start with the same step? Did they have the same or different ending step?
   - Were there any steps that were ordered concurrently in the process?

Note to Facilitator: Generally, the teams order their cards to look something like the following:
Step 3: Presentation of the Advocacy Process

10 minutes

1. Explain to participants that the purpose of the sequencing activity was to introduce advocacy as a systematic process with distinct steps and activities. While the steps may not always occur in the same order during an actual advocacy campaign, it is important to consider each step as a critical and integral piece of the advocacy effort.

2. Refer to handout: ‘Steps in the Advocacy Process’, or present it on an overhead transparency or flip-chart. Or you may wish to use the power-point presentation provided, to recap the session.

3. Briefly explain and discuss each of the steps in the process by using the notes and questions below as a guide. In the process, the facilitator may want to use one of the card sets and order them in the sequence suggested in the handout as each step is described; note some of the steps (especially data, and monitoring and evaluation) may be placed along the side to show these occurring throughout the process.

4. Debrief the activity with the following questions:

   - Do you think that any one of these steps is more important than the others?
   - Do you think that any one of these steps is more challenging than the others?

5. In closing, remind participants that advocacy activities are often carried out in turbulent environments. Frequently, groups do not have the opportunity to follow each step in the advocacy process according to the model presented here. Nevertheless, a systematic understanding of the advocacy process will help advocates plan wisely, use resources efficiently, and stay focused on the advocacy objective.

6. The workshop will address each of these steps in greater detail, in approximately the same sequence as in the model.

Reminder to Facilitator: Tape up one set of cards with the advocacy steps on the wall for the remainder of the workshop. The facilitator can then visually remind participants which steps they are working on in subsequent activities.
Introduction to Evidence-based Advocacy

**Purpose:**
Familiarize participants with the factors that shape the HIV/AIDS epidemic in India and the role of data in advocacy. Introduce participants to analyzing data and develop understanding about how this data can be used for advocacy.

**Sessions:**
B.1 Understanding the Epidemic: HIV/AIDS in India
B.2 What is Evidence-based Advocacy
B.3 Introduction to Data Analysis
B.4 Analyzing Behavioral and Epidemiological Data

**Objectives:**
By the end of this module, participants will:
- Understand the factors shaping the HIV/AIDS epidemic in India
Understand what the term 'evidence-based advocacy' means

Understand different types and sources of data (qualitative/soft and quantitative/hard)

Understand important factors that shape the quality of data

Be able to analyze existing secondary data to understand what the data shows, how such data may be used for advocacy, the limitations of data and identify data gaps
Understanding the Epidemic: HIV/AIDS in India

30 minutes

**Materials:** colored paper, markers, tape

**Prepared Materials:**
- **PPT:** HIV in India

**Participants’ Resources:** Page 16 (PowerPoint handout, Background Notes)

**Objectives:**
To familiarize participants with the factors shaping the HIV/AIDS epidemic in India
Introduction:

5 minutes

- Introduce all the objectives for this module.

- Highlight the specific objective for this session, which is: To familiarize participants with the factors shaping the HIV/AIDS epidemic in India. The session will highlight how data contributes to understanding the epidemic and how this is relevant to evidence-based advocacy.

- Refer back to the steps in the advocacy process, and ask participants to draw on those discussions and their own experiences and observations to answer the question of how advocacy issues get identified.

- Highlight that advocacy issues are often identified through a combination of evidence that may be collected, and people's own experiences and understanding of what is most important, and possible, to address in a particular place and at a particular time.

- Note, using data to identify advocacy issues of concern and to provide the evidence to make the case for policy solutions that address the concern, are both critical steps in the advocacy process. This session focuses on understanding how data can assist in identifying advocacy issues.

Note to Facilitator: If you are using the module G. Using data for Advocacy, you can also note that related sessions during the training will focus on analyzing and using data as evidence to make the case for policy changes you are seeking.
Session Instructions:

**Step 1: Lecturette**

25 minutes

1. Present the PowerPoint on ‘Understanding the epidemic: HIV/AIDS in India’ (15 minutes).

2. Invite comments and questions (10 minutes).

**Session Options:** You may choose to link sessions B.1 and B.2 by combining both lecturettes into one presentation and invite comments and questions at the end.
What is 'Evidence-based' Advocacy?

15 minutes

Prepared Materials:
- Flipchart: Data definition

Participants’ Resources: Page 32 (Background notes)

Objectives:
To familiarize participants with the concept of ‘evidence-based advocacy’ and what it means.
**Session Instructions:**

**Step 1: Lecturette**

15 minutes

1. Introduce the objective for this session: To familiarize participants with the concept of ‘evidence-based advocacy’

2. Introduce the concept of ‘evidence-based advocacy’, making the following points:
   - An evidence-based approach to advocacy means using data to provide evidence about the nature of a problem and to make the case for a recommended policy action or solution.
   - Data: Data is often perceived as quantitative data, such as HIV prevalence or percentage of sex workers who access STI services or who use condoms. Epidemiological and behavioral data are only two types of data that can be used for advocacy purposes. Refer to definition on flip-chart.

**Prepared Flip-chart:**

**Data:** facts or information to be used as a basis for discussing, reasoning, or deciding something. *The Oxford Dictionary*

- To be effective advocates it is essential to understand and accurately represent the dynamics and impact of the HIV epidemic and the needs, priorities, and interests of their constituencies. Many different types of data help us to do this.

- Good quality epidemiological and behavioral data interpreted together can provide a coherent picture of the epidemic, and these data can be used to produce estimates of the current epidemic and its future course.

- Any effective HIV/AIDS plan needs to be based on reliable information about:
  - The people infected and affected by HIV
  - The conditions and behaviors that put people at risk of HIV infection
The resources available for the response

Current efforts to intervene with prevention, treatment, care and support

The results of those efforts

This is often not the case. There are challenges in India, as in many other countries, in ensuring the necessary data is available to inform decision-making, but considerable efforts are going on to improve collection and analysis of data. Better data, well used, can and should improve the effectiveness of efforts to respond to HIV/AIDS.

Mainstream society disapproves of, and sometime harshly punishes, illicit drug use, sex between men, and sex work. This societal disapproval often means that IDUs, MSM and sex workers are ignored in surveillance systems, or inadequate data are collected, even though they are often at high risk of HIV infection.

Therefore, sometimes, advocacy is needed to ensure that the right kind of data are collected regularly over time, analyzed and used to inform decision-making about where the resources should be directed; about the types of programs needed; and about what changes are needed to ensure existing programs are effective in reducing HIV transmission.

Data is not just about numbers. Refer back to definition above. Qualitative data, information that is descriptive, records people's perceptions, attitudes and experiences, such as case studies that document the experiences of communities affected by HIV/AIDS, are also essential tools for advocacy.

Advocates need to know how current HIV/AIDS policies and programs affect individuals and communities, particularly the Key Populations (KPs) with whom you work. Much of this work is already happening in your programs. For example, many of you will know that laws and the practices of police, pressure groups and gatekeepers impact on Kp's access to prevention, care and legal services.

Understanding what policies or programs KPs think are needed or what changes are needed to existing policies, practices and programs is essential.
Example: Understanding the sexual health needs of men who have sex with men, Naz Foundation (India) Trust recognized that MSM were not accessing STI services, and were advocating for specific services to meet their needs. However, as this work involved more members of the MSM communities, it became clearer that MSM-specific services alone would not meet the needs of all MSM. Some MSM were concerned about being identified through accessing such services, and feared being stigmatized. Many men who have sex with men do not identify as MSM, and so they would be unlikely to access such services. So, advocacy efforts began to focus on both developing MSM-specific services as well as making mainstream STI services more accessible and appropriate for MSM. This included educating healthcare workers about sexuality and sexual health issues relevant to MSM, efforts to enable workers to reflect on their own values and attitudes to reduce discrimination against MSM, and to improve confidentiality policies and practices, so that MSM would have greater confidence in accessing such services. One approach that was used was to place counselors from Naz Foundation (India) Trust in mainstream services, both to build skills and capacities of healthcare workers and provide services for MSM as a transitional strategy.

As Advocates you should consider your own information needs as well as the information needs of policy makers.

Advocates need to be strategic in the data they collect and in how they analyze and use data. What data will help advocates persuade policy-makers about the need for policy changes? What data will best strengthen communities’ and policy-makers’ ability to design and implement better programs and policies?

Efforts to collect data with key populations should be part of a long-term relationship to ensure key populations are supported to understand and use data in their advocacy.

Data are tools that can be and are used in a wide variety of ways in the advocacy process:

- Assist in identifying the right advocacy issues to focus on
- Highlight the needs, experiences and concerns of key populations
- Provide evidence of the need for changes to policy and practices
- Persuade decision-makers to take a specific course of action
- Assist in understanding the perspectives of our target audiences for advocacy and therefore craft our advocacy messages more effectively
- Show whether or not advocacy efforts are making a difference
- The more relevant, reliable and appropriate the data advocates possess, the more realistic, representative and credible their policy demands will be

3. Invite any questions or comments
4. Invite the group to brainstorm different types and sources of data that they have used when doing advocacy.
5. Record ideas on flip-chart. Conclude by saying that we will look at this list in the next session, as we explore the different types and sources of data and how to analyze and use data for advocacy.

**Note to Facilitator:** At this stage, this is to brainstorm ideas only. You can review this list later when considering different sources and types of data and ask participants:

- Is it primary or secondary data?
- What was the source for the data?

See B.3, Step 2.
Introduction to Data Analysis

45 minutes

Materials: flip-chart, markers

Prepared Materials:

- **Flip-charts**: Quote; Definition of data; Qualitative/Soft & Quantitative/Hard characteristics and sources (headings only); Primary and secondary data definitions; List of different types of data

Participants’ resources: Page 36 (Introduction to data collection and analysis; Data Quality Issues; Data Quality Scenarios: Participant Worksheet)

Objectives:

To familiarize participants with the different types and sources of data (qualitative/soft and quantitative/hard) and the important factors that shape the quality of data, including the limitations of data.
Introduction:

**5 minutes**

1. Remind participants that data collection and analysis is an activity that informs the entire advocacy process, and briefly review how data informs the different steps of the advocacy process:
   - To decide what specific issue to advocate for
   - To analyze the knowledge that specific target audiences have about an advocacy issue
   - To develop appropriate message
   - To track support for its advocacy campaign
   - To monitor and evaluate the campaign.

2. Review the session objective: To familiarize participants with the different types and sources of data (qualitative and quantitative) and the important factors that shape the quality of data, including its limitations.

Session Instructions:

**Step 1: Use and Limits of Data in Advocacy**

**5 minutes**

1. Use the quote above, posted on a flip-chart or on whiteboard, and lead a discussion:

   “I've made up my mind; don't confuse me with the facts.”
   (Quoting a US Senator)
What is the quote saying?

What does the quote suggest regarding the role of data in decision making?

Some responses include:

- Decision-makers do not necessarily rely on evidence to inform what they do.
- Data can often be presented in ways that are not clear or clearly tied to concrete, actionable changes by decision-makers.
- While data are crucial to identifying responses that are needed and to providing evidence for the need for changes, evidence alone does not build political will and action.
- For data to have a better chance of being effective in informing policies and programs, data need to be analyzed and presented in a way that clearly points to key issues and actions needed by policy makers and programmers.

2. Note that data can also be a very important part of persuasive evidence, to motivate action in support of a policy issue but that data alone cannot achieve this.

Step 2: Kinds of Data and Data Sources

25 minutes

1. Remind participants about the definition of 'data' that was discussed in the previous session. Refer back to the definition on flip-chart.

Prepared flip-chart:

“Data: facts or information to be used as a basis for discussing, reasoning, or deciding something”. The Oxford Dictionary
2. Introduce this step explaining that it is important that participants have a shared understanding of key terms and concepts about types and sources of data.

3. Write “Qualitative/Soft” and “Quantitative/Hard” as column headings on a sheet of colored paper.

4. Ask one or two participants to explain briefly the differences between the two types of data and give an example.

5. Ask the group to provide characteristics of the different types of data i.e., what kind of information do the different types of data tend to provide? Use examples below as prompts, if needed.

<table>
<thead>
<tr>
<th>Qualitative/Soft Data Characteristics</th>
<th>Quantitative/Hard Data Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Descriptive, narrative</td>
<td>• Quantifiable, numbers</td>
</tr>
<tr>
<td>• Seeks to answer the question “why”</td>
<td>• Seeks to establish “how many”</td>
</tr>
<tr>
<td>• Focuses on processes</td>
<td>• Focuses on measuring discrete/pre-determined indicators of knowledge, behavior (actions), attitudes</td>
</tr>
<tr>
<td>• Encourages indepth probing</td>
<td>• Used to show trends over time or comparisons between different places or groups</td>
</tr>
<tr>
<td>• Records participants’ emotions, feelings, perceptions, attitudes, and motivations</td>
<td>• Allows for broad generalizations of findings to larger populations</td>
</tr>
<tr>
<td>• Enables the researcher to study selected cases, issues or events indepth</td>
<td></td>
</tr>
<tr>
<td>• Uses small, purposive samples</td>
<td></td>
</tr>
</tbody>
</table>

6. Ask the group to identify data collection methods for each category of data. Write the various responses under the appropriate heading.

Note that some types of data collection methods can include both types of data. Use examples below as prompts if needed.
7. Review with participants - the terms “primary” and “secondary” data. 
Reveal flip-chart definitions.

8. Illustrate these terms using these examples. Case studies or focus 
groups you document that describe key population experiences with 
police, or discrimination in using services, are primary data. Reports 
that document studies that show needle-and-syringe programs are 
effective in reducing HIV/AIDS transmission are secondary data.

9. Ask the group to consider what are the strengths and weaknesses of 
each type of data. Note that methodologically, each of the two types of 
data collection complement each other and also are often used 
iteratively (i.e., qualitative data collection helps identify key 
issues/categories to be investigated on a larger scale with quantitative 
data collection; in turn, when there are questions about relationships 
among quantitative findings, qualitative data collection may help to 
answer these).
10. Also ask what are some of the strengths and weaknesses of each type of data in the context of advocacy for policy change. Note, that in advocacy, concrete numbers that can be generalized to a larger number of people and that show clear trends are powerful to policy makers. They can help policy makers understand the need for action and the benefits to taking action on a larger scale. Nevertheless, being able to show what such numbers mean to individual people and communities is also crucial; for this qualitative evidence is invaluable.

11. Show the prepared flip-chart list of types of data

**Prepared flip-chart: List of different types of data**

- The most recent HIV/AIDS Epidemiological Surveillance and Estimates Report, NACO
- World Health Organization: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users
- Positive speaking: voices of women living with HIV/AIDS
- Participatory site assessment report of an NGO
- Key indicators for Frontiers Prevention Program: Report on Baseline study in Andhra Pradesh
- Case studies on MSM experience in accessing sexual health services
12. Ask - if they are likely to provide quantitative or qualitative data.

Suggested answers are outlined below.

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most recent HIV/AIDS Epidemiological Surveillance and Estimates Report, NACO</td>
<td>quantitative/hard</td>
</tr>
<tr>
<td>World Health Organization: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users</td>
<td>quantitative/hard</td>
</tr>
<tr>
<td>Positive speaking: voices of women living with HIV/AIDS</td>
<td>qualitative/soft</td>
</tr>
<tr>
<td>Participatory site assessment report of an NGO</td>
<td>can be both qualitative/soft and quantitative/hard</td>
</tr>
<tr>
<td>Key indicators for Frontiers Prevention Program: Report on Baseline study in Andhra Pradesh</td>
<td>quantitative/hard</td>
</tr>
<tr>
<td>Case studies on MSM experience in accessing sexual health services</td>
<td>qualitative/soft</td>
</tr>
</tbody>
</table>

13. Ask: Are these primary or secondary data? Look back at definition of primary and secondary data. Participants will need to ask who collected the data. For example, in the case of the last three documents, if these were collected by an organization that participants work for, it could be considered as primary data.
14. Conclude by raising the following points:

- It is likely that the kind of data collected will be both qualitative and quantitative data. For example, the M&E system for Avahan includes both qualitative and quantitative data collection methods, besides analysis of program impact.

- Secondary data will also be needed for advocacy work. The next session will focus on what advocacy issues emerge from analyzing behavioral and epidemiological data.

- There are MANY benefits of using different kinds of data to inform our advocacy efforts:
  - Data assist in identifying the right advocacy issues such as understanding the dynamics of the epidemic over time and the needs, experiences and concerns of people most affected by HIV/AIDS.

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The most recent HIV/AIDS Epidemiological Surveillance and Estimates Report, NACO</td>
<td>Secondary</td>
</tr>
<tr>
<td>World Health Organization: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users</td>
<td>Secondary</td>
</tr>
<tr>
<td>Positive speaking: voices of women living with HIV/AIDS</td>
<td>All remaining documents: Could be primary or secondary (i.e. if your organization collected the data, stories, focus groups, it could be primary)</td>
</tr>
<tr>
<td>Participatory site assessment report</td>
<td></td>
</tr>
<tr>
<td>Key indicators for Frontiers Prevention Program: Report on Baseline study in Andhra Pradesh</td>
<td></td>
</tr>
<tr>
<td>Case studies on MSM experience in accessing sexual health services</td>
<td></td>
</tr>
</tbody>
</table>
Data often provides evidence that can be used to show why changes to policy and practices are needed that can persuade decision-makers to a specific course of action.

Data helps to understand the perspectives of target audiences for advocacy and therefore to craft advocacy messages more effectively.

Data shows whether or not advocacy efforts are making a difference and help us learn from experiences to improve advocacy in future.

Step 3: Data Quality

15 minutes

1. Explain that in addition to advocates needing to understand potential sources of data, advocates also need to understand key issues related to the quality of data. Note that understanding the quality of data that is collected helps advocates be clearer in identifying and understanding key advocacy issues; it also increases the power and credibility of advocates when they use data.

2. Hand out the participant worksheet with each of the following scenarios printed, and explain that each scenario is designed to help identify a key issue with data quality.

3. Follow the same process for each Scenario (see scenarios below):
   - Ask a participant to read Scenario #1
   - Ask the group for their responses to the question
   - Debrief the question with the facilitators’ notes included in the box below and write the key word (i.e., validity, reliability, or bias) on a flip-chart when done debriefing
   - Repeat the process with scenarios #2, and #3
**Scenario #1:**

An advocacy network decided to focus its advocacy efforts to decrease the number of new HIV infections that are occurring among girls 15-21 years of age whose boyfriends or husbands were using injection drugs. The network wanted to address this issue in its advocacy messages and strategy and needed more information about these girls to make sure their advocacy approach was appropriate. The network found a survey on adolescent and young girls' knowledge and attitudes about reproductive health and decided to use that survey to gather information they could use for their advocacy strategy.

**Ask participants: What are the potential data quality issues here?**

**Note to Facilitator:** While the survey focuses on adolescent girls' reproductive health, it does not do so on their knowledge and behavior about HIV transmission or prevention. A general adolescent health survey would **not be a valid measure** of specific knowledge and attitudes about HIV/AIDS and IDU risk behavior. The network may be able to use some of the data from this survey, but to develop an advocacy strategy that would better address the issues of adolescent girls whose partners use injection drugs, a survey exploring specific issues related to knowledge and attitudes about HIV/AIDS and IDU risk behavior would have to be conducted.

**Scenario #2:**

At a presentation of a country's recent maternal and child health survey data, network members were shown data of HIV infection in all children 18 months of age tested at the National Pediatric Hospital outpatient clinic: at baseline the percent of all children infected with HIV was 12%, at 3 months the percentage was 25% and at 6 months the percentage was 6%.

**Ask participants: What are the potential data quality issues here?**

**Note to Facilitator:** Given the broad fluctuations in percent of children infected, one would question if the testing methodology, whether a rapid HIV test or an ELISA test, was
being administered correctly or reliably. The network should be very skeptical about using these data as their reliability is highly suspect. The network should demand that a quality assurance program be put in place at the hospital and the information gathered again.

Scenario #3:

An advocacy group wants to understand the HIV needs of MSM in their country. They have been able to access recent surveillance data for MSM. However, the surveillance data was carried out only in the capital city, and thus might not be valid for the whole country. They decided to find out more about the behaviors of MSM in rural areas. To gather this information, the advocacy group had providers of STI services for men ask their male patients who consented to be interviewed about their sexual behaviors. The service providers found very few men who reported sexual relations with other men. Therefore the data collected seemed to indicate that there were few men engaged in sexual relations with other men in rural areas.

Ask participants: What are the potential data quality issues here?

Note to Facilitator: Many of the men interviewed did not answer the questions completely because of fear of the reaction that their interviewer (as their health care provider) might have. Failing to have a trusted, neutral interviewer conduct the interview biased the findings resulting in under-reporting of important behaviors among men who have sex with men living in rural areas.

4. Ask participants in the context of the HIV/AIDS epidemic in their state/district and the issues they have worked on:

- What types of bias, reliability, and validity have been most notable?
- How have these affected the response to the epidemic so far?
- Are there any planned changes, work in progress, to address these issues about data quality?
5. Conclude the discussion by noting that policies or guidelines that use data that are not reliable, not valid, are biased, or have important gaps are unlikely to improve HIV/AIDS prevention, care or support services and interventions.

Part of an evidence-based approach to advocacy is for advocates to understand issues regarding data quality and gaps in available data in order to be able to advocate for good quality data to inform decision-making.
Analyzing Data: Behavioral and Epidemiological Data

1 hour and 30 minutes

Materials: flip-chart, markers

Prepared Materials:
- **Flip-chart**: Questions (Step 1)

Participants’ Resources: Data analysis exercises (see Facilitators’ Resources regarding access to data tables for this exercise)

Facilitators’ Resources: Review guidance notes on preparation for this session
Objectives:

To develop participants’ skills in analyzing behavioral and epidemiological data in order to understand what the data show and how such data may be used for advocacy, as well as the limitations of these data and to identify data gaps.

Introduction:

Explain that during this activity, participants will work in groups to examine behavioral and epidemiological data for India.

Note that the purpose of the activity is to help advocates understand the value of examining existing data and to identify the various uses of these data for the purposes of advocacy.

Session Instructions:

Step 1: Small Group Work

- Divide participants into small groups of five participants each

Note to Facilitator:

To obtain data analysis exercises and guidance on answers to issues for discussion see advice in Facilitators’ Resources section of this manual.

Data analysis exercises include five tables. Each group is to review and answer questions relating to Tables 1 and 2.

Example: For a group of 30 participants, there will be six small groups. Divide tables 3 to 5 among the six groups: Two groups will do Table 3; two groups will do Table 4 and two groups will do Table 5.
2. Distribute data analysis exercises to each group.

3. Explain the exercise set out on the flip-chart.

**Prepared Flip-chart:**

- Each group to do Tables 1 and 2 and only one of Tables 3 to 5, as allocated.
- Consider the questions that relate to each Table
- Record group's responses on flip-chart paper and select someone to present the group's output.

Time: 45 minutes.

**Step 2: Group Report Back and Discussion**

* 45 minutes

1. Review the responses to questions for Tables 1 and 2 in the large group.

2. Invite responses from the group and record on flip-chart and facilitate group discussion using facilitators’ guidance notes provided with data analysis exercises.

3. Invite the two presenters for Table 3 to briefly summarize their responses to the questions relating to that table. Facilitate group discussion using facilitators’ guidance notes provided with data analysis exercises.

4. Repeat (3.) above for Tables 4 and 5.

5. Invite reflections from the group on their process of data analysis. Use the following questions to generate discussion:
   - What was the process of analyzing data and consider how it might actually be used?
   - What were the learnings from this process?
Purpose:

Introduce participants to key aspects of the policy development process, including understanding the various factors and processes involved in policy development and the different types and levels of policy.

Sessions:

C.1 The Policy Process

C.2 Mapping Key Decision-making Processes for Advocacy Objectives
Objectives:

By the end of this module, participants will be able to:

- Understand how the policy development process works in India, at national, state and/or district level
- Understand and identify different types and levels of policy that can provide policy solutions for advocacy issues
- Develop a Policy Process Map for a new policy
Objectives:

Introduction:

1. Explain that a critical element of success of any advocacy effort is a thorough understanding of the policy process at the national level, or in your state or district. This includes how HIV issues are identified, how policies are formulated and implemented, which institutions and individuals are involved; what the roles, relationships and balance of power are among individuals and institutions; and how, where, and when to act to achieve maximum impact from advocacy efforts.

2. Explain that the purpose of this session is to gain insights and skills that will strengthen advocates’ ability to engage in dialogue with policymakers and move their advocacy agenda forward.
### Session Instructions:

**Step 1: Moderated discussion with guest panel**

1 hour

<table>
<thead>
<tr>
<th>Note to Facilitator: As facilitator, you will moderate this discussion. See the Facilitators’ Resources: Guidance notes on preparation for and conduct of this session.</th>
</tr>
</thead>
</table>

1. Welcome the guest panelists by name and role (Leave introductions until you invite each to make their opening remarks).

2. Introduce the objective for this session: To familiarize participants with the policy development process in India, at national, state or district level (depending on participants and therefore guest panels you have selected).

3. Explain that the format of this session is a moderated discussion:
   - The guest speakers have been asked to prepare ten minutes opening comments. Emphasize that you will ensure we keep to time so that there can be plenty of time for discussion.
   - After both guest panelists have made their opening remarks, there will be an opportunity for initial questions and comments, followed by interview style questions from panel chair and a moderated discussion.

4. Introduce each speaker, in turn, and invite them to make their opening remarks (20 minutes).

5. After both presentations, invite initial questions and comments from participants (10 minutes).

6. Moderate discussion, by drawing out key issues from each speaker and guiding discussion on the following issues:
   - Government representative - On the policy processes in government:
     - How are ideas or issues generated for new or revised policies?
     - What sort of process is followed in making or revising policy?
Where do policies get formulated (i.e., key committees, task force)?

How is a proposed issue introduced into the formal decision-making process?

What is the process for discussing, debating and, perhaps, altering the proposal?
  Who are the players involved?

How is the proposal approved or rejected?

If approved, what are the steps to move the proposal to the next level of decision making?

NGO representative - On influencing the policy-making process in government:

- How was the policy process intended to proceed and how did it take place in practice?
- What kinds of factors affected the way the policy process unfolded?
- What factors affected the views of policy-makers on the issue?
- What opportunities both formal and informal were available to you to get to know policy-makers and contribute to the policy development process?
- What was your role in the policy process?
  What different strategies did you use to influence decision makers and those who had influence with decision makers?
- What kinds of evidence and modes of delivery were seen as credible to policy-makers?

7. Thank the presenters and close the session by noting and highlighting some of the main lessons that have emerged from the session.

**Step 2: Brainstorming on Policy**

**15 minutes**

1. If workshop participants are not familiar with policy or policy actions, help participants to gain understanding through brainstorming and examples:
Ask participants what word(s) they associate with ‘policy’. Write responses on flip-chart.

Show the following definition of policy on a flip-chart and identify similarities with the words that participants gave:

2. Brainstorm different types of policies and record on flip-chart. Use some of the examples below to illustrate different types of policies at different levels

**Policy**: a law, rule, regulation or a set of guidelines, procedures, or norms from a higher-level authority to guide a course of action.

*Definition used in the Networking for Policy Change: An Advocacy Training Manual, 1999 POLICY Project*

If necessary.

3. Explain to participants that, as their brainstorming shows, there are different types of policies at different levels.

4. Review the different types of policies at different levels that emerge from the list the group has come up with and explain each term using examples below to illustrate types:
   - Laws
   - Plans or Strategies
   - Policies
   - Operational policies
   - Program guidelines

All are at different levels and in different types of institutions: national, state, Panchayat; public and private sector agencies.

**National and State Government policies**: In the public health field, the national government or the Ministry of Health is the high-level authority that decides policies that are intended to guide action in responding to HIV and AIDS. For example:

Plans/strategies: NACP III (2006-2011), is the five-year strategic plan to control HIV/AIDS in India. NACP III focuses on halting and reversing the epidemic in India over the next five years by integrating programs for prevention, care, support and treatment. The SACS have prepared Project Implementation Plans (PIPs) which are integrated in the National PIP.
There are also specific policies that guide different aspects of the HIV response. For example, at national level, The National AIDS Control Organization’s Voluntary Counseling and Testing policy provides guidance on voluntary testing and counseling, with a clear policy position that “no individual should be made to undergo mandatory testing for HIV” and that “mandatory testing should not be imposed as a precondition for employment.” The National Blood Policy 2000 sets out the Governments’ commitment to provide safe blood, blood components and blood products.

**Laws:** Laws can both support and hinder an effective response to HIV and AIDS. For example, laws that prohibit discrimination against people living with HIV and those affected by HIV, such as men who have sex with men, can protect people’s rights and support effective programs. Laws, such as Section 377 of the Indian Penal Code that criminalizes sex between men, undermine the rights of MSM and hinder an effective response to HIV.

**Panchayats** also have their own policies, regulations, and guidelines, such as policies on health and safety standards in health services, including universal infection control procedures. These policies are likely to be reflected in operational guidelines of public institutions, such as government clinics, giving details about how an infection control policy needs to be implemented in the health care setting.

**Private institutions** or companies also have their own policies; for example, a number of companies and sectors have developed workplace policies that address HIV/AIDS: Confederation of Indian Industry (CII) has formulated a model HIV/AIDS Policy for the Industry. Several companies like Tata Steel, Hindustan Lever Limited, Bajaj Auto among others have formulated company HIV/AIDS workplace policies.

5. **Note** again that many of these can exist within different institutions, i.e., within a national, state, district, local government, but also within, for instance, a faith-based organization, service providers, and at workplaces.

6. **Check** with participants to see if they have any questions or clarifications.
Mapping Key Decision-Making Processes

1 hour and 15 minutes

Materials: colored paper, markers, flip-chart, tape

Prepared Materials:

- Flip-chart: Discussion Questions: How Policy is Made

Participants’ resources: Page 42 (Policy Process Map)

Activity Option: This activity is optional. This session is more likely to be useful for those more experienced in advocacy and have some familiarity with the kinds of policy processes that are likely to be used in developing and agreeing to a specific policy that is the subject of this session.

This session needs to be framed around a specific policy. Facilitators will need to find a policy that at least some of the group may be familiar with. For example, the development of NACP III or a State Project Implementation Plan (PIP) for implementing the NACP III at state level.
## Objectives:

To develop a policy process map for a key policy.

## Introduction:

1. To be an effective advocate it is important to understand how specific policy decisions are made as well as the political climate in which they take place.

2. Now that participants have been introduced to some ideas about how the policy-making process works, we will now develop a map that shows the process of developing a specific HIV/AIDS policy.

3. Understanding the background of a particular policy decision-making process provides a basis for determining the degree of difficulty involved in changing that policy. It can also provide guidance for anticipating which groups will oppose the reform and which groups will support it.

## Session Instructions:

### Step 1: Mapping Decision-making Processes

1. Explain that in this exercise, participants will focus on mapping decision-making processes for a specific policy.

2. Introduce the session by providing information about the specific policy you will use for the session. You may wish to do this by preparing a flip-chart or a PowerPoint overview of the policy.

3. Explain that the exercise is to develop a decision-making/policy map that tracks the issue from its identification through the desired policy change.
4. Review:
   - Flip-chart with questions about How Policy is Made.
   - Handout with an example of a schematic map of an overall policy-making process and a specific policy process example.

5. Remind participants that this exercise is to draw on their own knowledge of the decision-making process, individuals and institutions involved in developing and agreeing on the specific policy you are considering in this exercise. If they do not have direct knowledge of this specific process, ask them to consider who they think would have been involved and what the process is likely to have been, drawing on their experience in other policy development processes.

6. Divide participants into groups and distribute flip-chart paper and markers to each group. Allow each group 45 minutes to draw its map.
**Step 2: Report Back and Discussion**

20 Minutes

1. As each group presents its map, discuss similarities or differences among the maps.

2. Facilitate a discussion to help the participants reach agreement on the most accurate details of each map. Highlight that the participants are likely to have gaps in the information that they need to find out in terms of who makes what decisions, following what process, on which timetable. Ask how they would go about finding out more.

3. Ask participants to take a few minutes to consider what struck them most about these sessions on the policy process. Then elicit some thoughts from the group.

4. Conclude by noting that even where there is a clear model or approach to making policy, the process is usually a dynamic and complex one. It is important to:

   - Understand both how the policy process works in theory and in practice
   - Consider what kinds of factors are likely to affect the views of policy-makers; what the political context is like at a given time
   - Look for opportunities to get to know and work with policymakers during the policy development process and to provide credible evidence for good policy decisions that supportive policymakers can use in the formal policy process (we will focus on this in more detail in forthcoming sessions)
   - Identify supporters and opponents both among those involved in the formal policy-making process and among those who have influence upon them
   - Identify opportunities, both formal and informal, to influence them in a timely manner as the policy process unfolds
Purpose:

Develop participants' skills in identifying advocacy issues, prioritizing these issues and identifying the kinds of policy solutions required to address these issues developing clear advocacy goals and objectives; identifying and understanding the target audiences that need to be influenced to achieve the advocacy goals.

Sessions:

D.1 Identifying Advocacy Issues
D.2 Prioritizing Advocacy Issues
D.3 Identifying Policy Solutions
D.4 Developing Advocacy Goals and Objectives
D.5 Primary and Secondary Target Audiences: Identifying Support and Opposition
D.6 Analyzing Target Audiences
Objectives:

By the end of this unit, participants will be able to:

- Apply a process to prioritize advocacy issues and identify policy solutions
- Develop advocacy goals and objectives specific to priority advocacy issues
- Identify the interests of primary and secondary target audiences and analyze how they may support or oppose advocacy issues

Background Notes: Goals and Objectives

The first two steps in any advocacy campaign are to select the advocacy issue and develop the goal and objective. These pieces of the advocacy process make up some of the most challenging, analytic work facing a country or group of people. Completing these steps requires an ability to analyze complex environments and inter-related problems, discern a policy solution for a selected problem, envision a long-term result, and articulate a short-term objective. The quality of the network’s efforts will have an important bearing on the success of the steps that follow. These elements provide the foundation for an effective advocacy campaign. Without a clear, articulated issue and well-defined goal and objective, the remaining steps of the campaign will lose focus.

An advocacy issue is the problem or situation that an advocacy group seeks to address. For example, a network may focus their efforts around issues such as stigma and discrimination of PLWHA. Some global advocacy issues that have attracted international attention are the use of anti-personnel landmines; universal, safe working conditions; and widespread sexual exploitation of women and girls. In this unit, participants will select an issue that is widely felt by their constituency and begin to build an advocacy campaign around that issue.
In various settings, the terms goal and objective are used interchangeably. In some instances, an objective is broad and a goal is narrow; in others, the meanings are reversed. For the purpose of the advocacy workshop, an advocacy goal is the long-term result (3-5 years) that the network is seeking. Participants should envision how the policy environment will be changed as a result of their advocacy efforts. Will all PLWHA have access to Anti-retrovirals? Will the government draft, approve, and implement a national HIV/AIDS policy using a transparent, participatory approach? These examples represent a long-term vision for policy change. A particular organization may not be capable of achieving its goal single-handedly, but the goal statement can orient an advocacy network over the long term.

Advocacy Objective:

The objective is a smaller and realistic step towards the achievement of your goal. It is usually what you hope to achieve in the next 1-3 years. Advocacy objectives need to be:

- **Specific**
- **Measurable**
- **Action oriented**
- **Realistic**
- **Time-bound**

An advocacy objective is a short-term target (1-2 years) that contributes toward achievement of the long-term goal. A sound objective is specific, measurable, realistic, and time-bound. Often, groups work on two or more objectives simultaneously in their efforts to achieve a single goal. It is important that an advocacy objective identify the specific policy body with the authority to fulfill the objective as well as the policy decision or action that is desired. Two examples of sound advocacy objectives follow:
To secure a written commitment from the Director General of Police by a certain timeframe to provide written instructions to the police department about the purpose of the Immoral Trafficking Prevention Act (ITPA), specifically that the ITPA is not a basis for arresting sex workers.

To secure a written commitment from the National AIDS Control Organization (NACO) by a certain timeframe, to prepare and promote guidelines for non discriminatory provision of HIV prevention, testing and care services, specifically to address discrimination against key populations such as men who have sex with men, people who inject drugs and sex workers.

Introduction:

1. Introduce this module by outlining the objectives:
   - Understand and apply a process of prioritizing advocacy issues and identify policy solutions they seek.
   - Understand and develop advocacy goals and objectives specific to the prioritized advocacy issue.
   - Identify support and opposition among primary and secondary target audiences related to specific advocacy issues and analyze their interest in that advocacy issue.

2. Outline that the next few sessions will focus on identifying and prioritizing advocacy issues and setting goals and objectives.

3. Provide an overview using the background notes.
Identifying Key Advocacy Issues

20 minutes

Materials: markers, flip-chart, tape

Prepared Materials:

- Flip-chart: Task instructions; Definition of “Advocacy issue”

Participants’ Resources: Page 50 (Background Notes)

Session Instructions:

Step 1: Brainstorm Advocacy issues

1. Ask participants to think about key HIV/AIDS advocacy issues in their state/ district/ local context.

2. Review two prepared flip-charts:
Task instructions:
1. What are the priority HIV/AIDS issues you have identified through your work? Why? Be specific. For example, discrimination against sex workers in accessing health services.

2. Jot down your thoughts (5 minutes)

3. Discuss in pairs (5 minutes)

3. Give an example of a 'policy solution' that would be relevant to one of the advocacy issues identified in the list.

4. Ask if there are any questions about policy actions to enable participants to undertake the task. Explain that another session shortly will explore in more depth the concept of policy solutions, but for now participants should begin to consider whether the issues they prioritize could be addressed by a policy action.

5. Lead a group discussion, asking people to contribute their ideas.

6. Record their responses on a flip-chart, recording only new issues as people contribute.

7. Group issues that have emerged where there are common themes coming up from the issues proposed. This should result in a list of about 8-10 major advocacy issues that can be used as the basis for prioritizing advocacy issues in the next session.
Objectives:

To understand and be able to apply a process for prioritizing advocacy issues.

Introduction:

Explain that prioritizing an advocacy issue is an important strategic decision that requires much analysis and consensus building. This activity provides an approach that can help a network or organization decide which issue or issues they should focus on and why.
### Session Instructions:

#### Step 1: Prioritizing by discussion

<table>
<thead>
<tr>
<th>Task instructions:</th>
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</thead>
<tbody>
<tr>
<td>1. Review list generated from brainstorming session</td>
</tr>
<tr>
<td>2. Discuss issues and agree on the top three advocacy issues</td>
</tr>
<tr>
<td>3. Record on a flip-chart in priority order 1-3.</td>
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<tr>
<td>20 minutes</td>
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</table>

#### Prepared Flip-chart:

**Advocacy Issue:** A problem that requires a policy action or solution.

<table>
<thead>
<tr>
<th>Task instructions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain to participants that they will now be asked to look in more detail at the key HIV/AIDS issues in their state/district/local context. Highlight that the purpose of this exercise is to use different methods to prioritize from the list of issues we brainstormed in the previous session.</td>
</tr>
<tr>
<td>2. Divide participants into small groups of about six people (Result is five groups of six, based on a group of 30 participants).</td>
</tr>
<tr>
<td>3. Review instructions on a flip-chart:</td>
</tr>
<tr>
<td>4. Remind participants about the definition of an advocacy issue posted on a flip-chart.</td>
</tr>
<tr>
<td>5. Repeat that participants only have 20 minutes, so they need to review issues, discuss and agree on their three priority issues, ranked 1-3. Write up on flip-chart paper.</td>
</tr>
</tbody>
</table>
**Step 2: Report Back and Discussion**

10 minutes

1. Ask each group to post their flip-charts listing three priority advocacy issues. Allow participants a few minutes to have a look at each of the lists ('gallery walk').

2. Lead a group discussion asking participants to reflect on the process: was it easy or was it a challenge to identify top three issues, and why.

3. Ask participants to identify the issues that seemed to appear most often and identify which issues emerge as priorities. Use this discussion to identify the five issues that receive the most attention.

4. List the top five issues on a flip-chart.

**Step 3: Prioritizing Using Criteria**

30 minutes

1. Explain to participants that there are many ways to prioritize issues. One way is through the discussions as they have just done. Another way is to rank issues according to key criteria that a group agrees are important.

2. Refer participants to handout “Checklist for Choosing an Issue” and review the criteria. Especially note: Is it an advocacy issue for which there is a clear policy solution?

3. Ask participants if there are any additional criteria they would like to add. If so, note these on a flip-chart and instruct participants to add them to the bottom of their checklist.

4. Divide participants into small groups and give them 25 minutes to work in groups to rank their three issues, 1-3, using the criteria.

5. Note that even though they have already chosen three priority issues in the previous exercise, this exercise is to see whether using criteria produces a different result, changes their thinking on which issues are priority or assist the group in deciding which issues to prioritize.
**Step 4: Report Back and Discussion**

1. Ask each group to post their three priorities next to their previous list. Allow participants a few minutes to have a look at the lists (a gallery walk). (Note: Ensure the small groups keep this list for use in session D.3)

2. Ask participants to identify the issues that seemed to appear most often and identify which issues emerge as priorities. Use this discussion to identify the five issues that receive the most attention.

3. List the top five issues on a flip-chart (Note: Keep this list for use in session D.3).

4. Facilitate a discussion with the whole group about whether using criteria produces a different result, change their thinking on which issues to prioritize or assists in deciding which issues to prioritize.

5. Ask participants what was different about prioritizing by discussion and issuing a checklist? What were the differences between the approaches? Which approach do they think would produce the choice of advocacy issue to work on? Why?

6. In conclusion summarize the main differences in each approach that emerged from the discussion and highlight the advantages in using a checklist to prioritize advocacy issues. Ensure you mention that using criteria assists in:
- Assessing the policy environment opportunities to pursue the issue or possible impediments

- Choosing issues based on whether there is data that supports your argument for the need for policy change

- Focusing on an advocacy issue you have the skills and resources to work on or can contribute to, together with other allies
Certain Caveats

- Three 1s beginning to emerge but needs strengthening
- Many programs have been initiated already but requires alignment
- Some processes have been triggered but would require consolidation in order not to lose the momentum
- Integration and convergence areas worked out in detail requires implementation
- Coverage through TI, Vulnerable groups and positive program initiatives have to make the prevention to care continuum oriented
- CBO and key population empowerment strategy to be more operational
Identifying Policy Solutions

30 minutes

Materials: markers, colored paper, flip-chart, tape

Prepared Materials:
- **Flip-chart**: Definition of “Advocacy Issue” (from D.2), Definition of “Policy”; List of five advocacy issues (from D.2); Task instructions.

Objectives:
Understand and identify different levels of policy solutions for advocacy issues.

Introduction:
Introduce the session by stating that in moving from an issue to what you might want to achieve through advocacy (i.e., what your advocacy goals and objectives might be), it is important to think about what policy solutions are needed and which could be considered most important.

Recapitulate and post the definitions of “Advocacy Issue” and “Policy” on
There are usually many possible policy solutions for a given advocacy issue, so it is important to understand the range of possible policy solutions for a specific advocacy issue.

It is important to note that not every issue is best resolved through a policy action or solution.

Having a clear understanding about what is the policy solution being sought helps advocates to prioritize which issues are best addressed through advocacy for policy change and define a clear goal and advocacy objectives for their advocacy campaign.

Ask all participants to review the five advocacy issues that emerged from the session D.2, and have a participant volunteer one of their issues to discuss:

Note for facilitators
There are specific restrictions about Āvāhan programs engaging in 'lobbying'. The general rule is that private foundations such as the Bill and Melinda Gates Foundation (and hence the BMGF Āvāhan Program) may not engage in lobbying, paying for or funding lobbying activities. However, what is meant by the term 'lobbying' is very specific. It does not refer to lobbying about all policy change, only lobbying about specific or proposed legislation.

See the information sheet provided in the Facilitators’ Resources Section C, Understanding the Policy Process.
Can it be addressed by a policy action?
If so, what types of policy action

Write the advocacy issue at the top of a flip-chart. Elicit ideas about types of policy actions that could address the issue. Record responses.

**Facilitator Tip:**
The following are examples of issues that you can use to help participants understand what is meant by “policy actions”:

<table>
<thead>
<tr>
<th>Examples of identified issues</th>
<th>Is a policy action needed?</th>
<th>What kinds of policy actions should be considered?</th>
</tr>
</thead>
</table>
| MSM in India are highly vulnerable to HIV, but some high prevalence states have no data      | Yes (to ensure that needed data are collected) | • The Ministry of Health & Family Welfare (MOHFW) decides to start BSS or to review existing BSS to ensure data collected on MSM  
• SACS develop guidelines to promote non-discriminatory approaches to delivery of VCT, HIV prevention and care services |
| Limited services & resources addressing sexual transmission of HIV in the North East (Manipur and Nagaland) because of perception that epidemic is only driven by injecting drug use. | Yes (data are available but not really used in policy and planning) | • MOHFW and SACS to develop and fund programs to address prevention of sexual transmission of HIV and integrate into existing programs  
• IDU service providers to better address sexual transmission of HIV as part of programs for IDUs and their sexual partners |
| HIV + workers are fired or discriminated against in workplaces                               | Yes                         | • The three largest businesses in the country approve anti-discriminatory workplace policies and train their staff  
• Ministry of Labour sets up system to regularly collect data on discrimination against HIV + workers |
Session Instructions:

Step 1: Identifying Policy Solutions

15 minutes

1. Instruct participants to return to the groups they worked with in prioritizing advocacy issues.

2. Review task instructions:

Task Instructions:

1. Review the top three issues that emerged from their prioritization process using criteria and choose two out of three advocacy issues.

2. Discuss what sorts of policy actions or solutions could be sought to address each of these advocacy issues.

3. List each advocacy issue and at least two policy actions for each issue on a flip-chart.

3. Ask groups to post their flip-charts, and allow participants to review the charts for a few minutes.

4. Allow participants to ask questions about any of the policy solutions/actions on the flip-charts.

5. Highlight examples that provide clear policy solutions. Ask who would need to be influenced to take on this policy action. Or putting it another way, who is the primary decision-maker?

6. Provide feedback on examples that are unclear and suggest alternatives or ask participants to suggest improvements. Again ask who would need to be influenced to take this policy action. Or putting it another way, who is the primary decision-maker?

7. Conclude by asking participants what they learned from having worked to identify possible policy solutions.
Objectives:
To understand and develop advocacy goals and objectives specific to the prioritized advocacy issue.

1 hour 30 minutes

Materials: markers, flip-chart, tape

Prepared Materials:
- Flip-chart: Definition of “Advocacy Goal” and “Advocacy Objective”; Examples of Advocacy Issues, Goals and Objectives; Five advocacy issues with six spaces per issue; Elements of an Advocacy Objective

Objectives:
Introduction:

1. Explain that now that the groups have prioritized advocacy issues, and possible policy solutions/actions, in this session participants will learn to develop and set advocacy goals and objectives around particular issues identified.

2. Highlight that defining advocacy goals and objectives is the key process by which an advocacy issue is shaped into a specific change that advocates hope to achieve. It is a critically important strategic moment, as there are often many possible solutions to a given issue. Setting an advocacy objective prioritizes which change will be sought.

3. Refer back to the introduction to this module by reminding participants about the definition of a goal and objectives by reviewing flip-chart definitions:

Prepared Flip-chart:

An advocacy goal is the long-term result (three years) of your advocacy effort; it is your vision for change

An advocacy objective is the short-term step (one year) that contributes toward your goal

Session Instructions:

Step 1: Developing an Advocacy Goal

30 minutes

1. Review the following examples on flip-charts:
Prepared Flip-chart 1: Example from sex workers’ group

- **Advocacy Issue:** Police harassment of sex workers and HIV prevention peer workers is undermining sex workers access to HIV prevention/STI services

- **Advocacy Goal:** Equal access to quality HIV prevention and STI services for all

- **Advocacy Objective:** Secure a commitment from the Police Department that there will be clear guidelines developed and training for police to increase awareness on issues relating to HIV/AIDS and successful strategies for reducing risk of HIV infection among sex workers, their clients and the wider community

Prepared Flip-chart 2: Example from MSM group

- **Advocacy Issue:** Discrimination towards MSM by counselors in VCTCs is driving the epidemic among MSM underground, as fewer MSM know their status and access HIV prevention information

- **Advocacy Goal:** Increase access by MSM to non-discriminatory mainstream HIV prevention, testing and health care services

- **Advocacy Objective:** Secure a commitment from NACO that within 12 months they will prepare and promote guidelines for non-discriminatory provision of HIV prevention, testing and care services, including for MSM
2. Ask participants to highlight the differences between the goal and the Objective.

3. Facilitate discussion making sure the following points are covered: The advocacy goal is a long-term result, often involving a range of players to bring about the policy change and implement it.
   - Example 1: It is unlikely that a sex workers’ group who developed this goal, can achieve the goal by themselves. Therefore, the goal is considered external to the group. In other words, the group will not hold themselves accountable for achieving the goal, even though the goal is the ultimate, desired result.
   - Example 2: Increasing access for MSM to mainstream prevention, testing and care services. Getting NACO to develop and promote guidelines for non-discrimination, specifically including MSM, may be a difficult goal to include by one group or organization by themselves. Services will play a critical role in making this possible.
   - The advocacy objective is something achievable by a specific group or organization.
   - Example 1: The objective is achievable by a sex workers’ group themselves or in coalition with other organizations advocating for this commitment. It is a short-term target that is achievable within the next one to two years. Success can be measured easily. Either the government states its commitment or not. The advocacy objective clearly contributes to the broader goal.
   - Example 2: The objective is achievable by a coordinated group of organizations. It has a target that is achievable within the time-frame.

4. Post up the prepared flip-chart with a list of five advocacy issues prioritized using criteria (Session D.2), with six spaces under each advocacy issue. Allow participants to choose an issue they wish to work on (result should be six participants for each issue).

5. Ask each group to draft an advocacy goal for the advocacy issue. The goal statement should describe a long-term, desired change related to the issue. Allow 10 minutes and ask the group to write their goals on colored paper.

6. Ask each group to present their goal statement (about five minutes).
7. Review each goal statement by using the following questions to guide the discussion:

- Is the goal achievable through a series of policy decisions, actions, or solutions? If policy change cannot contribute to achieving a particular goal, it is probably not an advocacy goal. Often, a goal calls for policy action as well as for public awareness raising. In that case, an advocacy strategy can be used to bring about the necessary policy changes, while an IEC/public awareness campaign can focus on changing public behavior or norms.

- How are the group's goal statements similar or different from each other?

### Step 2: Setting Advocacy Objectives

1 hour

**Note to Facilitator:**
You will need to tailor this session based on participants' knowledge of “SMART” criteria:

- If participants know “SMART”: Go ahead and introduce the idea of SMART and connect SMART to the three elements of the advocacy objective.

- If participants do not know “SMART”: Focus on the three key components of an advocacy objective and when processing these elements, also note that two additional criteria can be added (ask if the objective is achievable and realistic.)

1. Start by referring to the definition of ‘advocacy objective’ already on flip-chart.

2. Ask participants if they have experience in establishing program objectives. Explain that such experience is helpful in setting advocacy
objectives. Sound objectives are essential to any planning process whether planning an HIV/AIDS program or an advocacy campaign. Clear and concisely written objectives provide clarity and direction for the rest of the planning process.

3. Ask participants to list the criteria of characteristics they generally use to develop program objectives and write their responses on a flip-chart.

Note to Facilitator:
Many groups mention the SMART criteria for objectives as shown below, but others may be listed as well. If the group mentions SMART, go ahead and refer to it and open flip-chart with SMART posted. Ask:

1. Do the SMART objectives also apply to advocacy objectives?
2. What, if any, other criteria or elements should be included in an advocacy objective?

Criteria for Setting Objectives
- **S** specific
- **M** measurable
- **A** achievable
- **R** realistic
- **T** time-bound

4. Explain that an advocacy objective includes several key elements. Write the following on the flip-chart and give a brief description of each element:

Elements of an Advocacy Objective
- **Policy “actor” or decision-maker**
- **Policy “action” or decision**
- **Time-line and degree of change**
Policy actor or decision-maker is the individual who has the power to convert the advocacy objective into action (e.g., Union Minister for Health and Family Welfare)

Policy action or decision is the action required to achieve the objective (e.g., adopt a certain policy; allocate funds to support a specific program or initiative)

Time-line describes when the objective will be achieved. Advocacy objectives should be achievable within one to two years. Some advocacy objectives also indicate the degree of change or a quantitative measure of change desired in the policy action. For example, degree of change could be expressed as redirecting 25% of the regional HIV/AIDS budget to target adolescent services.

Note: If you have not introduced the idea of SMART, also tell the participants that it is important to assess whether the objective is ACHIEVABLE and REALISTIC.

5. Review one of the earlier examples, and ask whether it contains these three elements. Note: The example is not time-bound. Revise the example.

Prepared Flip-chart: Example from sex workers’ group

Advocacy Issue: Police harassment of sex workers and HIV prevention peer workers is undermining sex workers access to HIV prevention/STI services

Advocacy Goal: Equal access to quality HIV prevention and STI services for all

Advocacy Objective: Secure a commitment from the Police Department that there will be clear guidelines developed and training for police to increase awareness of issues relating to HIV/AIDS and successful strategies for reducing risk of HIV infection among sex workers, their clients and the wider community.
6. Ask participants to return to their groups to draft three key advocacy objectives that:

- Respond to the advocacy issue
- Contribute towards achieving the advocacy goal
- Meet the criteria and elements listed on the flipchart (three elements)

7. Allow 30 minutes for groups to complete this exercise.

8. When the groups have completed the exercise, invite each group to present its objectives. Be sure that the policy actor, policy action and time-frame are clearly identified in each group's objectives. Are they achievable and realistic? (20 minutes)

9. Alternative report back: Ask all groups to put up their objectives as a gallery walk and allow the group time to read each others work, then facilitate a group discussion on each set of objectives in turn, inviting questions, suggestions and providing specific feedback on each. If people need more time to develop their objectives, use this approach to save time.
To increase the chances of success, advocacy groups must identify and study all the individuals and groups that may support the group’s issue and goal as well as those that may oppose it. The advocacy campaign’s target audiences must be determined for each advocacy objective to be achieved and include the primary target audience persons and/or institutional bodies that themselves have decision-making authority as well as the secondary target audience persons and/or institutional bodies that can influence decision-makers. Documenting information on these audiences helps group target its advocacy activities, develop effective messages, and select appropriate channels of communication.

While the categories of people in the target audience are not identical in every setting, the HIV/AIDS policy target audience is likely to include political leaders, national and local government officials, private and public sector service providers, PLWHA groups, and groups representing other populations vulnerable to HIV (i.e. sex workers, MSM, IDUs) the media, religious and traditional leaders, NGOs, womens’ organizations, professional associations, and business and civic groups. In some places and for some issues, the range of audiences is even wider and may encompass groups that are unlikely ever to meet each other, such as foreign donors or traditional healers.
Once the audiences are identified, the group must determine the level of support or opposition to be expected from those in the primary and secondary target audiences. For many reasons religious, cultural, and historical, HIV/AIDS related issues are often controversial. People on both sides of the issue feel strongly that their position is the right one; therefore, they are willing to devote considerable resources to supporting that position.

Whether opposition is mild or strong, advocacy groups should be prepared to address it in ways that are most beneficial to their own efforts. The best advice is to be as informed as possible about the opposition's specific issues and base of support and to pre-empt oppositional efforts with messages that anticipate and refute the opponents' arguments.

On the other side of the coin, advocacy networks often dedicate themselves to broadening their base of support. The larger the number of persons or groups working to achieve the advocacy objective, the greater is the chance of success. Groups can create coalitions with other groups or formal networks, expand their own membership, create alliances with commercial or private sector entities, and/or generate public and community support to enlarge their support base.

Finally, advocacy groups cannot afford to forget the “undecided” or neutral parties. In some cases, the best investment of time and energy is to appeal to the neutral public. Public opinion can exert powerful pressure on decision makers. In other cases, the group may find policy makers and public officials who appear neutral but in fact hesitate to voice an opinion due to the controversial nature of the HIV/AIDS issue; they may support the advocacy efforts in private but prefer to appear neutral. The group may decide to direct its efforts to convincing these influential “neutrals” to join and publicly support the campaign.

Objectives:

By the end of the next two sessions participants will:

- Identify support and opposition among primary and secondary target audiences related to a specific advocacy issue
- Analyze their interest in that advocacy issue
Introduction:

1. Introduce the session: We are now going to look in more detail at the target audiences for our advocacy efforts. Who do we need to try and influence in order to achieve our advocacy goal and objectives?

2. This session and the session that follows will focus on identifying who the primary and secondary audience for our advocacy issues are; what level of support and opposition exists among these audiences related to specific advocacy issues and analyzing their interest in a specific advocacy issue.

3. Give an overview on target audiences using the background notes including that there are many strategic advocacy decisions that are based on a thorough analysis of the target audience. In this session, participants first learn a technique to identify primary and secondary target audiences for their specific advocacy objectives; then participants in the next session will assess the audiences' level of knowledge and support for the issue and objectives in more detail.
Target Audiences:
Identifying Support and Opposition

Materials: Each group should get numerous sheets of colored paper, markers, scissors, glue. Flip-chart, tape, colored paper. Old magazines that can be cut up for making a Power Map for each group.

Prepared Materials:

- **Flip-chart:** Sample Power Map; Task for group work; Definition of primary and secondary audience (in the facilitators’ resources).
Session Instructions:

Step 1: Introduction

45 minutes

1. Present the blank Power Map that you have prepared on a flip-chart or whiteboard. Make sure you divide the Power Map into quadrants to account for primary and secondary audiences.

2. Explain that participants will work in the same groups as for the advocacy goals and objectives.

3. The task for each group is to create a ‘power map’ that visually depicts the target audiences for their advocacy messages for one of its own advocacy objective.

4. Review the task written on the flip-chart by using the blank map as a model.

Advocacy Objective:

<table>
<thead>
<tr>
<th>Support</th>
<th>Neutral</th>
<th>Opposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Definitions:

- **Primary target audience:**
  - Persons and/or institutional bodies that have decision-making authority.
Task for Power Maps

1. List all institutions and individuals with interest in your issue/objective on a piece of paper

2. Note whether they are primary or secondary target audiences

3. Note whether they are supporters, in opposition, undecided, or unknown to the advocates

4. Only when you know answers to each of the above questions, then:
   - find an image or symbol to represent them
   - Locate where you want to place them on Power Map

5. You can use different sizes to show relative importance and influence of each decision-maker.

50 minutes

6. As you review the task, elaborate on several steps as follows:
   - Remind participants to think broadly when identifying the secondary audiences. Influential persons often extend beyond professional circles and include personal relationships. For example, a relative, spouse, or friend of a high-level decision-maker can be a great intermediary. Participants should also think of traditional as well as non-traditional “actors” in the policy process, including celebrities or relatives of the target audience
   - Make sure you decide:
     - Primary or secondary
     - Oppose, support, neutral, don't know

BEFORE you place symbol or image on Power Map
Placement: If the actor is highly supportive of the issue/objective, the symbol should be placed on the left side of the map. If the actor represents strong opposition, the symbol should be placed on the right side. The line of neutrality is in the center of the map, and those actors who are undecided or whose opinion is unknown should be placed closer to the center line. If any actor is closely linked to another actor, their symbols can overlap or touch to reflect the inter-relationship.

Note that size = power and that participants may want to make power relative with respect to primary and secondary audiences.

7. Use the following example to review the steps in the mapping process:

Advocacy objective: Within the next year, convince the state government that the PLWHA network needs to be represented on the SACS.

Target audience: Allies might include: National and regional PLWHA networks, coalition of AIDS service organizations, AIDS NGOs, women leaders and unions. These would be placed on the left of the map in proper relation to one another. Opposition might include government members who have expressed discrimination against PLWHA groups, among others. These would be placed on the right side of the map.

Step 2: Prepare and review Power Maps

80 minutes

1. Distribute colored paper and markers to the groups and show them the scissors, colored paper, magazines and glue that they can use to create their Power Maps.

2. Remind groups they have 50 minutes to complete their Power Maps.

Note to Facilitator: Move around the groups, listening to the discussions. Ask open questions as they discuss audiences. Be sure that people understand the difference between primary and secondary audiences. For primary: Ask - Do they have the power to bring about the policy solution/ change you seek? Are they the decision-making power?
If they do not know whether the person/group/institution's view on the issue - **Ask** how they would get more information to help them answer the question. What sort of information do they need?

If you have a camera or photographer at the workshop, this exercise offers a good photo-opportunity. Following the presentations, you can take photos of each group with its Power Map.

3. Ask for a representative from each group to provide a brief overview of their Power Map (five minutes each).

4. Moderate a discussion of each map with the full group, using the following questions:
   - Are there any additional allies that belong on the map? Who are they? Are there additional opponents? Who are they?
   - Does the map reflect the support, opposition, neutrality of different players?
   - Where on the map do most of the power and influence reside?
   - What does this map suggest about where to focus advocacy efforts?

   Allow five minutes discussion for each map.

**Alternative approach:**

You can have more time for feedback on Power Maps if groups post up their Power Maps as a gallery walk. Allow a few minutes of group time to view each other’s Power Maps, then lead a large group discussion on each map.

5. Conclude by noting that this mapping process also helps identify where/who to build alliances and support, and where advocates need to collect more data about target audiences in order to understand their knowledge, views and attitudes about the issue. Analyzing the target audiences is the subject of the next session.
Analyzing Target Audiences

1 hours 15 minutes

Materials: Markers, flip-chart, tape, 3-4 pairs of scissors, glue, colored paper that can be cut up for making the Power Map for each group.

Participants’ Resources: Page 57 (Primary and Secondary Audience Analysis Form)
1. As we have seen in the previous session, in order to understand support and opposition for an issue, it is important to understand the target audiences' knowledge, views and attitudes about an issue. This is likely to involve research. This session is designed to introduce participants to a method for analyzing target audiences.

2. Ask participants to continue working in the same groups as for the Power Map activity from the previous session.

3. Distribute and review Handout: Target Audience Analysis.

4. Explain that the form is a planning tool that will help the group to analyze the various actors in the target audience in order to design effective advocacy activities and messages.

5. Ask each group to refer to the actors they identified on their Power Map. Identify which of those actors are the Primary Audience - the person(s) and/or bodies with the power to achieve advocacy objectives directly; and the Secondary Audience - the person(s) and/or bodies that can influence the Primary Audience. The groups should transfer the names to the appropriate box on the form and complete the remaining columns as follows:

- Level of Knowledge about the Advocacy Issue. Is the audience well informed or does it lack accurate information? How much does the audience know about the issue?

- Level of Demonstrated Support for the Issue. Has the audience actively and/or publicly supported this issue? Rank and describe evidence of support.

- Level of Demonstrated Opposition toward the Issue. Has the audience actively or publicly opposed the issue?

- Undecided or Unknown. Has the audience failed to declare its position on the issue? Or are you uncertain of its position at this time?

- Potential Benefits to the Audience. How might the audience benefit from supporting the network's issue and objective?
Step 2: Analyze target audiences

1. Ask participants to choose 1-2 key audiences each from their primary and secondary audience list (brain-stormed for the power map).

2. Allow 40 minutes for the groups to complete their Target Audience Analysis forms.

Note to Facilitator: Move around the groups, listening to the discussions. Ask open questions as they discuss audiences and complete the Target Audience Analysis forms.

If they do not know the person/group/institution's view on the issue, ask where might they be able to get more information to help them understand the target audiences position or likely views on the issue.

Suggestions: media reports; meet with other advocacy organizations that have contact with the decision maker or their advisors; government reports or parliamentary debates; policy statements; election promises.

Step 3: Review analysis of target audiences

30 minutes

1. When the groups have completed the forms, invite each group to describe their analysis of one target audience.

2. Moderate a discussion with the full group on each question as follows:

   - What are the general observations about the audience analysis e.g., need more information on actors, the opposition is more vocal/public than supporters, etc.?

   - Based on the analysis, how might you focus your advocacy effort?

   - Why is it important to identify potential benefits? How might these be used to your advantage?
What, if any, additional information is needed for an accurate assessment of the target audience? Where will you get the information?

3. Conclude the activity by reminding participants that organizations should continue to collect information on its target audiences and collate it using a form such as this. Information on the various target audiences will help define the overall strategy and tailor your advocacy messages.
Implementation: Advocacy Action Plans

30 minutes - 3 hours

Materials: markers, flip-chart, tape

Prepared Materials:
- PPT: Action Plans: Implementation and M&E

Facilitators’ Resources: PowerPoint presentation Implementation: Developing an Advocacy Action Plan

Participants’ Resources: Page 58 (Indicators for Monitoring and Evaluating Advocacy Campaigns; Sources for Monitoring and Evaluating Advocacy Campaigns: Advocacy Action Plan template)

Purpose:
Familiarize participants with the framework and constituents of an advocacy action plan and develop their skills in developing a plan.
Sessions:

E.1 Introduction to Advocacy Action Plans
E.2 Developing an Advocacy Action Plan

Objectives:

By the end of this module participants will:

- Understand the key elements of an advocacy action plan
- Be able to prepare an advocacy action plan

Introduction:

5 minutes

Introduce this session by reviewing the objectives. State that this activity will focus on the steps involved in developing an advocacy action plan. Key points to include in your overview:

- This session represents the action planning phase of the training. Up to this point, the workshop has focused on building knowledge and technical skills to undertake the various steps in the advocacy process: defining issues, setting goals and objectives, and assessing support and opposition and researching target audiences.

- This session focuses on building the necessary skills to develop action plans for a specific advocacy issue. Here we will review a simple action planning process and have a chance to apply it to one of the advocacy objectives you have developed in an earlier session. You will have a chance to brainstorm sample advocacy activities, as well as to describe needed resources, responsible person(s), and an appropriate time-frame for each activity, develop indicators and collect data to monitor progress and outcomes and evaluate the impact of your advocacy efforts.
Introduction to Advocacy Action Plans

Activity Option:

- E.1 Introduction to Advocacy Action Plans. There are two options - either facilitated brainstorming or a PowerPoint presentation.

- If the purpose of the activity is only to introduce the idea of advocacy action plans, this session is sufficient to review the key elements of an action plan. If you want participants to develop an action plan, also do session E.2

Note to Facilitator:

You may wish to spend more time discussing monitoring and evaluating advocacy in E.1. If so, see Monitoring and Evaluating Advocacy in the Facilitators’ Resources.

You may also wish to use these materials when assisting small groups to prepare their action plans E.2 and providing feedback on action plans.

Objectives:

Understand the key elements of an advocacy action plan.
### Option 1: Facilitated Group Brainstorming

#### 25 minutes

1. Remind participants that they have completed several steps in the advocacy process. They have:
   - Identified an advocacy issue
   - Identified an advocacy goal - the long-term change they hope to achieve
   - Set specific advocacy objectives that will contribute to achieving that goal
   - Assessed the support and opposition and identified primary and secondary target audiences
   - Considered sources of data that they can use to support their advocacy messages and for monitoring and evaluating their advocacy efforts.

2. Explain that developing an Advocacy Action Plan is a key tool for translating their objectives into specific activities for action.

3. Ask who has developed implementation or action plans for any kind of project, and ask what are some of the key elements of such plans.

4. On a white-board put ‘Objective’ up at the top and the right number of columns as per the template for action plan. Ask what are the components of an action plan. Anticipate the following, and ask questions that will promote these responses if they don't come up.

   For each Objective the plan will set out:
   - What activities are needed to achieve the objective
   - When: Time-frame
   - Who is responsible?
   - How will the activities be accomplished? (What human and financial resources are needed?)
   - How will you know if you have achieved the outcomes you are seeking? What outcomes? What indicators can help to assess and monitor your progress, outcomes and evaluate the impact of your advocacy efforts?
5. Fill in the white-board - table activities, time-frame, etc.

6. Ask someone to suggest an objective that has been developed during the training. Ask participants to call out a few activities that might help them achieve the advocacy objective one group has identified during the workshop.

7. Ask if there might be additional elements to plan/track when developing an Advocacy Action Plan.

8. Solicit/write the responses. Anticipate the following, and prompt with questions if they don't come up:
   - Target audiences for individual activities
   - Expected results/evaluation plans
   - Actual results/documentation of results

9. Moderate a discussion about the points above noting the specifics of an advocacy objective (and its goal of achieving a particular change by a particular institution or person); as well then as the importance of specific target audiences to help build support and action for this change.

10. Ask participants to think of a specific target audience for each of the activities.

11. Ask, based on the sample issue and activities looked at above, what might be some different indicators you could use to monitor your progress and outcomes and evaluate the impact of your advocacy? What will they need to document or collect in order to assess your progress, outcomes and impact? Use the Monitoring and Evaluating Advocacy notes in the Facilitators’ Resources to guide discussion (These notes are also provided in the Participants’ Resources).

12. Facilitate a brief discussion about why monitoring and evaluation is important using the background notes provided in the Facilitators’ Resources). Donors request it. Bosses request it. But more importantly, for advocates and advocacy networks, this becomes a powerful source of understanding and documenting the impact of their work. We need to know: Are we making a difference? What have we learned from our advocacy efforts? What might we do differently to make more impact next time?
13. Ask participants for additional thoughts/considerations about advocacy action plans from having done advocacy or other project management work?

**Option 2: PowerPoint Presentation**

**45 minutes**

1. Present a lecturette using the PowerPoint presentation Implementation: Developing an Advocacy Action Plan provided in the Facilitator’s Resources (on CD).

2. Invite questions and comments from participants.
Note to Facilitator:

This session is for participants who need to develop skills in developing an Advocacy Action Plan that will actually guide implementation of their advocacy efforts.

Participants need to work in the same group they worked with when developing goals and objectives for a specific advocacy issue (Module D).

See template for Advocacy Action Plans in Participants’ Resources: Allow 30 minutes for each objective. For example, if developing an action plan for three objectives allow 1.5 hours.

Objectives:

Develop participants’ skills in developing an Advocacy Action Plan.
Session Instructions:

Step 1: Prepare Advocacy Action Plans

30 minutes to 1.5 hours

1. Explain that for participants to proceed with developing an Advocacy Action Plan, the group must decide whether to approach its advocacy objectives consecutively or simultaneously. If the former, participants must agree on the logical order. There may be some activities that can be done simultaneously and some that need to happen consecutively. For example, in the lead up to a face-to-face lobbying meeting they may want to gather data and case studies that they will use to prepare a policy brief paper, and have a range of meetings with different groups who can provide information to help put the case around the same time. After this advocates may then draft the policy brief, then meet as a network to agree on key issues and review the draft policy brief.

2. Divide participants into groups by advocacy issue. Ask the groups to discuss which advocacy objectives members want to address first. Provide the groups with the following questions to guide the discussion:

   - Is there a logical and obvious sequence? What is it and why?
   - Will any of the objectives make a greater contribution to the broader advocacy goal than others?
   - Does the group feel better prepared/qualified to undertake one objective over the others?
   - Once each group has decided on the sequence of the advocacy objectives, it is ready to develop an action plan.

3. Refer participants the Advocacy Action Plan template in the handouts and explain the following task:

   - Write the relevant advocacy objective at the top of the work sheet.
   - Next, identify each of the activities necessary to achieve that objective. Activities should be fairly detailed. For example, include information about message development and methods.
For each activity:

- Identify the target audience.
- Indicate who is responsible for undertaking the activity.
- Assign an appropriate time-frame or due date for each activity.
- Determine resources needed to support the activity. (Resources may be material, financial, human e.g. technical expertise, or technological).
- Consider what results the activity will achieve and how they can be documented.

Note: For each activity there are also usually a number of steps that need to be completed. For instance, to hold a press conference some of the following may be key: contacting the media, briefing journalists, securing a venue, making a banner, preparing and sending a media release, preparing a background sheet, identifying speakers and practicing their messages. Explain that groups often use another sheet to plan the details of each activity, but note it does not make sense to get to this level of detail until the overall plan is developed first.

4. Allow the groups 30 minutes to 1.5 hours to complete the template and to transfer their plan to flip-chart paper. Depending on time available, suggest the number of objectives the group should try and consider in their plan. For reference, allow 30 minutes for each objective.

Step 2: Review Advocacy Action Plans

30 minutes to 1 hours

Facilitators’ note: The time allocated for review is based on providing a facilitated group discussion that will provide feedback on plans from six small groups.

1. Post all plans on the wall. Allow participants about 10 minutes to review each other’s plans (a ‘gallery walk’).
2. Lead a discussion, using different plans as examples, considering these questions:

- Are the activities complete? Are the target audiences clear for each activity?
- How about the time-frame? Is it achievable given the schedules and responsibilities of network members? Are there special calendar dates toward which activities should be oriented?
- Do they have the data they need? If not, have they considered the steps to collect the data in their time-line?
- Who is responsible? Does the group agree with the task distribution? Is the workload shared among different people?
- Are the required resources accurate? Is it practical to think that the group can secure the indicated resources?
- Review the hoped for results - do these seem realistic and precise? Will plans to document help to see whether you are achieving your desired results? Are there plans to document the reports?
- Overall, is the plan missing any key activity that needs to be added? Is the plan too complicated? Can it be simplified?

3. Check if there are any final questions or comments about action plans.

4. Summarize by noting that action plans make the campaign come alive. By considering the myriad activities needed to reach each of the advocacy objectives, a group can sense the amount of work and energy required to achieve a policy change. The plan details the activities of the campaign in a logical and timely order and maps the next steps. In practice, things rarely follow a logical sequence. However, a plan helps to think through each step needed. They may be done in a different order or be changed to respond to changing circumstances, but the steps are known. Everyone is working as a team or a network, and everyone can see how each person’s/organization’s role is an important part of achieving the overall objective. It helps to give the group a focus on a common purpose, be clear about what they need to do and to ensure people commit to their specific tasks.
Purpose:
Develop participants' understanding about the components of effective advocacy messages for HIV/AIDS and improve their advocacy communication skills.

Sessions:
F.1 Introduction to Advocacy Communication
F.2 The One - Minute Message
F.3 An Advocate's Experience: Messages and Methods
F.4 Face-to-face Communication
F.5 Written Communication - Introduction to Policy Briefs
### Objectives:

By the end of this module, participants will be able to:

- Identify the factors that influence the effectiveness of advocacy messages
- Understand and apply the elements and characteristics of effective HIV/AIDS advocacy messages
- Develop and deliver effective advocacy messages for the media and during face-to-face communication
- Understand how to develop an effective policy brief

### Background Notes:

In today’s society, we are bombarded by messages every day. The intent of the message may be to sell us a product, inform or educate us in some way, or change our opinion about an issue. An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign. It is essential to know your audience thoroughly and to deliver a concise, consistent message that is tailored to your audience’s interests.

Most people shape their messages to the needs and interests of a particular audience as a matter of common sense. In other words, the message communicated to a parents’ group about providing sexual health and HIV-related services to young people would differ from the messages that address officials in the Ministry of Health and Family Welfare.

Audience research, particularly qualitative research such as focus group discussions and in-depth interviews, helps identify appropriate messages for various policy audiences. Whoever the target audience may be, it is important to remember three other points about advocacy message development.

First, there should ideally be only one main point communicated or, if that is not possible, two or three at the most. It is better to leave people with a clear idea of a few key messages than to confuse or overwhelm them with too many.
Second, messages should always be pre-tested with representatives of the target audience to ensure that the message sent is the one received. When a network develops an advocacy message directed toward the Minister for Health, for example, it is always useful to practice delivering the message to a supportive ministry official as a test run. The ministry official may offer valuable feedback about how the message is interpreted.

Third, the message should not only persuade through valid data and sound logic, but it should also describe the action the audience is being encouraged to take. The audience needs to know clearly what it is you want it to do, e.g., ensure the state HIV policy/plan addresses the needs of trans-gender people or participate in a community meeting designed to build community understanding of and support for harm-reduction programs.

This module addresses the essential components of a message: content, language, messenger/source, format, and time/place of delivery. Participants will develop their skills in advocacy communication, applying this knowledge about advocacy message development, through preparing and delivering advocacy messages in role-plays with decision makers.
Introduction to Effective Advocacy Communication

1 hour

Materials: Colored paper, markers, flip-chart, tape

Prepared Materials:
- **Flip-chart**: Characteristics of effective messages and characteristics of ineffective messages (headings only); Five elements of a message (heading only); each of five elements on coloured cards; Definition of advocacy communication: advocacy communication model; Method for delivering message (heading only)

Participants’ Resources: Page 68 (Background Notes, Five Key Elements of an Advocacy Message, How to Choose Appropriate Advocacy Methods)
Objectives:
To understand the key elements of effective advocacy messages.

Introduction:

Introduce this session using the background notes above, making the following points:

- We are bombarded by messages every day.
- The intent of the message may be to sell us a product, inform or educate us in some way, or change our opinion about an issue.
- An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign.
- It is essential to know our audience thoroughly and to deliver a concise, consistent message that is tailored to the audience's interests.
- Shape the message for the audience. Most people shape their messages to the needs and interests of a particular audience as a matter of common sense.
- Audience research, particularly qualitative research such as focus group discussions and in-depth interviews, helps identify appropriate messages for various policy audiences.
- Whoever the target audience may be, it is important to remember three other points about advocacy message development.
- Concise message - Ideally there should be only one main point communicated or if that is not possible, two or three at the most. It is better to leave people with a clear idea of one message than to confuse or overwhelm them with too many.
Pre-test messages e.g. with representatives of the target audience to ensure that the message sent is the one received. When a network develops an advocacy message directed towards the Minister for Health, for example, it is always useful to practice delivering the message to a supportive ministry official as a test run. The ministry official may offer valuable feedback about how the message is interpreted.

Say what action is desired. The message should not only persuade through valid data and sound logic, but it should also describe the action the audience is being encouraged to take. The audience needs to know clearly what it needs to do, e.g., ensure the state HIV policy/plan addresses the needs of trans-gender people or provide leadership by participating in a community meeting designed to build community understanding of and support for harm reduction programs.

This session addresses the essential components of a message: content, language, messenger/source, format, and time/place of delivery. You will have the opportunity to apply these ideas to preparing and delivering advocacy messages in role-plays with decision makers in a later session.

Session Instructions:

Lecturette: Characteristics of a Message, and Advocacy Communication Model

50 minutes

Step 1. Characteristics of an Effective Message

1. Remind the group that they have had a lot of experience in their lives evaluating what makes effective messages.

2. Drawing on your experience, we want to explore what makes some messages effective and some ineffective.
3. Invite the group to share their thoughts in buzz groups (1:1) about a message of any kind that stayed with you - a slogan; campaign; advertisement. What are the characteristics that make you remember that message?

4. Ask the group to share its ideas about what makes for appealing characteristics. Capture the key characteristics on the flip-chart. Be certain to include the characteristics shown below:

**Characteristics of Effective Messages**
- Simple
- Appropriate language
- Concise
- Credible messenger (spokesperson)
- Tone/language consistent with message (serious, humorous)

5. **Note:** Review the kind of messages they have recalled (Likely to be examples from advertising). Then ask the group to share any messages from the development sector (often difficult to come up with. Why?)

6. Ask the group to also consider characteristics of unappealing messages. Again, capture these on a flip-chart.

**Characteristics of Ineffective Messages**
- Complicated
- Uninteresting
- Too long
- Not relevant to audience
- Inappropriate images/language

7. Conclude by reminding participants to keep these characteristics in mind when they begin developing their HIV/AIDS advocacy messages. It is important to remember that not everyone understands HIV/AIDS issues or considers them priorities and that messages must be kept simple and precise in order to inform, persuade, and move audiences to act.
Step 2. Elements of Messages

1. Explain that in actually developing messages there are key elements or building blocks of messages that are useful to consider.

2. Have flip-chart with heading only. Have each topic on one sheet of colored paper, add to flip-chart as you talk through each one.

### Five Elements of Messages

- **Content/ideas**
- **Messenger/source**
- **Language**
- **Format/medium**
- **Time/place**

4. Review each element of a message using the following notes:

   - **Content/ideas.** The content refers to the central idea of the message. What is the main point or points they want to communicate to the audience? What do they hope the audience will take away after receiving the message?

   - **Language.** Language consists of the words chosen for communicating your message. Is the language appropriate for your target audience? Is the wording clear, or could various audiences interpret it differently? Is it necessary to use a local dialect or vernacular to communicate the message?

   - **Messenger/source.** Source refers to the person or people delivering the message. Is the messenger credible to the target audience? For example, a supportive community leader may be invited to join a high-level meeting with a policy-maker. Is it possible to include key populations as spokespeople or messengers? Often people affected by HIV, either who are HIV positive or those vulnerable to HIV infection, such as sex workers, or people who inject drugs, are powerful messengers because they speak from their own experience. Advocacy groups can often send a powerful and more meaningful message to policy-makers by letting the message come from a member of the affected population.

   - **Format/medium.** The format or medium is the communication channel chosen for delivering the message. What is the most
compelling format to reach the target audience? Different channels are more effective for certain audiences.

- Time/place. When and where will the message be delivered? Are there other political events that can be linked up to draw more attention to the issue? Is there an electoral campaign underway that might make policy-makers more, or less, receptive than normal to the message?

**Step 3. Advocacy Communication Model**

1. Explain that in communicating a message for advocacy, an advocate group will want the target audience to take action and bring about desired policy change.

2. Review advocacy communication definition.

3. Display flip-chart or overhead:

   “Advocacy communication is any planned communication activity that seeks to achieve the following communication goals: inform, persuade, or move to action.”

4. Explain that there is a model that explains the definition. Display flip-chart:

   **Advocacy Communication Model**
   - Move to Action
   - Persuade/Support
   - Inform

5. Tell participants that the key to effective communication is a clear understanding of the audience and an ability to see the issue from their perspective.
6. Tell participants to think back to their target audience analysis:
   - They identified how each individual in the audience could benefit professionally, politically, or personally from supporting their advocacy issue/objective.
   - The answers to these questions should be considered and incorporated into the advocacy message directed to each member of the target audience.

7. Tell participants to look at the model and note that advocacy communication often focuses on the first level - INFORM. Audiences need more information to develop a thorough understanding of the issue and desired policy change. But so do other kinds of communication, such as IEC activities.

8. Explain that once the audience is informed, in advocacy communication we need to PERSUADE the audience to feel as strongly as the advocates do about the issue. Once understanding and support are achieved, communication moves to the highest level. At this point, advocacy messages MOVE the audience TO ACT in support of the issue.

9. Explain that every advocacy effort should seek to reach the highest level and move the target audience to action.

Step 4. Advocacy Communication Methods

1. Remind the group that one of the elements of advocacy messages is the medium they choose to use and explain that the final part of the lecturette on advocacy communication basics will focus on this.

2. Ask the group to brainstorm a list of communication methods for advocacy messages. Record the responses on the flip-chart and be certain to include the following:
3. After the participants have brain-stormed an exhaustive list of ways to deliver messages, ask them to think about the criteria they would use when choosing an appropriate medium. Possible responses may include the following:

- **Audience** - Some formats are more effective and more appropriate for specific audiences. For example, high-level policymakers have little time and many constituencies. The message needs to give them the facts and move them to action quickly; also, always leave information for them to read later. Effective media for policymakers include briefing packets, fact sheets, face-to-face meetings, and policy forums.

- **Cost** - Using mass media such as radio or television can be extremely costly. Advocates should seek out any free or reduced-cost opportunities if the mass media is the medium of choice, e.g. holding a media conference or preparing spokespersons for media interviews at a rally.

- **Risk** - When advocates go public with an HIV/AIDS advocacy issue and they are often controversial, risk is always involved. Certain advocacy tactics entail more risk than others. Public debates and live forums highlighting both sides of an issue can turn into “heated” events. Nevertheless, risk can be minimized through careful planning, selection of speakers, rehearsals, etc.

- **Visibility** - The advocates may choose one medium over another if it can make use of a contact or connection to raise the visibility of an event. Perhaps a celebrity or high-ranking public official is willing to pay a site-visit to a project or make the opening speech at a meeting. Such an event may provide an excellent opportunity to recruit other decision makers and promote a particular advocacy objective.

### Methods (Medium) for Delivering Messages

- Face-to-face meetings
- Executive briefing packets
- Public rallies
- Fact sheets
- Policy forums
- Policy briefs
- Poster, flyers in public places
- Petition
- Public debate
- Press releases
- Press conferences
- **Time/Place** - When and where will the message be delivered? Are there other political events that you can link up with to draw more attention to the issue? Some advocacy groups connect their advocacy activities with events such as World AIDS Day or International Women's Day. Is there an electoral campaign underway that might make policymaker participants more receptive than normal to the message?

4. Ask to consider whether some methods (and messengers) are more appropriate to their local cultural context, or the advocacy issues that they have prioritized. Elicit a few responses.

5. Conclude by reminding participants that methods they choose interact with all of the other elements of an effective advocacy communication message. Also note that rarely is one method used in isolation, but rather that they are often combined at the same time, or over time.

6. Transition, explaining that now participants should have a basic understanding of the characteristics and elements of effective advocacy messages. The rest of the activities in this module provide an opportunity for the participants to practice developing and delivering advocacy messages to members of different target audiences using different methods.

7. Refer participants to handouts: Background Notes, Five Key Elements of an Advocacy Message, How to Choose Appropriate Advocacy Methods
Objectives:
To practice developing and delivering effective advocacy messages.

Materials:
markers, colored paper, flip-chart, tape

Prepared Materials:

- **Flip-chart**: One-Minute Message - Task instructions

Participants’ Resources: Page 72 (The One-Minute Message, Message Development Worksheet)
Introduction:

- Remind participants of the importance of presenting messages that are clear and concise in effective advocacy communication.
- Explain that to begin gaining practice with delivering messages, we will start by using a simple framework to structure our approach to developing the content of a message.

Options: Depending on the time available and the needs of the participants, you may choose to do either this session or the session F.4: Face-to-face communication, or both. Both sessions develop oral communication skills, for different purposes. This session is useful for participants who are likely to be doing media work as part of their advocacy work. Session F. is useful for developing the lobbying skills of those who are involved in meetings with decision makers.

Session Instructions:

Step 1: Introduction to the One-Minute Message

10 minutes

The One-Minute Message

Statement + Evidence + Example + Action Desired

1. Draw the “one-minute message” on flip-chart paper. Provide an overview:

- A critical component of some advocacy campaigns is media attention. Advocates may invite journalists to attend selected events to increase the visibility of the issue and to ensure that their message reaches a wider audience. Media presence usually means
that someone from the advocacy group will be interviewed about the event and the issue. In any interaction with mass media, it is vital that the spokesperson communicates both the main idea and the desired action of the advocacy message in 30 to 60 seconds.

- Mass media coverage of events and interviews is normally distilled into a 30 to 60-second tape for use on the television or radio news. To ensure that the central points of the message are communicated during this brief transmission, spokespersons must be skilled at delivering “the one-minute message.” This simple model will help the speaker focus on constructing or tailoring a message for a television or radio interview.

2. Explain that the “one-minute message” includes four components as follows:

   **Statement.** The statement is the central idea of the message (as defined on the Message Development Worksheet). The spokesperson should be able to present the “essence” of his/her message in several strong sentences.

   **Evidence.** The evidence supports the statement or central idea with facts and/or figures. The message should include limited data that the audience can easily understand such as “only 3% of people in Manipur have ever had an HIV test” rather than “only 78,544 people in Manipur have ever had an HIV test”.

   **Example.** After providing the facts, the spokesperson should add a human face to the story. An anecdote based on a personal experience can personalize the facts and figures.

   **Action Desired.** The desired action is what you want the audience to do as a result of hearing the message. The advocacy objective should be stated clearly to the target audience as an invitation for action.

3. Read one of the following examples provided by an advocacy network:

   **Example: One-Minute Message:**

   **Statement:**

   The Government of India committed to a target of providing free anti-retroviral drugs (ARV) for 100,000 HIV-positive people by 2005. But only one third of this number has access at the end of 2005.
Evidence:

At end of 2005, only 34,634 of PLWHA actually have access to ARVs. Of this number only 24,301 are provided ARVs through NACO-supported centers and a further 10,333 through the Global Fund to Fight AIDS, TB and Malaria, through government and NGOs clinics and private hospitals. (Socio-economic impact of HIV/AIDS in India, UNDP, 2006)

Example:

Ching lives in a joint family consisting of 22 family members, including his wife and two children, in West Manipur. For most of his working life Ching had a job with the Public Works Department, earning Rs. 6000 per month, which was 25% of the joint family income. Three years ago he tested HIV positive. His employer found out and sacked him.

Since then, Ching has run a petty trading business, earning on average Rs. 3,000 per month. He cannot afford to pay for ARVs and does not have access to the government's free ARV program. Ching became very sick and was in hospital for 2 weeks. This plunges the family deeper into debt. His brother has to sell equipment used for his automotive spare parts shop to pay hospital bills and so another source of family income is lost. The girls are pulled out of school and sent to work as domestic help to contribute to the family's income.

4. Ask participants the following:

- What is missing from the message? (Answer: The action desired from the audience)

- How would you complete this message? What action is required? (Answer: that the Government provide free access to ARV programs urgently, in line with their commitment.)

5. Ask participants if they have any questions about the elements and characteristics of effective messages.

6. Remind them that they need to develop messages for their different audiences.
Step 2: Group work - Prepare One-Minute Message role-play

Introduction:

1. Explain the One-Minute Message exercise to the group.
2. Highlight that, among other things, we saw that for messages to be truly effective, they need to reach their target audience as powerfully as possible with the right information and motivating images/language and evidence that will move their target audience to act to address the issue.

One-Minute Message

1. Decide the Advocacy Communication Objective: What do you want to achieve.
2. Choose one Target Audience
3. Decide the Context
   - Time/place;
   - Who is delivering the message
   - What method is being used
4. Develop a One-Minute Message role play

3. Review the following instructions on a flip-chart:

4. Ask participants to get in the same teams they were in for analyzing target audiences. Advise the group to choose an objective that they developed in that session (on colored cards) and decide what their advocacy communication objective is. Allow 30 minutes for each group to develop the message as a role play.

5. Refer participants to the handout: One-minute message; message development work sheet to help them prepare their one-minute message.
Step 3. Deliver Role-Plays and Feedback

30 minutes

1. Reconvene all of the groups.

2. Remind participants that they will have 1 minute each, which the facilitator will follow with debriefing immediately afterwards.

3. Suggest that a member of each group briefly set the scene by letting the audience know who the target audience is and any other important information about the context. E.g. it’s a radio interview after a public meeting.

4. Have each group present its role-play.

5. After each group, debrief with the following questions:

- **Ask the large group (audience plus presenters):**
  - What did you observe in this role-play?
  - What struck you the most?
  - Are there any special aspects of what the target audience or advocates did or said that stood out?

- **Ask the audience:**
  - What was the main advocacy message? (Check the response with the presenters)
  - Was the desired action clearly articulated? Was it appropriate?
  - Do participants agree with the choice of time, place, method, and messenger?
  - Were data used effectively?

- **Ask the full group (audience plus presenters):**
  - If there were certain reactions, why did they (target or advocates) respond that way?
  - Consider: Were there other options for time, place, method, messenger that might have been more effective?
  - What lessons can we learn?
6. After each discussion is completed, thank the participants and the audience for their feedback.

7. Repeat steps 2-6 for each group.

8. After all groups have presented, explain that we have been in the role play, but now we want to step back and think about how this applies to our own work. Ask:
   - Are there any main learning points or take-away thoughts from all of these role-plays that they want to share?
   - As advocates, how can we apply these lessons in our own work?

9. Conclude the session by noting that such practicing as we have done is a key way to prepare for developing effective advocacy messages. Note that debriefing after our efforts to deliver advocacy messages is also very important to improving the next advocacy effort. It helps to consider what worked well, what could be improved and how we might approach preparing our messages next time.

Note to Facilitator: Lessons may include actual techniques, preparation needed, and appropriateness of method, time, place, delivery, and messenger, what further information is needed about your target audience.
### An Advocate’s Experience: Messages and Methods

#### Materials:
- markers, flip-chart, tape

#### Facilitators’ Resources:
- Guest Speakers talking points

#### Objectives:
To deepen participants’ understanding of how to develop and deliver effective advocacy messages.

#### Introduction:
Explain that the real art of developing advocacy messages is best understood in the context of real world experiences and hence the importance of the opportunity to learn from people’s concrete experiences of how effective advocacy messages were developed and delivered in the context of real-world advocacy efforts.
Session Instructions:

Step 1: Lecturette from an advocate guest speaker

1 hour

1. Introduce the guest speaker (30 minutes).

2. After the presentation, facilitate a question and answer session (30 minutes).

3. Keep in mind the Guest Speaker Talking Points provided for this session and tease out any of the questions not fully explored or answered in the presentation:
   - What was the problem?
   - What was the advocacy objective?
   - Who decided to advocate to address the problem (who was involved)?
   - Who did you advocate to?
   - What were you key messages? And what methods did you use? (main focus)
   - What difficulties did you face and how did you overcome these?
   - What were the results of your advocacy?
   - What sources of support did you find most useful?
   - What did you learn from doing this advocacy?

4. Thank the presenter and conclude the session by noting some of the key lessons that can be drawn from the presenter’s experience about advocacy messages and methods.
Objectives:

By the end of the session participants will be able to lobby a decision-maker in a face-to-face meeting.

Materials: blank paper and pens

Prepared Materials:

- **Flip-chart**: Task for face-to-face communication role play

Participants’ Resources: Page 77 (Face-to-Face meetings: Background Notes; Scenarios for role-plays including instructions)
Options: This session has also been adapted and included in module G. Evidence-based advocacy: Using data for advocacy. If you intend to use the more advanced sessions in that Module, you should skip this session.

Introduction:

10 minutes

Make the following points using ‘Face-to-face communication: Background notes’ (in Participants’ Resources):

- A face-to-face meeting with a targeted decision-maker is also often known as 'lobbying'

- It is the most frequently used advocacy method and is often the starting point for a series of activities

- Personal contact provides the opportunity to:
  - build relationships with decision-makers
  - make the person aware of the work of your network
  - bring your issue to their attention for future action
  - assess their views and information needs on your advocacy issue
  - determine what more they need to know for follow up meetings

- Timing is important e.g. arrange a meeting when the issue or problem is already on their agenda or most likely to be taken up, such as in the lead up to budget sessions or an important meeting when the issues might be considered by decision-makers.

- Know your target audience: Try to imagine how the issue or problem looks from the decision-maker’s point of view. Consider: Why should they support your advocacy objective? How can they benefit from taking action that you are requesting? (Refer to sessions on Target Audiences). Try and collect information about their views or likely approach. Ask
people who you think may know. Have they made public comments on similar or related issues?

- Build the case for change: Be realistic about the options for action you propose. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message (use briefing notes to ensure the message is the same).

- Do not be satisfied with vague expressions of support. Return to two basic questions:
  
  - Does the decision-maker agree things need to change?
  - What are they willing to do to make change happen?

Session Instructions:

Step 1: Preparing for a face-to-face meeting

40 minutes

1. Ask participants to form small groups of three. Assign to each group one scenario that they will need to prepare and advocate in a face-to-face meeting (For a group of thirty there will be 10 small groups; four groups can do scenario 1, three groups can do scenario 2 and three groups can do scenario 3).

2. Explain the activity: Prepare for a face-to-face meeting with the influential person outlined in the scenario been given. Identify two people to act as the advocates and one person to act as the influential person.

3. Review task from flip-chart:

TASK: Face-to-face communication:

Prepare for a face-to-face meeting considering the following:

- What are the advocacy issues you want to raise?
- What action do you want from the policy maker?
- What facts and evidence will you use to support what you will say?
- What will the decision-maker say about the issue?
- What will your responses be?
- Consider how you want to behave during the meeting and why
- Decide what, if anything, you should take to the meeting
Step 2: Role-plays and discussion

1 hour 40 minutes

Note to Facilitator: Timing for step 2 in this session is based on a group of 30, with 10 small groups of 3 people, each having 5 minutes to present and 5 minutes for feedback. You will need to adjust the timing depending on the number of participants.

1. Ask each group to present their role-play in turn, allowing about five minutes for each group and five minutes for feedback for each group.

2. Ask the ‘audience’ to make note of one thing they thought worked well and one thing they thought could be improved.

3. After each role-play is presented, lead a plenary discussion for five minutes based on the following questions:
   - What worked well?
   - What could be improved?
   - Who was persuasive and why?
   - How might you follow up on the face-to-face meeting?
   - What did you learn about face-to-face meetings?
   - What are the advantages of having people directly affected by the issue or problem at such meetings?

4. Conclude by outlining some key issues from “Preparing for face-to-face meetings” in the participants’ resources:
   - Know your audience: Find area of agreement and mutual interest. Link your objective to an issue the decision-maker cares about
   - Prepare: gain a reputation for being knowledgeable about the issue; decide who will say what if there is more than one of you
Know what action you want: be willing to negotiate but be clear about how far you will compromise.

Immediate outcomes are not always possible - Importance of face-to-face meetings for relationship-building over the long term.
**Written Communication:**

**Introduction to Policy Briefs**

45 minutes

**Materials:** Stop-watch to indicate time left

**Prepared Materials:**

- **Flip-chart:** Five flip-charts ready with pros and cons columns at the top in Order to evaluate the five policy briefs

**Participants’ Resources** (also on CD): Page 74 (Five sample policy briefs copied to A3 size to be put up around the room).

**Objectives:**

To identify effective elements of policy briefs

**Note to facilitator:** This session has also been included in module G. Evidence-based advocacy: Using data for advocacy. If you intend to use Module G., you should skip this session.
**Session Instructions:**

1. Refer participants to the examples of policy briefs that are displayed around the room.

2. Ask the participants to circulate around the room, visiting at least three of the five stations with examples. At each station, ask participants to write comments on the colored paper about the positive and/or negative aspects of each brief.

3. Remind participants that the objective of this is not to fully read the brief, but rather to react to what works and does not work during a brief review of the document.

4. Remind participants that they have a total of 20 minutes to review and write their comments on at least three of the briefs.

5. When participants finish, move from station to station, reviewing comments and drawing out participants’ views on each brief - What works? What could be improved? Why? (About five minutes at each station)

6. Ask participants to return to their seats. Ask: “Does anyone have experience writing or developing policy briefs?” If so, ask them to share their lessons learned from developing policy briefs.

7. In conclusion ask: what they have learned from this about using data in effective advocacy messages? Be sure that these points are mentioned:

   - Data has to be clear, concise, and support main messages
   - You have to pick your numbers, i.e., cannot say everything
   - Often have only a short period of time or space to convey data
   - Graphs or tables are important but have to be able to send a clear message
   - Images used are appropriate, but they should protect and promote dignity, ensure consent to use, respect confidentiality
   - Policy briefs should contain clear recommendations about action required
Evidence for Action - Using Data for Advocacy

Purpose:
Develop participants' ability to analyze different kinds of data and use these data in crafting and delivering advocacy messages.

Sessions:
G.1 Written communication - Using data in a policy brief
G.2 Face-to-face-communication - Using data for 'lobbying'

Objectives:
By the end of this module, participants will be able to:

- Analyze and use data to support the case for a specific policy change in the context of a policy brief and through a lobbying meeting
- Practice writing a policy brief and conducting a lobbying meeting using data
Note to Facilitator:

This module focuses on skills building for participants who are more experienced in advocacy. It is designed to provide participants with the opportunity to analyze and use different kinds of data for advocacy.

This module adapts some of the sessions in module F: Advocacy methods and messages. So, if you are using this module, you should skip sessions F.4 Face-to-face communication and F.5 Written Communication - Policy Briefs. See suggested agenda for advanced program in Introduction to the manual.
Written Communication - Using data in preparing a Policy Brief

4 hours 15 minutes

Materials: flip-chart, markers

Prepared Materials:
- Flip-charts: Preparing a policy brief; reviewing policy briefs
- Other: Sample policy briefs (A3 size)

Participants’ Resources: Page 86 (Scenarios; template for policy brief)

Facilitators’ Resources: Guidance notes on preparation for and conduct of this session; Scenarios; Data and related resources relevant to each scenario to be distributed during session.
Objectives:

- Understand the key elements of what makes a ‘good policy brief’ and apply these elements in practice.
- Analyze specific data and use that data to support the case for a specific policy change by developing a policy brief.

Session Instructions:

Step 1: What makes a good policy brief?

45 minutes

Introduction:

1. Refer participants to the examples of policy briefs that are displayed around the room.

2. Ask the participants to circulate around the room, visiting at least three of the five stations with examples. At each station, ask participants to write comments, both positive and negative, about the brief on the flip-chart paper beside each station.

3. Remind participants that the objective of this is not to fully read the brief, but rather to react to what works and does not work during a brief review of the document.

4. Remind participants that they have a total of 20 minutes to review and write their comments on at least three of the briefs.

Note to Facilitator: Leave the flip-charts near each policy brief. Then, use a main flip-chart at the front of the room to summarize the positive characteristics of an effective policy brief.
5. When participants finish, move from station to station, reviewing comments and drawing out participants’ views on each brief - What works? What could be improved? Why? (About 3-4 minutes at each station)

6. Ask participants: Does anyone have experience writing or developing policy briefs? Ask the persons to share their lessons learned from developing policy briefs.

7. Also ask participants: What have you learned from this about using data in effective advocacy messages?

**Note to Facilitator:** Be sure that these questions and points have been covered during the session:

- Are the issues addressed by the policy briefs clear and concise?
- Need to have clear recommendations for action - Is it clear what action is sought from policy makers?
- Data have to be clear, concise, and should support main messages
- You have to pick your numbers, i.e., cannot say everything
- Often have only a short period of time or space to convey data
- Graphs or tables are important but have to be able to send a clear message
- Images used are appropriate, protect and promote dignity, ensure consent to use, respect confidentiality.

8. Refer to the handout in materials - Preparing a briefing note/position paper (International HIV/AIDS Alliance). Note the difference between a position paper/policy brief and a briefing note. Review some of the advantages and disadvantages of policy briefs.
Step 2. Preparing a Policy Brief

4.5 hours

Note to Facilitator:

This and the following exercise are based on a group of 30 participants.

Participants will remain in same groups of five people for both sessions G.1 and G.2.

- Two groups will do scenario 1
- Two groups will do scenario 2
- Two groups will do scenario 3

Output from this session should be a summary of a policy brief on two flip-chart pages.

1. Introduce the exercise by explaining that participants will now work in small groups of three to develop a policy brief using the data.

2. Explain that a policy brief is usually written for a specific primary and/or secondary target audience. That is, it is written for the policy/decision makers and people that influence those primary targets for your advocacy.

3. Post a flip-chart with scenario topics and space for two groups of five names for each of the three scenarios. Ask participants to sign up for the scenario they wish to work on.

4. Distribute the appropriate scenarios to each of the groups.

5. Ask participants to review their scenario and discuss and agree upon the two or three main advocacy issues in the scenario. Write them up on flip-chart. (25 minutes)

6. Ask each group to post them on the wall, grouping those about the same scenarios together.
7. Lead a discussion group on each list of advocacy issues for each of the 3 scenarios, to ensure groups are clear about what the three advocacy issues are in the scenario they are working on (25 minutes).

8. Explain the next part of the exercise using the prepared flip-chart.

### Preparing a policy brief:
- You have identified the key advocacy issues in your scenario
- Review policy brief template for guidance:
  - Issues
  - Evidence
  - Recommendations for action
- Review the documents you will be provided to see what evidence they provide that you can use to make your case for change
- Remember who the target audience for your policy brief is and what objections they may have or what they need to know to be persuaded to act on your recommendations
- Prepare a policy brief using the data to make your case for specific policy solutions = 2 flip-chart page summary

9. Remind participants that target audiences may not be well informed about the issues, so they need to think about what background information is needed.

10. Advise participants to plan how you will work together. For example, they might all do some reading and thinking first, then come together and brainstorm what should be in the document, then divide up who should write which sections. Suggest they undertake the work in whatever way works best for the group given the task and time available.

11. Suggestions for format. Participants should aim to produce as flip-chart a summary of no more than two pages. Suggest that they focus on
getting the main points down first in dot points, using the data to make their case. If they have time they can draft each section in full. They can draw diagrams, tables or graphs as examples of what they would include, or simply describe these.

12. Distribute data documents relevant to each scenario.

13. At the conclusion of the preparation time, ask each group to post their flip-charts on the wall.

**Note to Facilitator:**

Facilitators will need to play an active role in guiding, advising and providing critical feedback with small groups during their planning, reviewing data and writing of policy briefs, and during preparation of face to face role plays in the next session, as well as in formal feedback sessions at the conclusion of each session. Schedule this session to conclude at a break if possible, so you can review summary policy briefs.

You may want to try and schedule this session for the afternoon, so that it concludes at the end of the day. This enables facilitators to review draft briefs for feedback overnight.
Step 3: Reviewing Policy Briefs

1 hour and 30 minutes

1. Ask everyone to review at least three policy briefs on the wall (25 minutes).

2. Show the prepared flip-chart of questions. Ask that they consider these questions as they make notes on each policy brief that they review.

3. Lead a group discussion on each policy brief in turn, inviting participants to make comments as you consider each one and provide your own feedback on each brief (6 x 10 minutes per brief). See Facilitators’ Resource for guidance on conducting this feedback.

4. Conclude by asking participants what they learned from the exercise. What did they find difficult? What would they do differently next time?

- Is the policy brief clear and concise?
- Were the key issues identified and addressed?
- Was data used to demonstrate the problem?
- Was data used to support recommended actions?
- Were recommendations specific, realistic and appropriate?
Face-to-face Communication - Using Data for Advocacy

5 hours

Materials: flip-chart, markers

Prepared Materials:
- **Flip-charts**: Guidance for preparing role plays; planning advocacy messages
- **Other**: Guidance notes for facilitators

Participants’ Resources: Page 86 (Scenarios; data and related resources relevant to each scenario as for G.1 Step 2; Face-to-Face meetings: Background Notes)

Facilitators’ Resources: Guidance notes on preparation for and conduct of this session; Roles and Instructions to policy makers; Scenarios to be distributed during session.
Objectives:

By the end of the session participants will be able to lobby a decision-maker in a face-to-face meeting, using data to make their case.

Introduction:

1. Outline the objective of the session.

2. Make the following points from background notes (see Handouts - Advocacy Communication; background notes):

   - A face-to-face meeting with a targeted decision-maker is also often known as ‘lobbying’

   - It is the most frequently used advocacy method and is often the starting point for a series of activities

   - Personal contact provides the opportunity to:

     - build relationships with decision-makers

     - make the person aware of the work of your organization or network

     - bring your issue to their attention for future action

     - assess their views and information needs on your advocacy issue

     - determine what more they need to know for follow-up meetings

   - Timing is important e.g. arrange a meeting when your issue or problem is already on their agenda or most likely to be taken up, such as in the lead up to budget sessions or an important meeting.
Know your target audience: Try to imagine how the issue or problem looks from the decision-maker's point of view. Consider: Why should they support your advocacy objective? How can they benefit from taking the action you are requesting? Refer to sessions on Target Audiences. Try and collect information about their views or likely approach. Ask people who you think may know. Have they made public comments on similar or related issues?

Build the case for change: Use the data available to you to make your case and persuade the decision maker that your recommendations are the most effective course of action. Be realistic about the options for the action you propose. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message (use briefing notes to ensure the message is the same).

Do not be satisfied with vague expressions of support. Return to two basic questions:

- Does the decision-maker agree things need to change?
- What are they willing to do to make change happen?

Session Instructions:

Step 1: Preparing for a face-to-face meeting

1 hour and 30 minutes

Note to Facilitator:
This exercise assumes a group of 30. Participants will remain in the same groups as for the previous session on policy briefs.

Suggested timing:
- Introduction and preparation for exercise (10 mins)
- Preparation (80 mins)
- 20 minutes to present x 6 groups (120 mins)
- 15 minutes feedback per group (90 mins)
  Total - 5 hours

Alternatively, you could divide the group into two and conduct presentations and feedback sessions in separate rooms (with one facilitator per group). You will need separate rooms to conduct the role plays and feedback sessions.

1. Explain that participants will work in the same groups of five as in the previous session.

2. Advise participants that they will use the same scenarios and data related to each scenario that they used in the previous session. In each team of five, two will be the policy makers and three will be the advocates.

3. Explain that this session is about practicing communicating the issues, and using data to persuade a specific audience.

4. Explain that two of the team will be policymakers and three will be advocates in a role play. Explain that the policymakers will be given instructions about how to perform their role. They are NOT to share this information with the advocates in their team. They can help the
advocate prepare what they will say, but not say how they will perform at the meeting.

5. Distribute the roles for each scenario (See Facilitators’ Resources) and ask each of the groups to discuss and decide who will take on which of the roles.

6. Distribute instructions to policymakers for each scenario about how they will play their roles.

7. Ask everyone to join the large group for a moment to review the task and answer any questions.

8. Tell participants they will have 1 hour and 20 minutes to prepare their role play and 20 minutes to present it. There will be 15 minutes for feedback for each group.

9. Display and review two prepared flip-charts to guide preparation:

**Guidance for role-play:**
- What are the key issues you want to raise?
- What facts and evidence will you use to support what you will say?
- What will the policy makers say about the issue?
- What will your responses be?
- What action do you want the policy maker to take?
- Consider how you want to behave during the meeting and why?
- Decide what, if anything, you should take to the meeting

**Planning Advocacy Messages:**
- Statement
- Evidence
- Example
- Action

10. Ask if there are any questions about the task.
Step 2: Role-plays and discussion

1 hour and 30 minutes

1. Ask each group to present their role-play, allowing about 20 minutes for each group.

2. Ask the 'audience' to make note of one thing they thought worked well and one thing they thought could be improved.

3. After each role play has been presented, lead a review discussion (15 minutes per group) based on the following questions:
   - What worked well?
   - What could be improved?
   - Who was persuasive and why?
   - How well was the data used?
   - How might you follow up on the face-to-face meeting?

4. Conclude by outlining some key issues from “Preparing for face-to-face meetings” in the participants’ resources:
   - Know your audience: Find areas of agreement and mutual interest. Link your objective to an issue the decision-maker cares about
   - Prepare: Gain a reputation for being knowledgeable about the issue; decide who will say what if there is more than one of you
   - Know what action you want: Be willing to negotiate but be clear about how far you will compromise
   - Immediate outcomes not always possible - Importance of face-to-face meetings for relationship building over the long term.
The Power to Change

Facilitators’ Resources
Contents: Facilitators’ Resources

A: Introduction to HIV/AIDS Advocacy
A.2 About the EAP and a Rights-based Approach to Advocacy 2
A.5 Examples leading to policy change 3
A.6 Steps in the advocacy process 5

B: Introduction to Evidence-based Advocacy
B.4 Analyzing Behavioral and Epidemiological Data 8

C: Understanding the Policy Process
C.1 The policy process 10

E: Implementation - Advocacy Action Plans
E.1 Implementation: Advocacy Action Plans 18

F: Advocacy Messages and Methods
F.3 An Advocate’s Experience: Message and Methods 28
F.5 Written Communication: Introduction to Policy Briefs 30

G: Evidence for Action: Using Data for Advocacy
G.1 Policy briefs 49

Resources for Scenario 1:
Access to services for MSM and trans-genders 50

Resources for Scenario 2:
Police raids hamper effective HIV prevention among sex workers 53

Resources for Scenario 3:
Resistance to harm reduction and a changing epidemic 56

Guidance on feedback for policy briefs (G.1) and role plays (G.2) 59
About the EAP and a Rights-based Approach to Advocacy

The Essential Advocacy Project (EAP) of Constella Futures is working towards strengthening the enabling environment for key populations to claim their rights. A rights based approach is central to the work of the EAP.

Why a Rights-based approach?

- Where rights are protected, vulnerability to HIV infection is reduced and impact of HIV/AIDS alleviated.
- Violating human rights undermines HIV prevention and access to care for people who are often already marginalized.

(A detailed PowerPoint presentation on the EAP and a rights-based approach to advocacy is on the CD provided)
A.5 Examples leading to policy change

**Guest Speaker’s Talking Points:**

**To:**

**From:**

**Re:** Speaker Invitation for “Examples leading to policy change”
EAP HIV/AIDS Advocacy Workshop on XX

**Date:**

The Essential Advocacy Project (EAP) will be holding an HIV/AIDS Advocacy Training Workshop in xx on xx. The training will involve approximately XX participants from state/ district/ local NGOs/ KPs. This workshop is part of Āvāhan - the India AIDS Initiative of the Bill and Melinda Gates Foundation. The EAP works to strengthen the capacity of Āvāhan partners, key stakeholders and people living with and affected by HIV/AIDS to advocate for an evidence based approach to responding to HIV/AIDS, supported by effective policies and practices that protect the rights of those affected and ensure effective programming.

We are hoping that you might be able to contribute your expertise by participating in a session about your organization’s advocacy work that has led to policy change. This would involve your giving a 20 - 30 minute presentation. Your presentation will be followed by a moderated discussion. This session is scheduled for xx.

The overall goal of the training is strengthen participants' understanding of advocacy and build participants' skills to carry out advocacy in their work. The purpose of the session is to provide real examples of how advocacy has led to policy change in India.

If you were available to make a presentation we would suggest that the presentation focus on a specific example of an advocacy issue your organization has worked on, by addressing the following questions:

- What was the advocacy issue or problem that you identified?
- What was the policy change you were seeking?
Who were the targets for your advocacy efforts? Why?

Did you work with other allies in your advocacy efforts? If so, who did you choose to work together with and why?

How did you inform yourself about the issue and the views of the target audiences you sought to influence?

What did your advocacy efforts involve?

What were some of the outcomes of your advocacy efforts? What do you think you achieved?

What challenges did you face in bringing about change and how did they address these?

What worked well and what would you do differently?

We hope that we will be able to benefit from your valuable experience and time. Please do not hesitate to call if you have any questions. We will also call you to follow-up on this invitation.
A.6 Steps in the advocacy process

Card templates

**Issue**
The problem that requires a policy action

**Goal**
Goal: A statement of the general result you want to achieve

**Objective**
Objective: Incremental steps towards achieving your goal that are
- specific
- measurable
- realistic
- time-bound

**Target Audience**
The policymakers you are trying to influence to support your issue, e.g., Parliamentarians, local officials, ministry officials

**Building Support**
Building alliances with other groups, organizations, or individuals who are committed to support your issue
The means by which a message is delivered to the various target audiences, e.g., Radio, television, flyers, press conferences, meetings

Statements tailored to different audiences that define the issue, state solution, and describe the actions that need to be taken.

Identify and attract resources (money, equipment, volunteers, supplies, space) to implement your advocacy campaign

Carry out a set of planned activities to achieve your advocacy objectives (action plan)
Data Collection

Gathering, analyzing, and using appropriate quantitative and qualitative information to support each step of your campaign.

Monitoring:
A process of gathering information to measure progress toward your advocacy objectives.

Evaluation:
A process of gathering and analyzing information to determine if the advocacy objectives have been achieved.
Analyzing Behavioral and Epidemiological Data

Guidance for session preparation

Data analysis exercises, using some of the epidemiological and behavioral data available at the time of publication have been prepared and used in field testing this manual. The data tables used provide the figures and a series of questions relating to each table. The Data Analysis Exercise developed at the time of publication includes:

**TABLE 1:** HIV prevalence trends (%) in ante-natal clinics (ANC) and STI clinics (2003-2005). This table includes percentages nationally and for the six high prevalence states of Karnataka, Andhra Pradesh, Maharashtra, Tamil Nadu, Manipur and Nagaland.

**TABLE 2:** HIV prevalence (%) among key populations (2003-2005). This table includes percentages nationally and for the six high prevalence states.

**TABLE 3:** Data on knowledge and behavior of female sex workers (2001). This table includes data for each of the six high prevalence states.

**TABLE 4:** Data on knowledge and behavior of MSM, (2002). This table includes data across 5 locations - Delhi, Mumbai, Kolkata, Chennai and Bangalore.
TABLE 5: Data on knowledge and behavior of IDUs, 2002. This table includes data across 5 locations - Delhi, Mumbai, Kolkata, and Chennai. In case of Imphal, Manipur data was used as city data was not available.

These data tables need to be adapted and accompanying guidance notes for facilitators prepared to ensure the relevance and currency of these data for each state. Gathering data specific to each state and different key populations, including epidemiological, behavioral, case studies, research findings on best practice, will be an ongoing process.

Data will also change over time and better data will become available. The EAP also intends to update these data tables as new data become available, including the Integrated Biological and Behavioural Assessment (IBBA) by FHI for Āvāthan; National Behavioural Surveillance Survey (BSS) 2006; National Family Health Survey (2005).

As new data become available, data analysis exercises will be developed for specific training workshops, so they are tailored to the needs of different states and different groups of participants.

Given the need for relevant and current data, the data analysis exercises are not provided as part of this manual. If you wish to conduct this session, you will need to contact the EAP head office to discuss your specific needs. The EAP will make every effort to assist you in conducting this session using data analysis exercises that have been developed at that time.
C.1 The policy process

Guidance for session preparation

A training module that provides a standard model for the policy process does not provide this kind of insight, both because the policy process in a given context rarely conforms to such models in real life, and the policy process varies considerably in different contexts.

The policy process is a dynamic and complex one. Participants need to be able to:

- understand how the policy process works in theory and in practice;
- understand the array of factors that influence decision/policy makers, and how to get to know and work with them during the policy development process;
- identify supporters and opponents both among those involved in the formal policy-making process and among those who have influence upon them; and
- identify opportunities, both formal and informal, to influence them in a timely manner as the policy process unfolds.
This session is important for giving participants an insight into the policy process in practice. Preparation for this session is important. You will need to know whether participants are likely to be advocating at national, state, district or local level. This will inform the guest speaker you choose for this session.

The choice of guest speakers is critical. It is worth taking time to find the right people. One speaker needs to be directly involved in the policy-making process in government, preferably HIV/AIDS or health related, as different departments are likely to employ somewhat different approaches to policy-making. The second speaker needs to be involved in influencing the policy-making process, say a leader or policy advisor from an NGO. This way, through hearing from both perspectives, the participants will be provided with an overview of the policy process in that state/district/local context and insights into how the policy process actually unfolds in practice.

Experience in using this session in practice has shown that it can be challenging to ensure that the speakers speak to the topic. That is, to describe and analyze the policy-making process from their particular perspectives within government and in influencing government policy processes. In order to assist you, we have provided guest speaker's letters which will need to be amended to suit your session. Where additions are needed is indicated by xx.

We suggest that you follow up with your speakers and discuss their presentations, emphasizing what the session aims to achieve, the time allocated for each presentation and that the presentations will be followed by a moderated discussion to explore:

- How the policy process works in theory and practice
- What kind of factors affect the views of policy makers in the policy process
- What opportunities both formal and informal are available to advocates in getting to know policy makers and contribute to the policy development process
- What kinds of evidence and modes of delivery are seen as credible, using specific examples where possible.
Guest speaker’s talking points: Government representative

To:

From:

Re: Speaker Invitation for “The Policy Making Process in xx” Session, EAP HIV/AIDS Advocacy Workshop on XX

Date:

The Essential Advocacy Project (EAP) will be holding an HIV/AIDS Advocacy Training Workshop in xx on xx. The training will involve approximately XX participants from state/ district/ local NGOs/ KPs. This workshop is part of Āvāhan - the India AIDS Initiative of the Bill and Melinda Gates Foundation. The EAP works to strengthen the capacity of Āvāhan partners, key stakeholders and key populations including people living with and affected by HIV/AIDS to advocate for an evidence-based approach to responding to HIV/AIDS, supported by effective policies and practices that protect the rights of those affected and ensure effective programming.

We are hoping that you might be able to contribute your expertise by participating in a session about the policy process in government. This would involve giving a 10-minute presentation about the “The Policy Making Process in XX” and being part of a panel for a moderated discussion. There will also be a speaker from xx who will present on their experience in influencing the policy process in government. These presentations will be followed by 40 minutes of moderated discussion. This session is scheduled for xx.

The overall goal of the training is strengthen participants' understanding of advocacy and build participants' skills to carry out advocacy in their work. The purpose of the session is to increase participants understanding of how the policy-making process works in practice.

During your presentation and the moderated discussion, we would like to explore the following questions, drawing on your experience in policy processes in government:

- How are ideas or issues generated for new or revised policies?
- What sort of process is followed in making or revising policy?
Where do policies get formulated (i.e., key committees, task-force)?

How is a proposed issue introduced into the formal decision-making process?

What is the process for discussing, debating and, perhaps, altering the proposal? Who are the players involved?

How is the proposal approved or rejected?

If approved, what are the steps to move the proposal to the next level of decision making?

If you were available to make a presentation we would suggest that the presentation focus on the questions outlined above, which we can also explore in the discussion. It may also help increase participants' understanding if you could include a simple diagram of the policy-making process followed at the state/district/local level (two samples are attached).

We hope that we will be able to benefit from your valuable experience and time. Please do not hesitate to call if you have any questions. We will also call you to follow-up this invitation.

**Attachments: Overall Policy Process Map**

- President
- Prime Minister
- Ministers
Guest Speaker’s talking points: NGO representative

To:

From:

Re: Speaker Invitation for “The HIV/AIDS Policy Making Process in xx” Session, EAP HIV/AIDS Advocacy Workshop on XX

Date:

The Essential Advocacy Project (EAP) will be holding an HIV/AIDS Advocacy Training Workshop in xx on xx. The training will involve approximately XX participants from state/district/local NGOs/KPs. This workshop is part of Avahan - the India AIDS Initiative of the Bill and Melinda Gates Foundation. The EAP works to strengthen the capacity of Avahan partners, key stakeholders and KPs including People living with and affected by HIV/AIDS to advocate for an evidence-based approach to responding to HIV/AIDS, supported by effective policies and practices that protect the rights of those affected and ensure effective programming.

We are hoping that you might be able to contribute your expertise by participating in a session about the policy process in government. This would involve you giving a 10-minute presentation about your experience in working to influence the policy making process in government - “Influencing the policy making process in government: An advocate's perspective.” There will also be a speaker from xx who will present on the policy process in government. These presentations will be followed by 40 minutes of moderated discussion. This session is scheduled for xx.

The overall goal of the training is strengthen participants' understanding of advocacy and build participants' skills to carry out advocacy in their work. The purpose of the session is to increase participants’ understanding of how the policy-making process works in practice.

During your presentation and the moderated discussion, we would like to explore the following questions, drawing on your experience:

- How the policy process was intended to proceed and how did it take place in practice?
- What kind of factors affected the way the policy process unfolded?
- What factors affected the views of policy makers on the issue?
What opportunities both formal and informal were available to you to
get to know policy makers and contribute to the policy development
process?

What was your role in the policy process?

What different strategies did you use to influence decision makers and
those who had influence with decision makers?

What kinds of evidence and modes of delivery were seen as credible to
policy makers?

If you were available to make a presentation we would suggest that the
presentation focus on one or two specific examples of your work in
influencing the policy development process, in line with the above questions.

We hope that we will be able to benefit from your valuable experience and
time. Please do not hesitate to call if you have any questions. We will also
call you to follow-up this invitation.
## Limitations on ‘lobbying’

### 1. General rule

Private foundations like the Bill and Melinda Gates Foundation may not engage in lobbying, paying for or funding lobbying activities.

**BUT** what is meant by ‘lobbying’ is very **narrow**:

1. Direct lobbying of legislators, legislators’ staff, government officials, about **specific legislation or proposed legislation**.

2. Grassroots lobbying: Communication to general public/media about **specific legislation or proposed legislation**.

This would also include building capacity of Avahan partners to undertake either of the above.

### 2. Exceptions

1. **Discussion of broad social issues**

   May be discussed even if they are about existing or pending legislation, as long as you do not address the merits or problems of any specific legislation/legislative proposal.

   E.g. raise awareness about HIV/AIDS, including where existing or proposed laws are/will impede effective responses to HIV/AIDS. You can provide examples of best practice laws from other countries, but not take a position on the need to change a specific law or support or oppose pending legislation.

2. **Technical Assistance**

   You can provide technical assistance on law reform, about specific legislation or proposed legislation in response to a **written request by a legislative committee or other government body** (e.g. Parliamentary Forum or SACS).

   Such technical assistance can include facts, analysis why the law or proposed law would hinder/ benefit responding to HIV/AIDS, recommendations for law reform or views on specific legislative proposals.

   You cannot provide this to individual legislators.
E.1 Monitoring and Evaluating Advocacy

PowerPoint presentation on advocacy action plans is on the CD provided.

Why is monitoring and evaluating advocacy important?

Advocacy for policy change is an incremental process, often taking years to achieve impact of a substantive nature. Advocacy takes place in a dynamic and ever-changing environment, where external factors can affect whether or not you are able to achieve your goal. Given the long-term nature of advocacy work and the complex and dynamic environment in which it takes place, it is as important to be able to measure your progress as you work toward your goal. Tracking the impact of your efforts over time will contribute to a better focused programme and one which has measurable success.

Sharing the results of evaluation with communities, donors and others stakeholders creates a culture of continuous learning that can be motivating at every level.
Plan for monitoring and evaluation at the beginning

To monitor progress and evaluate the impact of advocacy you should start by defining the change you want to bring about and carefully plan the steps towards achieving that goal.

The goal is your vision, it is what you hope to achieve in the long term (three-five years). Objectives are the smaller steps towards achieving the goal (usually one-two years). Setting objectives that are SMART at the outset - Specific, Measurable, Action-oriented, Realistic and Time-bound, makes monitoring and evaluation of advocacy possible.

An advocacy action plan defines these goals and objectives. Below are some considerations to make when drawing up this plan:

- Who is the primary target audience for advocacy?
- Who are the decision makers that can bring about the policy solution?
- What activities need to be undertaken to achieve the specific objectives?
- Who will be responsible for these activities?
- What resources will be needed to undertake the activities?
- When will the activities be undertaken?
- What indicators will be used to measure progress, outcomes and impact?
- What information will need to be documented or collected to measure whether you have fulfilled the indicators you have set?

The next two sections look in more detail at how to:

- develop indicators to monitor progress, outcomes and evaluate impact, and,
- use different types of data or information to document or show the progress, outcomes and impact of your advocacy efforts.
Indicators for monitoring and evaluation

Indicators are pre-determined milestones, “check-in” points, used to monitor and evaluate your advocacy efforts. An advocacy action plan should include indicators that enable you to review progress, record outcomes and assess impact. Different kinds of indicators can be used to help you do this. Review as example the table of different indicators and types of documentation (and data for monitoring and evaluating advocacy) in relation to advocacy with police outlined below.

Progress indicators

Progress indicators, sometimes called ‘process indicators’, measure the smaller incremental steps towards achieving specific objectives and ultimately your goal, as well as to help record, understand and explain what happened and why and when unexpected events occur.

In a dynamic environment over the long-term, circumstances change and unplanned events occur that affect what you should do. For example, you may be on track to plan training for police, and then the senior officer is transferred and you need to develop a relationship with a different officer to move forward. In this way, advocacy action plans are not static documents, prepared at the outset and then forgotten, but help you to take into account these changes and adjust your approach. Understanding these challenges and changes provide important opportunities to learn about what works and does not work so that you can improve your advocacy efforts over time. Flexibility is often the key to successful advocacy.

Monitoring your progress along the way also highlights smaller successes that contribute to achieving the goal. These are milestones that can encourage advocates, communities and donors, assisting in keeping them engaged in the long term work of advocacy. When developing progress indicators it is important to monitor your external progress and as well as your own advocacy capacity (which could be seen as ‘internal progress’).

Examples: Progress indicators for monitoring external progress:

- obtained a face-to-face meeting with the Head of the District Police
- established an on-going working relationship with senior police
- Secured police agreement to develop a circular
While these achievements have not yet produced an outcome, it is likely that they have been hard-won. So it is important to know how to document these successes along the way, show how they contribute to achieving your goal and understand what contributed to achieving these successes.

**Example:** Progress indicators for monitoring progress in developing your own advocacy capacity:

- coalitions function effectively through regular, well-chaired meetings, clear communication during meetings and agreed activities undertaken within agreed time frame
- expanded number of champions involved in contributing to addressing your advocacy issue

The kind of documentation you could develop or collect to monitor whether you are meeting these two types of progress indicators are highlighted below.

**Outcome indicators**

Outcome indicators are concrete results that you want to generate as a result of your advocacy activities.

**Examples:**

- Police circular is developed and distributed to all police stations
- Police training is developed and conducted in collaboration with NGOs and key populations.

**Impact indicators**

Impact indicators are used to show what positive change there has been in the lives of the people you want benefiting from your advocacy efforts.

For example, if the goal is to protect the rights of sex workers and ensure their access to condoms and HIV prevention services, specific objectives might be:

- that the Police issue a circular within twelve months to all units stating that arrest of sex workers and HIV outreach workers for carrying condoms is not consistent with the Immoral Trafficking Prevention Act, and hampers effective HIV prevention efforts
- that Police carry out training in collaboration with sex workers and NGOs, to increase forces’ understanding of HIV prevention and ensure compliance with the circular within eighteen months
The impact you would want to be able to show is not just that the circular was produced or that the training was undertaken, but that the impact of the circular and the training was to reduce harassment and arrest of sex workers and outreach workers by the police.

**Data for monitoring and evaluation**

There are many different tools that you can use to record the incremental steps in moving towards your advocacy goal and to assess the impact of your advocacy efforts. But monitoring and evaluation does not need to lead to wasted effort and endless paper work!

Far too often, too much information is collected and much of it not used. Think carefully about what you want to collect or document, so that it is useful for monitoring your progress, outcomes and impact. See the examples of data and documentation that could be used to show whether each of the indicators set out in the example below were achieved.

Data for monitoring and evaluation can be quantitative (hard) or qualitative (soft). Qualitative data include reports from focus groups, case studies and interviews, for example, with outreach staff and key populations. These can be used to document the problems you are seeking to address, as well as to measure the progress and impact of your advocacy efforts. Quantitative data can be collected through surveys, by collecting the number of media releases distributed, recording the numbers of people who attend events. However, it is important to remember that quantitative data often simply tracks outputs while qualitative data often reveals more about their effects. Quantitative data can lead to asking the right questions to improve your advocacy efforts. For example, recording the numbers of police trained does not tell you anything about the effect of the training. But if the numbers attending are low, this should prompt you to ask why and think about how you can work with senior police to ensure better attendance at the training.

Monitoring media coverage of your advocacy issue, recording minutes of meetings, conducting interviews and surveys can all help to track your progress and outcomes. One to one interviews are particularly useful to develop deeper insight into both whether and how your advocacy efforts are influencing decision makers and measuring the impact that your advocacy is having on people’s lives. For example, when your progress is slow or you are facing particular challenges, you might decide to interview political advisors or community leaders with whom you have developed a relationship and who understand the issues you are seeking to address, to identify different
ways you could approach the problem or persuade the decision maker.
Interviews with key populations and field workers about their experiences
can be used to develop case studies, stories, and quotations about the
impact of your advocacy efforts. This is essential to explore whether the
outcomes you may have achieved along the way are producing real benefits
in people’s lives.

**Evaluation report**

It is not easy to clearly show that the impact, such as reduced harassment
and arrests of sex workers, is the direct result of your advocacy efforts.
Advocacy is complex, long term, and there are often many players involved.
Rather than trying to show that the impact was the result of your advocacy
efforts, it is often more credible to show how your efforts have contributed to
that impact. By monitoring progress and outcomes along the way, and
documenting the impact that your advocacy efforts have on the lives of the
people you wanted to benefit, you should be in strong position to determine
what you have achieved.

The more your evaluation report tells the story about what happened during
the course of your advocacy campaign, the more it will be useful for your
own organisational learning, and for advocacy partners, communities and
donors.

In preparing an evaluation report consider and answer the following
questions:

- What did we set out to achieve: set out your goal, objectives, what policy
  change did you seek and why?
- What did we do and how did we go about it?
- What incremental successes did we achieve that moved us towards
  achieving your goal, how and why were these steps successful?
- What challenges did you face along the way? How did you respond?
  What worked and what did not? What would you do differently?
- What positive changes have there been in the lives of the people we
  sought to benefit by our advocacy efforts?
- How have our advocacy efforts contributed to these changes?
Example: Indicators and documentation for monitoring and evaluating advocacy with police

**Goal:** Protect the rights of sex workers and ensure their access to condoms and HIV prevention services.

**Advocacy Objective:**

That the Police:

- issue a circular within twelve months to all units stating that arrest of sex workers and HIV outreach workers for carrying condoms is not consistent with the Immoral Trafficking Prevention Act, and hampers effective HIV prevention efforts

- carry out in collaboration with sex workers and NGOs, police training to increase their understanding of HIV prevention and ensure compliance with the circular within eighteen months
<table>
<thead>
<tr>
<th>Activities</th>
<th>Monitoring &amp; Evaluation</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Progress Indicators</td>
</tr>
<tr>
<td>Document the problem; gather data to show the problems</td>
<td>Problem clearly documented</td>
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<tr>
<td>Explore allies who have relationship with police and could influence police</td>
<td>Allies identified and involved in advocacy efforts</td>
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<tr>
<td>Research senior police attitudes to the issues</td>
<td>Meetings obtained</td>
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<tr>
<td>Identify and contact key police personnel to arrange meeting(s) to seek policy solution: circular &amp; training</td>
<td></td>
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<tr>
<td>Activities</td>
<td>Monitoring &amp; Evaluation</td>
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<tr>
<td>Prepare for meetings with the police to secure commitment to obtain circular for trainings</td>
<td>Activities: Prepare for meetings with the police to secure commitment to obtain circular for trainings.</td>
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<tr>
<td>Contribute to development of circular and training including involving sex workers in developing an implementation of training</td>
<td>Activities: Contribute to development of circular and training including involving sex workers in developing an implementation of training.</td>
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<tr>
<td>Use documentation to review progress and amend plan</td>
<td>Activities: Use documentation to review progress and amend plan.</td>
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<tr>
<td>Evaluate advocacy impact</td>
<td>Activities: Evaluate advocacy impact.</td>
</tr>
<tr>
<td><strong>Progress Indicators</strong></td>
<td><strong>Expected Outcome</strong></td>
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<tr>
<td>Advocates well prepared for meetings (assesses capacity)</td>
<td>Circular produced and disseminated</td>
</tr>
<tr>
<td>Meetings held and on-going working relation established with Police</td>
<td>Training program developed and training held</td>
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<tr>
<td>Sex workers involved in circular and training development</td>
<td></td>
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<tr>
<td>Plan monitored and plans adjusted (assess capacity)</td>
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</tr>
<tr>
<td>Evaluation report prepared</td>
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</table>
### Advocacy Action Plan

**Advocacy Objective:**

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Activities</th>
<th>Person Responsible</th>
<th>Resources Needed</th>
<th>Time-frame</th>
<th>Monitoring &amp; Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Expected Outcome</td>
</tr>
</tbody>
</table>

- Expected Outcome
- Indicator
- Documentation
Guest Speaker’s talking points: Advocate's experience

To:  
From:  
Re: Speaker Invitation for “An Advocate's Experience: Messages and Methods” EAP HIV/AIDS Advocacy Workshop on XX

Date:

The Essential Advocacy Project (EAP) will be holding an HIV/AIDS Advocacy Training Workshop in xx on xx. The training will involve approximately XX participants from state/ district/ local NGOs/ KPs. This workshop is part of Āvāhan - the India AIDS Initiative of the Bill and Melinda Gates Foundation. The EAP works to strengthen the capacity of Āvāhan partners, key stakeholders, key populations and people living with and affected by HIV/AIDS to advocate for an evidence-based approach to responding to HIV/AIDS, supported by effective policies and practices that protect the rights of those affected and ensure effective programming.
We are hoping that you might be able to contribute your expertise to the workshop by giving a 30 minute presentation titled “An Advocate's Experience: Messages and Methods,” followed by 30 minutes of questions and discussion. The presentation would be scheduled on xx.

The overall training workshop goal is to strengthen participants' understanding of advocacy and build participants' skills to carry out advocacy in their work. The purpose of your presentation is to give participants an insight into how to go about effective advocacy communication.

We would like you to focus on sharing a specific example of a successful advocacy effort you have been involved in with an emphasis on the particular advocacy methods and messages used.

We also suggest that it might be helpful to address the following questions.

1. What was the problem?
2. What was the advocacy objective? (What did you want to achieve?)
3. Who decided to advocate to address the problem (who was involved)?
4. Who did you advocate to?
5. What were your key messages? And what methods did you use? (main focus)
6. What difficulties did you face and how did you overcome these?
7. What were the results of your advocacy?
8. What sources of support did you find most useful?
9. What did you learn from doing this advocacy?

We hope that we will be able to benefit from your valuable experience and time. Please do not hesitate to call if you have any questions. We will also call you to follow-up on this invitation.
Sample policy briefs

Sample policy briefs are on CD provided

We would like to acknowledge the following for use of sample policy briefs in this section:

- Burden of Disease Research Unit, Medical Research Council, South Africa, Dec, 2003
- The Henry J. Kaiser Family Foundation, May, 2005
- Poverty and Development Division, ESCAP, June, 2006
- Department of Reproductive Health and Research, WHO, October, 1999
- Centre for Research on Environmental Health and Population Activities (CREHPA), Nepal, October, 1999
What are the leading causes of death among South African children?

Debbie Bradshaw, David Bourne, Nadine Nannan

Burden of Disease Research Unit, Medical Research Council, PO Box 10970, Tygerberg, 7505, South Africa.
Tel. +27 (0)21 938 0327. http://www.mrc.ac.za/bod/bod.htm

Investing in the health and wellbeing of the children of South Africa is an investment in the future development of our country. South Africa still has a relatively youthful population with a third of the population under 15 years of age, although we are in the midst of demographic transition. The health of these children needs to be a priority, a principle adopted through the ratification of the 1990 United Nations Convention of the Rights of the Child.

The level of mortality is a fundamental indicator of child health and understanding the causes of death of children provides insight as to how it can be reduced. The lack of reliable vital statistics has created a void when it comes to these indicators, but the recent burden of disease study has made use of available data from the emerging health information system to estimate the levels and causes.

The 1998 Demographic and Health Survey found that the Infant Mortality Rate was 45 per 1000 live births for the preceding 10 years. This overall figure is lower than the WHO ‘Health for All’ target of 50 per 1000 births, but does conceal the variations between population groups, according to socio-economic status or region. The survey also highlighted the wide racial and socio-economic status inequalities in child mortality. It also conceals the reversal in the downward trend that occurred during the 1990’s. This has largely been ascribed to the impact of the HIV/AIDS epidemic. Furthermore, the level of mortality has not given any insight into the causes of mortality.

The South African National Burden of Disease Study (NBD)

Since the disease burden in South Africa is undergoing rapid change due to the spread of HIV/AIDS, the usual burden of disease approach was considered inappropriate and a modelling approach calibrated to empirical data was adopted. An adapted version of the 1990
Global Burden of Disease (GBD) list of causes of death\(^{6-7}\) was developed for the South African National Burden of Disease study. The total number of deaths, as well as the age-specific population was calculated using the ASSA2000 model of the Actuarial Society of South Africa\(^{4}\). Empirical estimates from surveys and vital registration of the level of childhood and adult mortality were used in the model for the period prior to the AIDS epidemic. Ill-defined causes within a disease category were reallocated proportionally by age and sex to specified causes within that category. Cause of death information processed by the Department of Home Affairs was used to estimate the overall proportion of deaths due to injuries by age and sex. Finally the UNISA/MRC national injury mortality surveillance system (NIMSS)\(^{9}\) was used to estimate the profile of deaths arising from injury. The estimates are hence a synthesis derived by analysis of a variety of often incomplete data sources. Full details of the methodology appear in the complete report\(^{1}\). Variations of prevalence at a subnational level are not reflected in this study.

The NBD study estimated just over half a million deaths of which 106 000 were of children under the age of 5 years and a further 7800 were children aged 5-14 years. In general, young babies are much more vulnerable than older. In addition, the cause of death patterns in the different age groups are very different.

**Infant and Under-5 mortality**

The NBD study estimates that by the year 2000, the Infant Mortality Rate had risen to 60 per 1000 live births and the Under-5 mortality rate had risen to 95 per 1000. This deterioration in child health occurred despite the introduction of free health care and nutrition programmes and was attributable to paediatric AIDS, commensurate with the high prevalence of HIV observed among pregnant women.

The top twenty causes for children under the age of 5 are shown in Table 1 and by age and sex in Figures 1 and 2. HIV/AIDS is the leading cause of death among young children and accounts for 40% of the deaths in 2000. Although the percentage of deaths due to HIV/AIDS is higher in the 1-4 year age group, the largest number of deaths occurs in the under-one age group. Low birth weight, diarrhoea, lower respiratory infections and protein energy malnutrition account for a further 30% of the childhood deaths. A large number of these deaths are preventable through the delivery of the standard conventional primary health care package approach. Birth defects, particularly of the heart and neural tubes also are among the top ranking infant deaths. Protein-energy malnutrition begins to approach. Birth defects, particularly of the heart and neural tubes also are among the top ranking infant deaths. Protein-energy malnutrition begins to show in the 1-4 age group. There is little gender difference in mortality among the under-fives.

Projections indicate that without effective prevention of mother-to-child transmission (PMTCT), the child mortality rate is likely to have continued to rise in subsequent years\(^ {10}\). This pattern, however, can be expected to change as the epidemic matures and as the roll-out of PMTCT takes effect, reducing the number of infected babies.

Most of the other causes of death of infants and toddlers are associated with poor socio-economic conditions. The 2001 census reveals extensive variations in living conditions. Over two thirds of households have formal homes, 16% are informal and 14% are traditional. Access to clean water and basic sanitation is important from a health perspective. The census shows that the majority of households do have access to piped water (84.5%) – whether it is in the home, the yard or a public facility. However, the Eastern Cape has a much lower proportion with only 62.4% of households having access to piped water. The Eastern Cape also had a very high proportion of households without any toilet facilities (30%). Nationally, 13.6% of households have no toilet facility, also a health hazard. Just over half the households have regular refuse removal services. The high levels of poverty and unemployment are dearly

<table>
<thead>
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<th>Rank</th>
<th>Cause of Death</th>
<th>Deaths</th>
<th>%</th>
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<td>1</td>
<td>HIV/AIDS</td>
<td>42749</td>
<td>40.3</td>
</tr>
<tr>
<td>2</td>
<td>Low birth weight</td>
<td>11876</td>
<td>11.2</td>
</tr>
<tr>
<td>3</td>
<td>Diarrhoeal diseases</td>
<td>10786</td>
<td>10.2</td>
</tr>
<tr>
<td>4</td>
<td>Lower respiratory infections</td>
<td>6110</td>
<td>5.8</td>
</tr>
<tr>
<td>5</td>
<td>Protein-energy malnutrition</td>
<td>4564</td>
<td>4.3</td>
</tr>
<tr>
<td>6</td>
<td>Neonatal infections</td>
<td>2920</td>
<td>2.8</td>
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<td>7</td>
<td>Birth asphyxia and trauma</td>
<td>2584</td>
<td>2.4</td>
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<tr>
<td>8</td>
<td>Congenital heart disease</td>
<td>1238</td>
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<td>9</td>
<td>Road traffic accidents</td>
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<td>1.1</td>
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<td>10</td>
<td>Bacterial meningitis</td>
<td>1141</td>
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<tr>
<td>11</td>
<td>Fires</td>
<td>1102</td>
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<tr>
<td>12</td>
<td>Neutral tube defects</td>
<td>1019</td>
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<tr>
<td>13</td>
<td>Septicaemia</td>
<td>980</td>
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<tr>
<td>14</td>
<td>Tuberculosis</td>
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<td>Homicide/violence</td>
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<tr>
<td>16</td>
<td>Drowning</td>
<td>532</td>
<td>0.5</td>
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<tr>
<td>17</td>
<td>Cot death</td>
<td>491</td>
<td>0.5</td>
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<tr>
<td>18</td>
<td>Down syndrome and other chromosomal</td>
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<td>19</td>
<td>Congenital disorders of GIT</td>
<td>379</td>
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**Table 1:** Top twenty specific causes of death in children under 5 years, South Africa 2000

**Figure 1.** Leading causes of death among infants under 1 year of age, South Africa 2000
fundamental issues that bear on child health, also indicated by the estimated 4564 deaths from protein-energy malnutrition (Kwashiorkor). Many of these deaths can be prevented. Reducing poverty, meeting basic needs and adopting a comprehensive primary health care approach with renewed vigour must be high on the agenda in the next few years.

Older children 5-14 years

As children get older, external causes of death (eg. road traffic injuries and drowning) rise in importance. This is particularly noticeable among boys who die in greater numbers than girls. This pattern becomes particularly marked among the 10 -14 year age group, where road traffic accidents is the leading cause of death. Homicide and suicide feature in the top causes
The mortality data indicates that many of the child deaths occurring in South Africa are preventable. We have identified three broad areas that will require differing approaches for intervention:

- The prevention of mother-to-child transmission of HIV, even at its current efficacy, is the single most effective intervention to reduce mortality among under-5-year olds, eclipsing all other interventions for other causes of death combined.
- Although dominated by the rise of HIV/AIDS, the classic infectious diseases such as diarrhoea, respiratory infections and malnutrition are still important causes of mortality. Environment and development initiatives such as access to sufficient quantities of safe water, sanitation, reductions in exposure to indoor smoke, improved personal and domestic hygiene as well as comprehensive primary health care will go a long way to preventing these diseases. Poverty reduction initiatives are also important in this regard.
- Road traffic accidents and violence, which includes homicide and suicide is another group of high mortality conditions that will require dedicated interventions.

The data presented in this policy brief represent an average for the whole country and do not highlight the inequalities in health care and outcomes that exist in different parts of the country. Detailed investigation of these inequalities will, however, require more comprehensive information systems that are currently available, and are beyond the scope of this policy brief.

Acknowledgements
This research work had partial financial support from UNICEF, South Africa. The modeling of the HIV/AIDS epidemic was carried out at the Centre for Actuarial Research at the University of Cape Town.

References
With more than 5 million people estimated to be living with HIV/AIDS, India’s HIV/AIDS prevalence is second in the world only to South Africa, and there are signs that the epidemic may be spreading.\textsuperscript{1,2} India is considered to be a “next wave” country; that is, it stands at a critical point in its epidemic, with HIV poised to spread quickly, but where large-scale prevention and other interventions today can help to avert a major epidemic in the future.\textsuperscript{3} As the second most populous nation in the world\textsuperscript{4}, even a small increase in India’s HIV/AIDS prevalence rate will represent a significant component of the world’s HIV/AIDS burden.

**Background\textsuperscript{5-7,8}**
- The first case of HIV disease was reported in India in 1986.
- Later that year, the Government of India established a National AIDS Control Committee under the Ministry of Health and Family Welfare to formulate a strategy for responding to HIV/AIDS in the country; it launched a National AIDS Control Programme in 1987.
- NACO has facilitated the development of 38 State AIDS Control Societies (SACS), which operate in all states and Union Territories and in three cities.
- The Indian Government reports that it will provide 196 Crore (about $45 million) to Phase II of the National AIDS Programme, which is also supported by other donors.

**Current National Estimates**
NACO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and other international experts develop estimates of HIV prevalence (people living with the disease) and incidence (new HIV infections) in India:

- As of the end of 2003, there were an estimated 5.1 million people living with HIV/AIDS in India.\textsuperscript{2}
- HIV/AIDS prevalence among adults\textsuperscript{9} in India is still relatively low, at just below 1%.\textsuperscript{2} Because of India’s large population size, a small increase in prevalence represents a large number of people. Once a country’s prevalence is greater than 1%, it is considered to have a “generalized epidemic” and HIV may spread rapidly.
- HIV/AIDS prevalence in India represents approximately 78% of HIV/AIDS prevalence in the South/South East Asian region, and 13% of global prevalence.\textsuperscript{2} By comparison, India represents 17% of the world’s population\textsuperscript{9} (see Figure 1).
- Six Indian states are considered to have high HIV/AIDS prevalence (>1%) – Manipur, Nagaland, Andhra Pradesh, Tamil Nadu, Karnataka and Maharashtra – as are 49 districts within states.\textsuperscript{8}
- Most HIV infections in India are due to sexual transmission (84-86%). In the North East, however, injection drug use is the main mode of transmission.\textsuperscript{6,7}
- Women account for 38% of India’s estimated adult\textsuperscript{6} HIV/AIDS prevalence; HIV prevalence has been increasing among pregnant women in many regions within the country.\textsuperscript{1}
- Among young people, ages 15-24, the estimated number of young women living with HIV/AIDS was almost twice that of young men.\textsuperscript{10}
- Tuberculosis (TB) plays a role in fueling India’s HIV epidemic. NACO reports that TB is the most common opportunistic infection among people living with HIV.\textsuperscript{9}

![Figure 1: India as Percent of World Population and Global and Regional HIV/AIDS Prevalence, End 2003](image)

**HIV/AIDS in India**

May 2005

**Key Trends**
- NACO estimates that HIV/AIDS prevalence increased by 46% since 1998, including an increase of 11% in the most recent period (2002-2003) (see Figure 2). This recent increase was not as sharp as the increase between 2001 and 2002 (15%), which NACO believes indicates no significant upsurge in new infections.\textsuperscript{7} However, data on new infections are not currently available. One way to approximate the number of new HIV infections in India is to apply India’s share of the global total of people estimated to be living with HIV/AIDS (13%) to the global total of estimated new HIV infections (5 million), yielding an estimate that more than 600,000 Indians were newly infected with HIV last year.\textsuperscript{1,2}
- India’s share of people living with HIV/AIDS has grown as a proportion of global HIV/AIDS prevalence, rising from 11% at the end of 2001 to 13% at the end 2003. Similarly, India’s prevalence as a proportion of South/South East Asian prevalence rose from 67% to 78% over this period.\textsuperscript{2}
- NACO also collects AIDS case surveillance data from SACS\textsuperscript{7,8} but these data only provide a snapshot of the epidemic, given the delay in progression from HIV infection to an AIDS diagnosis and the large number of people living with HIV who do not know their status. This is the case in every country, including the United States.

**Projections**
Several different projections have been developed to model the potential impact of the epidemic in India over time, including:

- **U.S. National Intelligence Council (NIC):** A 2002 report by the NIC projected that by 2010, India could have 20 to 25 million people living with HIV/AIDS, the highest number of any country in the world.\textsuperscript{11}
- **Eberstadt:** Researcher Nicholas Eberstadt of the American Enterprise Institute modeled several scenarios to project the epidemic’s impact between 2000-2025. For example, he projects that life expectancy in India in 2025 could fall by 3-13 years, depending on epidemic severity.\textsuperscript{12}
- **World Health Organization (WHO):** The WHO estimated that HIV/AIDS caused 2% of all deaths and 6% of deaths due to infectious diseases in India in 1998. If current HIV/AIDS trends
continue, by 2033, HIV could account for 17% of all deaths and 40% of deaths from infectious disease. The United Nations recently estimated that life expectancy gains in India are expected to be lower than otherwise would be due to HIV/AIDS.13

- **World Bank:** A recent World Bank report examined alternate scenarios for expanding antiretroviral therapy in India, concluding that such an expansion is cost effective. However, without strengthened prevention efforts, the epidemic will not substantially slow.13

**HIV/AIDS Services/Activities**

- **Support Groups and Networks:** As of 2003, there were 51 community care centers run by non governmental organizations (NGOs) in India. NACO supports 17 networks of people living with HIV/AIDS.7
- **HIV Counseling and Testing:** There were 709 voluntary counseling and testing (VCT) centers in India as of June 2004, 628 of which are supported by NACO through SACS. NACO and WHO established 3 model VCT sites in Chennai, Imphal and Mumbai.7
- **Antiretroviral Therapy (ART):** In 2003, the Indian Government announced its intention to provide free ART at government hospitals to people living with HIV/AIDS in the six high prevalence states and in the city of Delhi, beginning in April 2004. The WHO is procuring ARVs for the treatment roll-out. Eight government hospitals were selected for the initial launch (expected to increase to 25 in 2005).7 As of December 2004, an estimated 28,000 people were receiving ARV therapy, including 2,841 people receiving treatment through the public sector. This represents 4% of the estimated 770,000 adults in need of ART in India.15
- **Public Education Initiatives:** The Heroes Project, a national initiative co-chaired by Richard Gere and Parmeshwar Godrej in partnership with the Kaiser Family Foundation and supported by a grant from the Bill & Melinda Gates Foundation’s Avahan Initiative, works with a cross-section of Indian media and societal leaders on a coordinated HIV/AIDS campaign. Population Services International (PSI) has social marketing activities on HIV/AIDS that span 22 States and Union Territories as well as the national highway system in the southern states.16 The BBC World Service Trust has a co-production partnership with NACO and Doordarshan, the government-supported broadcaster, on HIV/AIDS programming.17 There are other national and regional efforts to work with media on HIV/AIDS, including journalism programs developed by the Kaiser Family Foundation and the Avahan Initiative.
- **Generic Drugs:** India is one of the key manufacturers of generic antiretroviral drugs in the world,7 which are sold within India and in other countries, including those in sub-Saharan Africa. India is expected to soon comply with World Trade Organization requirements to protect product patents on medicines, which some fear may drive up prices for these generics.18,19

**HIV Vaccine Trials:** The first Phase I clinical trial for an HIV vaccine recently began in India. Conducted by NACO, the Indian Council of Medical Research, and the International AIDS Vaccine Initiative (IAVI), the trial will take place at the National AIDS Research Institute in Pune.20

**Major Donors/Other Support**

- The U.S. Government provides bilateral assistance to India for HIV/AIDS, and supports through its contributions to the Global Fund. USAID has supported activities in India since 199521 and the CDC since 2001.22 India is not one of the 15 focus countries of the President’s Emergency Plan for AIDS Relief (PEPFAR), but has been identified as a country of “concern outside of the focus countries”;23 U.S. bilateral aid for India was $36 million in FY 2004, the largest outside of the 15 focus countries.24
- The United Kingdom, Australian, and Canadian governments also provide donor aid to India.7
- The Global Fund has approved the following grants in India:25
  - HIV/AIDS Round 2 (signed): $100,081,000 requested; two year funding of $26,116,000 approved.
  - HIV/AIDS Round 4 (one component signed): $140,878,119 requested; two year funding of $25,831,024 approved.
  - HIV/TB Round 3 (signed): $14,819,773 requested; two year funding of $2,667,346 approved.
- The World Bank has been a main financier of NACO, providing $84 million for Phase I of the National AIDS Programme and $191 million for Phase II.26
- UNAIDS, WHO, UNICEF, UNDP, and the other UNAIDS co-sponsors provide technical assistance and other support, through in country offices and partnerships.
- The Bill and Melinda Gates Foundation has committed $200 million through its Avahan Initiative.27

**References**


The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

Additional copies of this publication (#7312) are available on the Kaiser Family Foundation website at www.kff.org
Men in Nepal ignoring risks from unprotected casual sex

Background

- In 1997, the population of Nepal was approximately 22.5 million, with an estimated 26,000 adults and children living with HIV/AIDS.
- A major route of HIV transmission in Nepal is heterosexual sex, including contact with commercial sex workers (CSWs).
- Contact with CSWs is particularly common in towns near the border with India. However, little is known about the sexual behaviour of men in these towns and their risks of acquiring and transmitting HIV.
- To help provide reliable data for AIDS prevention campaigns in Nepal, researchers studied the sexual behaviour and risk perceptions of adult males who reside in or who visit five border towns in Nepal.

Study design and sample

- Interviews were conducted in 1997 with a sample of 500 resident men and a sample of 300 non-resident men aged 18–40 in Kakarbhitta, Birgunj, Bhairabha, Nepalgunj, and Dhangadi.
- In-depth interviews were conducted with a subsample of 50 men (24 resident, 26 non-resident) who were found to be practising high-risk sexual behaviour.

Major findings

- Over one-fourth of men had had casual sex in the 12 months before the interview. Adjusting for other factors, non-resident men who visited border towns one or more times per month were over seven times more likely to have casual sex than those visiting for the first time or only a few times per year. Among the residents, unmarried men were over four times more likely to have casual sex than married men were. Residents aged 18–24 years were 2–3 times more likely to have casual sex than those aged 25 or older, irrespective of marital status. Alcohol consumption was associated with an increased risk of having casual sex among both the residents and non-residents. About 30% of married, non-resident men and about 12% of married, resident men had had casual sex during the 12 months before the survey.

- Most residents (89%) and non-residents (85%) who had had casual sex did not perceive themselves to be at risk of contracting STIs/HIV. Reasons mentioned for not feeling at risk included: always using condoms (41% resident and 58% non-resident) and partner not infected (54% resident and 39% non-resident). Concerns about HIV reportedly began when men experienced symptoms of STIs.

- A large proportion of men who had had casual sex during the 12 months before the survey had not always used a condom during casual sex. Reasons mentioned by the residents for non-use of condoms during the last casual sex included: not feel like using one (34%); no time to wear/buy one (19%); partner objected (19%); and not carrying one (11%). Other common perceptions of condoms were that they made sex less enjoyable, they were most appropriate for a couple, and women did not like men to wear them.

- Meetings with CSWs were reported to have taken place at hotels or restaurants, bazaars, sex workers’ homes, bus terminals, and roadside settlements.

---

1This brief is based on research conducted by Anand Tamang, Mahesh Puri, Binod Nepal, and Devendra Shrestha, Centre for Research on Environmental Health and Population Activities (CREHPA), Kathmandu, Nepal. E-mail: crehpa@crehpa.wlink.com.np.

For further information, please contact the authors directly or Dr. Iqbal Shah, World Health Organization, CH-1211 Geneva 27, Switzerland. Fax: 41-22-791-4171, Tele: 41-5416, Tel: 41-22-791-3332. E-mail: shahi@who.int

This research was supported by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development & Research Training in Human Reproduction.

2Results for resident and non-resident men are not comparable owing to differences in sampling procedures.
### Characteristics of the samples

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<tr>
<td>- Can prevent STDs</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>- Can prevent STDs but not AIDS</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>- Help only in family planning</td>
<td>84</td>
<td>83</td>
</tr>
<tr>
<td>- Need not use if one has only one partner</td>
<td>85</td>
<td>80</td>
</tr>
<tr>
<td>- Most appropriate for a couple</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>- Against my religion</td>
<td>62</td>
<td>51</td>
</tr>
<tr>
<td>- Easy to use</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>- Too expensive to use regularly</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>- Make sex less enjoyable</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>- Break frequently</td>
<td>34</td>
<td>21</td>
</tr>
<tr>
<td>- Women do not like men to wear</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td>Risk behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ever had sex</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>- Median age at first sexual experience (years)</td>
<td>56</td>
<td>73</td>
</tr>
<tr>
<td>- Had casual sex in the 12 months before interview</td>
<td>26</td>
<td>33</td>
</tr>
<tr>
<td>- Last casual sex partner a commercial sex worker</td>
<td>34</td>
<td>61</td>
</tr>
<tr>
<td>- Used a condom during last casual sex</td>
<td>51</td>
<td>61</td>
</tr>
<tr>
<td>- Always used a condom during casual sex</td>
<td>44</td>
<td>53</td>
</tr>
</tbody>
</table>

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### Conclusions and recommendations

- Knowledge about condoms is high, yet condom use tends to be irregular. Therefore, information campaigns should focus on changing attitudes that create barriers to regular use.
- Resident and non-resident men practise risky behaviours. As a priority, programmes to promote safe sex should focus on sub-groups of men who are more likely to have casual sex, including mobile, non-resident men, resident men under 25 years of age, unmarried resident men, and men who consume alcohol.
- Substantial proportions of married men have casual sex. However, since most men see condom use by couples as appropriate, STD/AIDS prevention programmes have the potential to protect marital partners by encouraging condom use within marriage.
- Condoms should be readily available at the places where men have casual sex, such as bus terminals, hotels, restaurants, and bazaars. Proprietors should be encouraged to ensure condom availability at these places, and sex workers should be encouraged to use condoms with all partners.
- Because most men who have casual sex do not perceive themselves at risk of STDs/AIDS, research should focus on the impact of mass media on perceptions of risk, negative attitudes toward condoms, and risky behaviours.

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3Resident n=500; non-resident n=300; all respondents.
4India has more defined red-light districts, and commercial sex is a known reason for some travel between Nepal and India.
5Resident n=499; non-resident n=297; those who knew about condoms.
6”Dampati” or “couple” generally denotes a married couple in Nepali. However, the study did not confirm whether respondents also understood regular, unmarried partner.
7Resident n=394; non-resident n=255; those with sexual experience.
8Casual sex was defined for unmarried men as “Apart from your regular sex partner, during the past 12 months, did you have `sex with anyone?’ and for married men as “During the past 12 months, apart from your wife, did you have sex with anyone?”
9Resident n=101, non-resident n=83, those having had casual sex during the 12 months before the survey.

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“I have had sex with many girls and ...some may have had relations with others...I never used a condom as the brain does not work while enjoying, but so far I have no symptoms of AIDS.”
— 18-year-old student, unmarried resident

“As I have sex with clean... women, there is no need to use condoms. It is natural to fear (AIDS) but I take precautions by being selective about my partners.”
— 22-year-old truck driver, married non-resident

“By paying Rs. 40–50 to the hotel people, one can ... have sex with (such girls) in the hotel.”
— 22-year-old businessman, married non-resident
An estimated 9 million people are living with HIV in the ESCAP region. While 1 million people in the region were newly infected in 2005, half a million lives were lost due to AIDS in the same year.

Young people are the hardest hit – half of all new infections have occurred among youth. In Viet Nam, 63 per cent of the people infected by HIV are under the age of 30. In Thailand, 50 to 60 per cent of new infections each year are among people under 24 years of age. While young people in general are vulnerable to HIV infection, the most at risk are those engaged in commercial sex and those injecting illicit drugs – the main drivers of the HIV pandemic in the region.

There is a high prevalence of HIV among brothel-based sex workers. In Cambodia, HIV among brothel-based sex workers accounted for 21 per cent of the total in 2003. In Viet Nam, the average prevalence of HIV among sex workers is about 16 per cent; in Mumbai, India, it remains above 50 per cent among female sex workers. Data from a number of Asian countries reveal that 32 to 74 per cent of female sex workers are below 25 years of age (figure 1). Young men who have sex with other men (MSM) are also at a high risk of HIV infection. In Bangkok, studies carried out in 2003 and 2005 found that the HIV infection rate among this group had increased from 17 to 27 per cent. Among transgender sex workers in Jakarta, HIV prevalence increased from 6 to 22 per cent in 2002.

Figure 1. Percentage of female sex workers under the age of 25

Source: National behaviour surveillance data.

\(^1\) The figure for the ESCAP region was obtained by adding the number of people living with HIV and AIDS in East Asia, South-East Asia, South Asia, Oceania, Central Asia and the Russian Federation (UNAIDS, 2005a).
Why are youth so vulnerable?

Throughout the region the face of HIV/AIDS is becoming younger and more feminine. While most countries in the region have a national HIV prevalence below 1 per cent, vulnerable groups are much more prone to HIV infection due to globalization, poverty, gender discrimination and lack of access to information and health services. Figure 3 below shows aspects of the population at risk of HIV infection:

- Globalization and poverty increase population migration within and across countries in search of better economic opportunities. The majority of migrant workers are young people. Isolated from mainstream society and with little knowledge and few life skills, they are at risk of acquiring HIV as a result of unprotected casual sex and injecting drugs.

- Biological and social factors render girls and women more vulnerable to HIV/AIDS. Young women constitute more than half the young people living with HIV in Asia and the Pacific. Research shows that, during unprotected sex, the risk of HIV infection is two to four times higher for women than men.

- Entrenched gender biases often deprive girls of education; as a result, girls and women have much less knowledge of HIV/AIDS than men. Also, early marriage and gender violence increase the risk of HIV infection among them.

- Adolescents and young people are poorly informed about sexuality, reproductive health and the consequences of unprotected sex or drug use. In a 2004 survey in China, 80 per cent of high school students said they had never participated in a course, or in extracurricular activities, at school related to HIV prevention.

- Access to essential health services is lacking in the region. For example, the coverage of voluntary counselling and testing services was less than 0.1 per cent of the population (aged 15-49) in Asia and the Pacific in 2003.
How to turn the tide against HIV/AIDS

Focusing HIV prevention on youth offers the greatest hope for containing the spread of HIV in Asia and the Pacific. To be effective, prevention efforts should go hand in hand with treatment and care.

1. Enhancing knowledge, skills and preventive services

Schools are the best channels for reaching the majority of teenagers and youth. Merely incorporating information on HIV/AIDS in the curriculum, however, is not sufficient. Schools should be encouraged to promote a life-skills approach, which emphasizes interactive teaching methods to encourage young people to face health risks and make responsible decisions.

There is no easy way to reach youth who are out of school. While workplace HIV/AIDS education can be an efficient way to reach some, community-based peer education would be more effective for targeting a larger segment of youth. Positive peer influence and the community approach – engaging parents, teachers, health workers, village leaders and religious leaders – can foster positive behaviour among young people.

Life skills-based education in schools and community settings needs to be complemented by providing access to youth-friendly health services, including the availability of condoms, the provision of voluntary and confidential HIV counselling and testing, and the treatment of sexually transmitted infections. Youth-friendly health services can be delivered through hospitals, clinics, community outreach services, schools, the workplace and youth centres.

2. Scaling up comprehensive services to those at risk

In September 2005 at the United Nations General Assembly, Governments resolved to move towards providing universal access to HIV prevention, treatment and care. To achieve this goal, it will be necessary to expand these comprehensive services for the populations most at risk. Countries that have targeted vulnerable groups have successfully contained the spread of HIV. For example, Cambodia and Thailand managed to reverse the spread of HIV through 100 per cent condom use among sex workers.

Investments in harm-reduction programmes that target IDUs have proven to be effective. These programmes typically include substitution therapy, the provision of clean injection instruments, access to health-care facilities, law enforcement and prevention education. Australia invested US$ 122 million in a needle-exchange programme during the late 1980s and 2000. It succeeded in preventing 25,000 HIV and 210,000 hepatitis C virus infections. More recently, the Government of China has announced plans to establish 1,400 needle-exchange sites and over 1,500 clinics for the treatment of drug users.

3. Improving policy coherence

Lack of policy coherence has been one of the major obstacles to scaling up HIV-prevention services for those most in need of them. While one ministry tries to promote safe and healthy behaviour among sex workers and drug users, another may arrest the same sex workers and drug users simply because they are in possession of a condom or a needle.

To ensure the effectiveness of HIV-prevention programmes, Governments also need to reform legal and policy frameworks, including decriminalization of HIV-related risk behaviour. Where proactive and coherent policies do exist, there is often a gap between policies and implementation. Addressing this gap calls for wider engagement of the ministries of health with the ministries of justice, public security, law enforcement and other key actors that have not been part of the public health response to the AIDS pandemic.

4. Closing the resource gap

A comprehensive response to the AIDS pandemic in Asia and the Pacific will require an estimated investment of US$ 5.1 billion annually by 2007. It is estimated that only US$ 1.6 billion would be available. Most of it would come from bilateral donors, foundations and international institutions, including the Global Fund to Fight AIDS, Tuberculosis and Malaria.
To close the resource gap, significantly increased international assistance would be needed, particularly for the lower-income and the least developed countries. At the same time, domestic resources would have to be bolstered. Creative financing mechanisms, such as taxes on alcohol and tobacco, could be considered by countries. Also, better targeting of funds is needed in order to have a strategic impact on the AIDS pandemic. Funding should be prioritized for programmes and services for vulnerable and marginalized groups, including youth most at risk.

5. Addressing root causes of vulnerability

Poverty and gender discrimination are the root causes that endanger youth and other vulnerable groups with regard to the spread of HIV. Youth employment should be placed at the top of the national development agenda. Youth-oriented livelihood and income-generation projects need to be developed to prevent young people from seeking survival in the treachery of the streets and from exploitation by the sex industry.

Eliminating gender discrimination thatsubjects young girls and women to health risks requires strong political will and the full participation of society in order to change cultural and social norms as well as to do away with laws that perpetuate gender bias. It is crucial to build enabling environments for girls and women to fulfil their rights to sexual and reproductive health and to live a dignified life.

6. Initiating a pro-poor regional compact to fight HIV/AIDS

A “pro-poor” regional compact could be developed to ensure that essential commodities are available for vulnerable and marginalized populations, including young people. Access to condoms, antiretroviral therapy, treatment of opportunistic and sexually transmitted infections, and substitution drugs and clean needles at affordable prices is therefore a priority in scaling up prevention and treatment services. Furthermore, countries should fully utilize the flexibility and safeguards allowed under the Agreement on Trade-Related Aspects of Intellectual Property Rights to ensure their access to affordable life-saving medicines. Major producers of these drugs and supplies, such as China, India and Thailand, could consider the formation of a regional compact to make them available at prices which the poor and vulnerable groups, including youth, could afford.

REFERENCES


Monitoring the AIDS Pandemic Network (2005). Drug Injection and HIV and AIDS in Asia; Sex work and HIV and AIDS in Asia; Male-Male Sex and HIV and AIDS in Asia (Geneva, MAP)


UNAIDS (2005b). A Scaled-up Response to AIDS in Asia and the Pacific (Bangkok, UNAIDS Regional Support Team for Asia and the Pacific)


United Nations Regional Task Force on Injecting Drug Use and HIV and AIDS for Asia and the Pacific, Background Paper, February 2006

BACKGROUND

One of the most tragic consequences of the HIV/AIDS epidemic is the huge number of children orphaned as a result of parents dying from AIDS. (Some of these children are HIV-positive themselves - having been infected by their mothers either at birth or through breast milk.)

In South Africa up to now the number of these orphans has been increasing quite slowly and from a low base - and hence has attracted relatively little attention to date. South Africa’s AIDS epidemic is still in its early stages relative to other African countries, and the levels of orphanhood seen elsewhere in Africa have yet to be experienced in this country. As the epidemic matures and AIDS mortality increases, the number of orphans is predicted to rise dramatically.

Currently there are more people infected with HIV in South Africa than in any other African country - and ultimately we are likely to have to look after amongst the highest number of AIDS orphans.

South Africa will face significant costs in the long term if we do not plan to look after these orphans now - such costs include increased juvenile crime, reduced literacy, and increased economic burden on the state. Orphaned children are not only traumatised by the
loss of parents (whose physical deterioration they may often have witnessed), they may lack the necessary parental guidance through crucial life-stages of identity formation and socialisation into adulthood. The impact on the ability of these children to eventually participate constructively in social and economic life is likely to be significant, and will no doubt increase levels of juvenile crime. Psychosocial effects will be worsened by accompanying threats to the basic survival (food, housing, education, health care) and security (protection from exploitation and abuse) frequently experienced by orphans.

Many of these costs can be reduced if action is taken now. Models of community-based care must be further developed, and forms of state assistance to those caring for orphaned children must be expanded.

It is imperative that the number and profile of orphans expected in future be understood if successful strategies to provide and care for them are to be developed. A recent study has estimated the number of orphans using the ASSA2000 AIDS and Demographic model of the Actuarial Society of SA. The focus of this study was primarily on ‘maternal orphans’ (those whose mothers have died), but it also estimated the numbers of ‘dual orphans’ (children that have lost both parents) and ‘paternal’ orphans.

It should be noted that HIV-positive orphans constitute a relatively small part of the orphan population, since about two-thirds of babies born to HIV-positive parents will not be infected, and because most infected children do not survive long enough to make up a sizeable proportion of the orphans.

Figure 2 shows numbers of AIDS orphans (those whose mother died while HIV-positive) as against ‘non-AIDS’ orphans (those whose mothers were HIV-negative when they died) over time. Projections indicate that the number of non-AIDS orphans will gradually decline – mainly as a result of greater numbers of mothers dying of AIDS, and declining levels of fertility. However, the number of AIDS orphans is expected to rise enormously over the next decade, peaking at about 1.85 million in 2015.

Without significant changes in sexual behaviour or interventions, about 15% of all children under the age of 15 are expected to be orphaned by 2015. This percentage varies significantly with regard to age (Figure 3). The older a child is, the greater the chance that their mother has died during the time they have been alive. So, for children born in the last 12 months the percentage is close to zero, but at over 15 years of age the percentage is well over 30%. By 2015...
more than 30% of all children between the ages of 15 and 17 will have lost their mothers.

**Figure 3: Percentage of children maternally orphaned in 2015.**

Alternative definitions of orphans
The most commonly used definition is children under the age of 15 whose mothers have died. But orphans do not cease to have need of parenting on reaching 15. In addition, the loss of a father also has a significant impact. AIDS modellers and demographers typically use age definitions with cut-off points of 14, 15, 18 or 21 years. The Constitution defines children as being persons under the age of 18, and most policy makers would agree that children under this age should not be expected to be self-supporting. Using age 18 as a cut-off results in a much higher estimate of orphans than using 15. The number of maternal orphans under the age of 18 is likely to peak at roughly 3.1 million in 2015, as opposed to 1.85 million using 15 years as the cut-off.

To aggravate this, orphanhood may in practice begin long before the death of a parent. This will happen where there is a sole parent and that parent becomes sick with AIDS. Often the household is without income and the parent is no longer able to support the child. This and the trauma of watching the parent slowly dying are the first stresses the orphan has to face. Studies of AIDS orphans show that they have low self-esteem and tend to display more aggression, anxiety and depression than other children.

Regardless of the definition used, the number of orphans is likely to peak at around 2015 - at roughly 2 million in the case of maternal orphans under 15, and 3 million in maternal orphans under 18. The number of paternal orphans under 18 is expected to peak at 4.7 million in 2015, and the total number of children compromised by having lost one or both parents is likely to reach its highest level around 2015, at 5.7 million. The number of paternal and double orphans may be an underestimate of the number of children compromised, since it does not take into account fathers who are still alive but absent (i.e. no longer taking responsibility for their children).

Roughly a third of all children under the age of 18 will have lost one or both parents by 2015 if there are no changes in sexual behaviour and no significant health interventions.

**IMPACT OF MOTHER-TO-CHILD TRANSMISSION PREVENTION PROGRAMMES**

In developed countries the probability of perinatal transmission of HIV can be reduced to very low levels through the provision of long-course antiretroviral treatment during pregnancy and through caesarean sections. In resource-poor settings it has been shown that giving short-course antiretroviral treatment to mothers prior to birth and to babies after birth can also be effective in reducing the probability of transmission by between 35-50%.

It is often suggested that introducing a mother-to-child transmission prevention (MTCTP) programme will result in a substantial increase in the numbers of orphans. Figure 4 shows the projected number of maternal orphans under the age of 15 if a MTCTP programme is introduced, compared to the levels expected if such a programme is not introduced. It is clear that if MTCTP was phased in, fewer children would be infected by their HIV-positive mothers, and hence children would survive for longer. By 2015 the total number of orphans under 15 is likely to be around 2.26 million - 200 000 more than in the absence of MTCTP. Thus a MTCTP programme will only slightly increase the number of orphans, accounting for an additional 10%.

**Figure 4: Numbers of orphans, with and without an MTCTP programme.**

**IMPACT OF OTHER INTERVENTIONS**

The expected number of orphans is - in the short term at least - relatively insensitive to changes in sexual behaviour patterns, condom distribution, AIDS awareness programmes, etc. These changes reduce the number of orphans substantially in the long term (by about 10% around 2015). However, such interventions are unlikely to change the fact that 12 years from now, South Africa will have close to 2 million orphans on its hands.

Although prevention programmes may not achieve a short-term reduction in the number of orphans, a significant reduction in the number and trend in number of orphaned children can be achieved through antiretroviral treatment programmes to all HIV-positive individuals who need treatment. Such programmes may succeed in extending the lives of a large number of parents to the stage where their children are self-sup-
Supporting. By 2015 the number of maternally orphaned children could be roughly half the number expected without any antiretroviral intervention (Figure 5), at 1.15 million. The cost-effectiveness of such interventions needs to be assessed as a matter of urgency.

**Figure 5: Numbers of orphans, with and without antiretroviral interventions.**

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**POLICY RESPONSES**

A number of different strategies exist and the response will have to be multipronged. However, any attempt to manage the situation is likely to require considerable expenditure by the state. Saving on short-term costs will just result in escalation of the long-term costs to society in terms of reduced literacy levels, increased crime and increased economic strain on affected households.

**Options for the protection of orphaned and vulnerable children**

Meeting the needs of orphaned children will be a massive challenge, clearly overwhelming the formal (statutory) systems such as orphan, foster and residential care. It is widely acknowledged that informal systems are likely to shoulder the biggest share of the burden of orphan care. Most commonly, orphans will be cared for by their older siblings, grandparents or extended families. Various additional models of community-based orphan care have emerged in recent years and include:

i. Community Child Care Committees, community structures set up to identify orphaned and vulnerable children and to safeguard their rights, e.g. assisting them and their families to obtain child welfare grants, access health care, education, protecting them from abuse etc.;

ii. placing adults (usually older women) in the homes of orphaned children; and

iii. ‘create a family’ or ‘cluster foster care’ programmes where surrogate mothers are identified and hired to look after a number of orphans in homes in the community.6

**Creating an enabling environment**

The following measures should be taken to ensure that the emotional and physical needs of South Africa’s children are met in the face of rising adult mortality:

- **All forms of State support for children must be expanded.** It has been argued that the Child Care Act should be modified to allow alternative placement options for children in need of care and support.7 The Care Dependency Grant should be extended to parents/guardians looking after children with chronic conditions like AIDS, and the basis for eligibility should be a ‘needs test’ rather than strict application of the medical definition of disability. However, this will only deal with those children accessing formal welfare systems.

The Committee of Inquiry into a Comprehensive System of Social Security for South Africa8 has recommended a general widening of the social security safety net to also support those children who are likely to fall within informal systems of care by measures which include: extending access to the Child Support Grant (CSG) to all children below the age of 18 years (currently limited to children up to the age of 7 years) and providing free health care up to the age of 18 years. The current uptake of the CSG grant, however, is significantly hampered by difficulties in accessing necessary documentation such as birth and identity registration.9 The evidence to date is that the children most in need are least likely to receive these grants, and mechanisms to address this have been recognised as a national priority.

- **Promote community based systems** of orphan support and care by providing support and funding for non-governmental and community-based organisations undertaking this work. The current government initiatives around home-based care could be extended to include a focus on children. However, external organisations and government agencies must be wary of undermining traditional coping mechanisms.4 It must be recognised too that children are in need of support long before their parents die - interventions need to be directed at households where children are having to care for sick parents and are in need of emotional and material support.6

- **Making antiretroviral treatment freely available** to HIV-infected adults will have a dramatic effect on the numbers of orphans needing care and support. The potential impact of providing anti-retrovirals on reducing welfare costs urgently needs to be investigated.

**South Africa’s capacity to provide care for these orphaned children will determine the long-term social stability of the country.** Little can be done to reduce the number of orphaned children in the short term, short of introducing a national antiretroviral treatment programme.

**References**

Module G. is designed to provide experienced advocates with the opportunity to examine different types of data, identify how the information can be used to support the arguments they will make for specific policy changes they seek and to practice using the data. For these sessions to work effectively, this module requires thoughtful preparation.

**Preparation: Compile data sets for each scenario**

You will need to compile a set of documents (data sets) for each scenario, ensuring you have sufficient copies for each participant to receive a set of documents at least for the scenario they will be working on. So, if there are 30 participants, you will need 10 data sets for each of the three scenarios. In field-testing the manual, we provided enough data sets for participants to take away sets related to all scenarios. This was well received, so this approach is encouraged. Alternatively you might distribute the suggested documents list below, so that participants can download the resources from the Internet.

The suggested documents for each scenario are provided in the resources below. The website links are provided and documents are also on the enclosed CD. A range of resources are provided.
Preparation: Review scenarios and data sets

Review each scenario and the data sets thoroughly before commencing this module. In order to provide feedback on the use of the data for both the policy briefs and face-to-face role plays, you will need to be clear about what the main advocacy issues are in each scenario and what information in the data sets can be used to make the case for policy change related to each of these issues.

You do not need to include all of the suggested documents. You can choose a selection, but you will need to make sure that materials provided offer enough data that is relevant to and useful for each advocacy issue in a specific scenario. Once you have reviewed each scenario and the related documents, you'll be in a position to choose which data you want to include.

Conducting sessions

As participants are working in small groups planning, reviewing data and writing policy briefs, and during preparation of face-to-face role plays, you will need to play an active role in guiding, advising and providing critical feedback. This is as important for the participants as are the formal feedback sessions at the conclusion of each session.

You may want to schedule session G.1 to conclude at a lunch break or at the end of a day, to allow you time to review the summary policy briefs in preparation for providing feedback. See guidance for feedback sessions for G.1 (Policy briefs) and G.2 (Face-to-face Communication) for each scenario, set out below.

G.1 Policy briefs

Sample policy briefs

Sample policy briefs are on the CD provided. See hard copies of policy briefs above in materials for session F.5.
Scenario 1

Akash, an NGO in Bangalore, provides a range of HIV prevention services. As part of their outreach activity, Akash staff is becoming increasingly aware that men who have sex with men (MSM) and trans-genders are at particular risk of HIV infection and that many in the city are already living with HIV. Yet, there seem to be barriers to access to mainstream health services. There is very little information available about sexual behavior and HIV/STI risk among MSM and transgenders, and the impact of HIV on PLWHA.

With Akash’s support, some MSM and transgenders formed an advocacy group called ‘Hamare Haq’ (Our rights). Members of Hamare Haq and Akash outreach workers have been talking to MSM and transgenders and documenting their experience such as their access to condoms, lubricants, HIV prevention information and services to meet their HIV treatment and care and/or sexual health needs. Together Akash and Hamare Haq have run four focus groups, focus groups, in all seventy people attended these group discussions. They also conducted thirty individual interviews. A total of 100 people reported their experiences.

They found that many MSM and transgenders report a lack of access to condoms and lubricants. Forty percent report having had the symptoms of one or more sexually transmitted infections (STIs) in the last twelve months. Of these forty people only eight (20%), sought treatment for the infection. Fifteen people reported that the staff at the OPD of one of the city’s largest public hospital’s Out Patients’ Department are known to be dismissive of MSM and transgenders and often have no experience in handling oral and anal STIs affecting the community. There is also evidence about breach of confidentiality about clients’ sexual orientation and HIV status by health workers, leading to family and community harassment or rejection. As a result many people say that they will not go there.

Together Akash and Hamare Haq discuss what action they could take to improve the situation for MSM and transgenders. They build partnerships with other NGOs who want to work on these issues and agree to set up a coalition, Transgender and MSM Advocacy Coalition (TRAM), to work together on an advocacy agenda. The coalition meets and agrees to focus its advocacy efforts on:

- access to condoms and lubricants, and
access to non-discriminatory and good quality HIV prevention, sexual health, HIV treatment and care services

In addition to their own research, there is also some data that can be used to make the case for their advocacy goals.

Target audience for policy brief: SACS

Scenario 1: Suggested documents

These documents are on the CD accompanying this manual.

  - (Tables used in this manual: Self reported STI prevalence, MSM sex with female partners, MSM condom use)


- Resource pack for interventions with MSM and Hijra, NACO, 2006. www.nacoonline.org

- MSM and HIV/AIDS risk in Asia: What is fuelling the epidemic among MSM and how can it be stopped, TREAT Asia, 2006 www.amfar.org (selected extracts).

- UNAIDS: www.unaids.org
  - Policy Position - Condom and HIV Prevention, UNAIDS 2004
  - Policy Brief: HIV and Sex Between Men, UNAIDS, 2006
**Scenario 1: Roles**

**Policy makers**

- Senior Policy Advisor from the Health Department
- Representative of Karnataka SACS

**Advocates**

- Representative of Hamare Haq
- Representative of the Transgender and MSM Advocacy Coalition (TRAM)
- Representative of NGO, Akash

**Scenario 1: Instructions for policy makers**

These instructions are to provide some guidance to your team about how you should play your roles. Please do not share these details with the advocates, as it is important that they learn to adjust their approaches as the meeting unfolds.

**Senior Policy Advisor for Health Department**

You are generally not well informed on issues, and initially, you do not appear to be that interested. However, as the meeting progresses and advocates make a number of points you think are important, you become more attentive and engaged. You start to see the consequences of inaction, particularly the fact that HIV is likely to spread rapidly if transgender/MSM's sexual health and prevention needs are not meet, given the extent of MSM who also have sex with women.

**Representative of the SACS**

You are impressed by the arguments about why better data is needed on sexual behavior, supportive of the need for more programming efforts and open to ideas.
Scenario 2

There is a district election coming up in the north west of Karnataka and there has been considerable community pressure about cracking down on sex work in a number of blocks in the area. In the last two months, police have been regularly rounding up street sex workers and conducting random raids on brothels, arresting sex workers. In 2004, the Director General of Police in Karnataka issued a circular explaining what the police powers are under the Immoral Trafficking Prevention Act (ITPA). These raids do not comply with the circular and therefore with ITPA.

The sex worker collective, Mahila Sangha, is spending much of their time trying to assist sex workers who have been arrested and charged with soliciting. They report that many sex workers are being fined and are unable to pay the fine. In their experience, many men demand, and are willing to pay more for sex without condoms. Many sex workers are being forced to do so, just to make more money to pay back these fines. They report that sex workers are increasingly worried about carrying condoms or being identified as sex workers.

The NGO, Prajal Foundation runs a number of sexual health clinics for sex workers in the north west of Karnataka. They work in partnership with Mahila Sangha providing outreach to brothels and street sex workers, to ensure their access to condoms, HIV prevention information and sexual health services. In the last two months, staff have noticed a sharp drop in the numbers of sex workers attending their clinic.

Brothel madams in the area are increasingly worried about these raids, and the effect of them on their businesses. Prajal Foundation and Mahila Sangha are finding that their working relationships with many madams have deteriorated as a result. Some madams refuse to provide condoms and safer sex resources, because they will be used as evidence that the premises are being used as a brothel.

It is more difficult to locate brothels and street sex workers. A number of brothels have moved premises to avoid police exposure. Some madams are colluding with the police offering them sex with their workers in exchange for agreeing not to raid their brothels. Frequently police insist on not using condoms and the sex workers are powerless to refuse, exposing both workers and officers to the increased risk of HIV infection.
The Karnataka Health Promotion Trust, Prajal Foundation and Mahila Sangha meet to discuss how to take action to address these issues. They want to advocate for the police to comply with the Police circular and the ITPA and to improve understanding about how the raids impede effective HIV prevention efforts.

**Target audience for the policy brief: Police Department of Karnataka**

**Scenario 2: Suggested documents**

These documents are on the CD accompanying this manual.

- Police circular on interpretation of the Immoral Trafficking Prevention Act (ITPA) for Karnataka, 2004
- National baseline high risk and bridge population behavioral surveillance survey, 2001 (Female sex workers), NACO 2001
  [www.nacoonline.org](http://www.nacoonline.org)
  - Tables used: Awareness of STI and STI symptoms, STI prevalence; treatment seeking behaviour
- Sex work and HIV in India, Essential Advocacy Project, Constella Futures, August 2006
- Sex Workers of Kerala, India: Moving beyond HIV/STI prevention, Subhash Thottiparambil, [www.kit.nl](http://www.kit.nl)
- World Health Organization (WHO): [www.who.int](http://www.who.int)
  - Sex Work: Key facts and figures
Scenario 2: Roles

Policy makers
- Member of the District Assembly
- Head of District Police

Advocates
- Director of the Karnataka Health Promotion Trust (KHPT)
- Director of Prajal Foundation
- Representative Mahila Sangha

Scenario 2: Instructions for policy makers

These instructions are to provide some guidance to your team about how you should play your roles. Please do not share these details with the advocates, as it is important that they learn to adjust their approaches as the meeting unfolds.

Member of the District Assembly

You start by raising the issue of community concerns about sex work, and your need to be responsive to community views on this (as that is what you are directly concerned about). You are surprised to hear about the police circular and you want to know more about it. As the discussion unfolds, and you start understanding that the raids will not reduce sex work, they will only move somewhere else in the area. Meanwhile STIs and HIV infections will rise.

Towards the end of the meeting you openly make suggestions about the way forward and are open to ideas about what you can do to raise these issues with other members of the District Assembly.
Head of District Police

You became head of District Police about six months ago and only became aware of the circular in preparation for this meeting. You are open to hearing what the advocates have to say. You acknowledge that more needs to be done to ensure that officers in your district know about the circular and comply with it. You express concern about the allegations of police corruption, and want to know what evidence they have to support the allegations. When they have made their case on this point, you say you are prepared to look into the matter, but you would need to document some case for investigation. You are concerned that your police officers may be exposing themselves to risk of HIV and indeed, some may already be infected. You are open to hearing and discussing options for action.

Resources for Scenario 3: Resistance to harm reduction and a changing epidemic

Scenario 3

There is high HIV prevalence among injecting drug users (IDUs) in Manipur. There are a number of NGOs working to implement a range of strategies to reduce HIV infection among IDUs and address the treatment and care needs of those living with HIV. Ukhzul Foundation is an NGO that provides Needle and Syringe Programs (NSPs), peer outreach, IEC, advocates for access to appropriate and non-discriminatory drug treatment and HIV treatment and care services, as well as increases community awareness about the effectiveness of harm reduction approaches to injecting drug use and the contribution that this makes to reduce HIV transmission.

Ukhzul also works with an IDU network of current and ex-users that they have been trained as peer educators. Through the network’s work with their peers, they want to take action about the many challenges that IDUs are facing. Together they have started to document the challenges through focus group discussions and one on one interviews. Eighty people participate. The work reveals that most IDUs have poor access to appropriate drug treatment services such as drug substitution programs. While 50% of those surveyed had been detained and forced into detoxification programs, with no support or follow up upon release. The survey also found that 45% of those surveyed were HIV- positive. Of these, 90% had experienced discrimination in accessing HIV- related health care.
There is also considerable community resistance to the harm reduction work of NGOs, particularly by a vocal womens’ group that is advocating that the NSP will increase injecting drug use. This is building community resistance, and this has created a climate of fear and violence against IDUs. Increasingly, IDUs are not carrying injecting equipment because they fear this will lead to their arrest by police or violence from ‘pressure groups’.

Data in Manipur also shows a trend of increasing STIs among women, which suggests that they are increasingly exposed to HIV, likely through their male IDU partners. There is inadequate evidence to confirm this trend, but Ukhzul is aware that few programs exist that address the HIV prevention needs of partners of IDUs or HIV/AIDS treatment and care needs of IDUs, partners and others living with HIV/AIDS. Existing programs and services do not necessarily have the capacity to expand their work without additional funding and support to meet these emerging needs.

Ukhzul and the Network find other allies and form an advocacy group, called the Manipur Action Coalition (MAC) to take action together. MAC meets to discuss what action they could take to address these issues. They want to:

- increase understanding of harm reduction and how it contributes to preventing the spread of HIV;
- ensure access to appropriate drug treatment, HIV related treatment and care for IDUs and their partners;
- address stigma and discrimination by pressure groups and services and address programs gaps, particularly the needs of women partners of male IDUs.

Target audience for policy brief: SACS

Scenario 3: Suggested documents

These documents are on the CD accompanying this manual.

Tables extracted from this document for data sets: Last time condom use with commercial, non regular and regular partners; Needle and syringe sharing behaviour; knowledge of availability of new/unused needles and syringes; Needle and syringe sharing behaviour - frequency of sharing cooker, vial, container in past month; Treatment for drug use; Treatment for drug use- type of treatment/ help received.


- Asian Harm Reduction Network (AHRN): [www.ahrn.net](http://www.ahrn.net)
  - Evidence based HIV/AIDS prevention
  - Evidence for harm reduction

  - Policy Brief: Provision of sterile injecting equipment to reduce HIV transmission
  - Policy brief: Reduction of HIV transmission through outreach
  - Policy Brief: Reduction of HIV transmission through drug dependence treatment


**Scenario 3: Roles**

**Policy makers**
- Senior advisor from the Health Department
- Representative of Manipur SACS

**Advocates**
- Ukzhul Foundation Executive Director
- Representative from the Manipur Action Coalition
Representative from the IDU network, who is an experienced IDU peer outreach worker and was central in the survey that Ukzhul and the network undertook.

Scenario 3: Instructions for policy makers

These instructions are to provide some guidance to your team about how you should play your roles. Please do not share these details with the advocates, as it is important that they learn to adjust their approaches as the meeting unfolds.

Senior policy advisor, Health Department

Initially you are concerned about community outcry about NSP because of the political implications, given the Meirapbies' lobbying against harm reduction approaches. On hearing the advocates’ case, about the evidence of effectiveness of NSPs, drug treatment and outreach approaches, you are more inclined to listen to the advocates and are open to at least discussing strategies for increasing acceptance of harm reduction within the community.

Representative of the SACS

You focus your attention on the issue about the changing epidemic in Manipur and the fact that different approaches are needed to meet emerging needs.

Guidance on feedback for policy briefs (G.1) and role plays (G.2)

Scenario 1: Access to services for MSM and transgenders

When providing feedback on summary policy briefs and on the content of the role plays for this scenario consider whether teams used available data to make the case for resources and programming to address the needs of MSM and transgenders and address barriers in accessing services.

For example did they use data to support or illustrate the following issues:

- MSM disproportionately affected by HIV in India compared with general population (NACO 2005; compare MSM and ANC national data)
While available data shows high prevalence among MSM in India; there is a need for better data, both epidemiological and behavioural to understand and address HIV risk among MSM, and transgenders (e.g. Lancet, 2006; NACO 2005; Dandona et.al 2005)

Effectiveness of condoms (UNAIDS 2006), yet lack of access to condoms and lubricants and/or lack of use with male partners (e.g. NACO Resource Pack; NACO BSS 2001; Dandona et.al 2005; own research study)

High rates of STI among MSM (e.g. NACO BSS 2001)

Untreated STIs, and how this increases risk of HIV transmission (e.g. MAP 2005)

MSM often also have female sexual partners and implications for spread of HIV (Dandona)

Stigma and discrimination impedes efforts to respond effectively to HIV risk and impact among MSM and transgenders (e.g. UNAIDS 2006; TREAT Asia; MAP 2005; own research)

Role that addressing stigma and discrimination has in responding effectively to HIV and sexual health needs of MSM and transgenders (e.g. UNAIDS 2006; TREAT Asia; MAP 2005).

Scenario 2: Police raids hamper effective HIV prevention among sex workers

When providing feedback on summary policy briefs and on the content of the role plays for this scenario consider whether teams used available data to make the case for police compliance with the ITPA circular and specific strategies to improve police understanding of how these raids impact on the rights of sex workers and the effectiveness of HIV prevention efforts.

For example did they use data to support or illustrate the following points:

- District police practices are inconsistent with State police policy and ITPA (e.g. Circular; EAP Sex work brief; Thottiparambil)

- Data on HIV prevalence among female sex workers in Karnataka shows that sex workers still disproportionately affected by HIV compared with the general population (NACO 2005; compare FSW and ANC national data)
Effectiveness of condoms in HIV prevention (UNAIDS 2004), but access to condoms reduced by raids

Evidence of successful HIV prevention in brothel setting is also being undermined by raids (WHO Sex work fact sheet)

In studies where reported condom use is high, HIV prevalence is relatively low among female sex workers (Lancet; HRW 2004 example)

High rates of STI among sex workers in Bangalore (NACO BSS 2001)

Implications of sex workers being driven away from STI clinics, increasing untreated STIs (Prajal Foundation clinic data)

Untreated STIs increase risk of HIV transmission; STI prevention and treatment contributes to reduced vulnerability to HIV infection; presence of STIs increasing risk of HIV infection ten fold (e.g. WHO STI fact sheet)

The value of sex worker involvement in strategies to implement the circular through police trainings to improve police understanding of the ITPA, the circular and rationale for HIV prevention (e.g. UNAIDS Case Study 2000)

Police practices undermine effective HIV prevention among sex workers (Best practice: sex worker involvement in HIV prevention strategies; the ability to protect themselves from HIV infection and meet their own treatment and care needs (e.g. UNAIDS 2002; UNAIDS case study 2000)

The value of sex worker involvement in strategies to implement the circular through police trainings to change police practices (e.g. UNAIDS Case Study 2000)

**Scenario 3: Resistance to harm reduction and a changing epidemic**

When providing feedback on summary policy briefs and on content of the role plays for this scenario consider whether teams used available data to make the case for the effectiveness of harm reduction including needle and syringe programs and drug treatment.

For example did they use data to support or illustrate the following points:
IDUs disproportionately affected by HIV in Manipur compared to the general population (NACO 2005; compare IDU Manipur and national prevalence and ANC national data)

The rationale for and effectiveness of harm reduction approaches (e.g. ARHN 1; WHO Harm Reduction fact sheet)

Need for and key components of a comprehensive harm reduction program, including NSPs, drug treatment and drug substitution (ARHN 1; ARHN 2; WHO Harm Reduction fact sheet)

Evidence regarding needle sharing behaviour in Manipur (NACO BSS 2001)

NSPs have contributed to substantially reducing HIV transmission in many countries; provision of needles and syringes does not increase drug use; creates opportunities for referral to treatment and primary care services (WHO NSP brief)

Nearly half of the IDUs in Manipur have never received drug treatment; very few have access to drug substitution (NACO BSS 2002)

Of those that have had any access to drug treatment, many are forced into detoxification and released with follow up (Ukhzul Foundations' own study; see scenario)

Strong evidence that drug substitution treatment is effective: significantly reduces unsafe injecting practices and criminal activity; increases social functioning and is cost effective compared with costs of later treatment of HIV/AIDS (WHO brief HIV transmission and drug treatment; AHRN 1; WHO Harm Reduction fact sheet)

Evidence that the epidemic is changing in Manipur (Ukhzul gathered data in Manipur, see scenario) as a basis for arguing for analysis of data and assess whether resources are being allocated to meet the changing nature of the epidemic.
The Power to Change

Participants' Resources
Identifying and Analyzing Target Audiences
Background Notes  54
Power Map for Audience Analysis  56
Primary and Secondary Audience Analysis Form  57

Implementation : Advocacy Action Plans
Indicators for Monitoring and Evaluation Advocacy  58
Sources for Monitoring and Evaluating Advocacy Campaigns  65
Advocacy Action Plan template  67

Advocacy Communication: Messages and Methods
Background Notes  68
Five Key Elements of an Advocacy Message  69
How to Choose Appropriate Advocacy Methods  69
The One-Minute Message  72
Sample Policy Briefs  74
Preparing a Policy Brief  75
Face-to-face communication: Background Notes  77
Scenarios for ‘lobbying’ activity  79
Preparing for face-to-face meetings  83

Evidence for Action: Using Data for Advocacy
Sample Policy Briefs  86
Scenarios: Using evidence for advocacy  86
Policy brief template  90
A Rights-Based Approach and Advocacy

Background Notes

Centrality of human rights in responding to HIV

HIV-related stigma and discrimination influence how individuals, communities, and governments, respond to the epidemic. Stigma and discrimination are often a reflection of the social taboos associated with behaviors that can transmit HIV. Policies and programs must effectively address these risk behaviors, as well as health promotion for people living with HIV (PLWHA), if the epidemic is to be confronted effectively. Stigmatization of people living with or affected by HIV also affects the preparedness of governments to implement HIV prevention programs.

The realization of human rights is central to reducing vulnerability to HIV infection and addressing the impact of HIV. When human rights are respected, people living with or affected by HIV can live a life of dignity without discrimination; vulnerability to HIV infection is reduced; and the personal and societal impact of HIV infection can be alleviated. Laws, policies and programs that protect and promote human rights ensure better public health outcomes. When people most affected do not have assurances that their rights will be respected, they will be driven underground and out of reach of HIV-related services. This is particularly the case for people who are already socially marginalized, such as sex workers, injection drug users, and men who have sex with men.
Governments have specific obligations under international human rights laws. These obligations provide the framework for a rights-based approach to responding to HIV/AIDS. The International Guidelines on HIV and Human Rights provide explicit guidance on how best to protect, promote and fulfill human rights in the context of the HIV epidemic.


Human rights that are important in the context of HIV include:

- Rights to comprehensive HIV/AIDS prevention, treatment, care and support services;
- Rights to non-discrimination on the basis of HIV status, including in health-care services, housing and work;
- Rights of all to equality in laws, policies and programs (in particular women and girls);
- Rights of children to education and the services necessary for their health and life;
- Rights to privacy (including sexual privacy), confidentiality of HIV status, and informed consent to HIV testing;
- Rights to liberty, freedom of movement, and protection against arbitrary and oppressive laws and policies;
- Rights to security of the person and freedom from violence, including gender-based violence; and
- Rights of PLWHA and those vulnerable to HIV to participate in planning and delivery of programs and advocacy efforts.

The GIPA Principle:

People living with HIV and AIDS and people who are vulnerable to HIV infection, should be involved in all aspects of responding to the epidemic, as they contribute their expertise through their lived experience of the epidemic. This includes involvement in the design, implementation, and evaluation, of
policies and programs for HIV/AIDS prevention, treatment, care and support.

An important expression of the right to participation is the “GIPA principle” - the Greater Involvement of People Living with and Affected by HIV, was first articulated in a statement adopted by countries attending the Paris AIDS Summit in 1994. One way that people living with or affected by HIV can contribute their expertise is through peer education. This has proved as effective as an HIV prevention and health promotion method because people living with or vulnerable to HIV infection respect their peers as a source of health education and information, and because peer educators have a better understanding, through personal experience, of HIV health promotion issues.

It is not only medical or scientific expertise which determines how effectively we respond to HIV/AIDS. The causes of HIV vulnerability are multi-dimensional, and include biological, behavioral, social, and economic factors. HIV transmission is mostly the result of intimate behaviors which take place in private, such as sex or injection drug use. Being able to draw on the experiences of people who are vulnerable to or living with HIV/AIDS can enhance the effectiveness of HIV policies and programs at all levels, whether that involvement is as a target audience, program implementer, or the highest level of decision and policy making.

Involving people living with or affected by HIV in advocacy efforts needs to be handled carefully and peoples’ right to privacy respected. People can face the risk of violence, social ostracism, loss of employment, and rejection by family and community, if HIV-related information about a person becomes publicly known. The decision whether or not to publicly disclose should always be made by the person whose identity may be disclosed. Other alternatives to disclosing one’s status and identity should also be considered. For example, a person can be quoted or interviewed as a person living with HIV, without disclosing their identity. HIV advocacy coalitions should always include people living with and affected by HIV, but will usually include other concerned people and organizations. In these circumstances, advocacy activities and events can be structured in such a way that it is unnecessary to identify which members of a coalition are living with or affected by HIV.

See: Enhancing the Greater Involvement of People Living with HIV in NGOs/CBOs in India: A handbook of information and tools for NGOs/CBOs, International HIV/AIDS Alliance, India, 2006.

www.aidsalliance.org/sw38800.asp
Unpacking “enabling environment”

- Policies and programmes that ensure rights, equal participation and involvement of all stakeholders

- Environment that builds confidence of individuals and groups and facilitates
  - freedom from stigma
  - absence of discriminatory practices
  - safe spaces to raise concerns
  - confidence among the vulnerable groups to access services
  - empowerment of groups to demand/exercise rights
What is Advocacy?

Background Notes

There is no one internationally agreed definition of the term “advocacy”. You will find as many definitions of advocacy as you will find groups, networks, and coalitions advocating. However, each definition shares common language and concepts. Advocacy is also strategic, and targets well-designed activities to key stakeholders and decision-makers. And lastly, advocacy is always directed at influencing policy, laws, regulations, programs, or funding decisions made at the upper-most levels of public or private sector institutions.

Advocacy includes both single-issue, time-limited campaigns as well as ongoing work undertaken around a range of issues. Advocacy activities may be conducted at the national, regional, or local level.

Within the HIV/AIDS policy arena, advocacy efforts might address such things as affordable access to medications for HIV infection and related conditions, or the enactment of laws prohibiting discrimination on the basis of a person’s HIV status. Operational HIV/AIDS policies where specific resource allocation and service delivery guidelines are formulated (for example voluntary HIV testing and counseling, or interventions to reduce mother to child transmission of HIV) are also potential objects for advocacy campaigns.

Advocacy is a method and a process of influencing decision-makers and public perception about an issue of concern, and mobilising community action to achieve social change and a favourable policy environment to address the concern.
Definitions of Advocacy

“Advocacy is a set of targeted actions directed at decision makers in support of a specific policy issue.”


“Advocacy means putting across your message to other people to bring about wider public understanding about HIV and other issues, changes in policies, laws and services. Advocacy work can involve action at all levels, locally and through representation of national decision-making bodies.”


“Advocacy is not just about getting to the table with a new set of interests; it is about changing the size and configuration of the table to accommodate a whole new set of actors. Effective advocacy challenges imbalances of power and changes thinking.”


“Advocacy is an action directed at changing the policies, positions, and programs of any type of institution”.

**Advocacy and Related Concepts**

**Related Concepts Chart**

The following chart illustrates the difference between advocacy and several related concepts. Advocacy can usually be distinguished from other approaches in that the objective of advocacy is policy change.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Actors/Organizers</th>
<th>Target Audience</th>
<th>Objective</th>
<th>Strategies</th>
<th>Measuring Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Change Communication (BCC)</td>
<td>Service providers, Community organizations</td>
<td>At-risk groups, Segments of a community (women, men, youth)</td>
<td>Raise awareness and change behavior</td>
<td>Community outreach, Peer education, Mass media campaigns</td>
<td>Process indicators (numbers reached), Change in knowledge, attitudes, and behavior, Focus groups, Service statistics</td>
</tr>
<tr>
<td>Community Mobilization</td>
<td>Community members and organizations</td>
<td>Community members and leaders</td>
<td>Build a community’s capacity to rank needs and take action</td>
<td>Door-to-door visits, Village meetings, Participatory Rural Appraisal (PRA)</td>
<td>Issue-specific process and outcome indicators, Quality and quantity of participation</td>
</tr>
<tr>
<td>Advocacy</td>
<td>NGOs/networks, Special interest groups, Professional associations</td>
<td>Public institutions and policymakers</td>
<td>Change policies, programs, and resource allocation</td>
<td>Focus on policymakers with the power to affect advocacy objective, High-level meetings, Public events (debates, protests)</td>
<td>Process indicators, Media scans, Key informant interviews, Focus groups, Opinion surveys</td>
</tr>
</tbody>
</table>

Examples of advocacy leading to policy change

The following PowerPoint presentations are on the CD included in this manual:

1. Advocating with the police on sex worker issues: a case from CHANGES, an NGO working in the Kakinada district of Andhra Pradesh

2. Advocating with the police on harm reduction for Intravenous Drug Users (IDUs): a case from Dedicated People’s Union (DPU) in the Bishnupur district of Manipur
Steps in the Advocacy Process

Advocacy Process

- Issue
- Goal and Objectives
- Target Audience
- Building Support
- Message Development
- Channels of Communication
- Fundraising
- Implementation
Steps in the Advocacy Process

Define the Issue

Advocacy begins with an issue or problem that the network or group agrees to support in order to promote a policy change. An issue should meet a group's agreed-upon criteria and support the network's overall mission (e.g., issue is focused, clear, and widely felt by network constituents). Ways in which a group could identify issues include the following:

- analysis of the external environment, including political, economic, social, and other factors;
- discussion with PLWHA and other affected groups;
- organizing issue identification meetings; and
- Collecting and analyzing data about the HIV/AIDS situation (surveillance data, UNAIDS country data, surveys, focus groups, census)

Set Goal and Objectives

A goal is a general statement of what the group hopes to achieve in the long term (three to five years). The advocacy objective describes short-term, specific, measurable achievements that contribute to the advocacy goal.

Identify Target Audience

The primary target audience includes the decision makers who have the authority to bring about the desired policy change. The secondary target audience includes persons who have access to and are able to influence the primary audience, other policymakers, friends or relatives, the media or religious leaders. Just as advocates need to use data to define their issue, goal, and objectives, wise advocates also collect data to identify and understand their target audiences. The group must identify individuals in the target audience, their positions, and relative power base and then determine whether the various individuals support, oppose, or are neutral to the advocacy issue.
Build Support

Building a constituency to support the group's advocacy issue is critical for success. The larger the support base, the greater are the chances of success. Advocates must reach out to create alliances with other NGOs, networks, PLWHA groups, care and treatment organizations, donors, coalitions, civic groups, professional associations, womens’ groups, activists, and individuals who support the issue and will work with you to achieve your advocacy goals. How do you identify potential collaborators? Members can attend conferences and seminars, enlist the support of the media, hold public meetings, review publications, and use the Internet. Many groups have found that it is helpful to develop a database with their supporters’ contact information for sending information and other advocacy materials.

Develop the Message

Advocacy messages are developed and tailored to specific target audiences in order to frame the issue and persuade the receiver to support the group's position. There are three important questions to answer when preparing advocacy messages: Who are you trying to reach with the message? What do you want to achieve with the message? What do you want the recipient of the message to do as a result of the message (the action you want taken)? Other questions that need to be asked are: How can pre-testing your advocacy messages help gather information about the effectiveness of your messages? How/with whom might you do a pre-test?

Select Channels of Communication

Selection of the most appropriate medium for advocacy messages depends on the target audience. The choice of medium varies for reaching the general public, influencing decision makers, educating the media or generating support for the issue among like-minded organizations/networks. Some of the more common channels of communication for advocacy initiatives include press kits and press releases, press conferences, fact sheets, a public debate or a conference for policymakers, among others.
**Raise Funds**

Advocacy campaigns can always benefit from outside funds and other resources. Resources can help support the development and dissemination of material, cover group members' travel to meet with decision makers and generate support, underwrite meetings or seminars or absorb communication expenses. Advocates should develop a fund-raising strategy at the outset of the campaign to identify potential contributors of financial and other resources.

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**Implementation - Develop Advocacy Action Plan**

Advocates should develop an action plan to guide their advocacy campaign. At a minimum, the plan should identify activities and tasks, target audiences, responsible persons/committees, the desired time frame, expected outcomes, and needed resources.

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**Ongoing Activities**

**Collect Data**

As we have noted throughout, data collection supports all stages of the advocacy process shown in the model. Advocates should collect and analyze data to identify and select their issue as well as develop advocacy objectives, craft messages, expand their base of support, and influence policymakers. Data collection is an ongoing activity for the duration of the advocacy campaign.

**Monitor and Evaluate**

As with data collection, monitoring and evaluation occur throughout the advocacy process. Before undertaking the advocacy campaign, the network must determine how it will monitor the activities in its implementation plan. In addition, the group should decide how it will evaluate or measure results. Can the group realistically expect to bring about a change in policy, programs, or funding as a result of its efforts? In specific terms, what will be different following the completion of the advocacy campaign? How will the group know that the situation has changed?
Understanding the epidemic: HIV/AIDS in India

This section contains a reproduction from the Lancet, Infectious Diseases, 2006
Containing HIV/AIDS in India: the unfinished agenda

Padma Chandrasekaran, Gina Dallabetta, Virginia Loo, Sujata Rao, Helene Gayle, Ashok Alexander

India’s HIV epidemic is not yet contained and prevention in populations most at risk (high-risk groups) needs to be enhanced and expanded. HIV prevalence as measured through surveillance of antenatal and sexually transmitted disease clinics is the chief source of information on HIV in India, but these data cannot provide real insight into where transmission is occurring or guide programme strategy. The factors that influence the Indian epidemic are the size, behaviours, and disease burdens of high-risk groups, their interaction with bridge populations and general population sexual networks, and migration and mobility of both bridge populations and high-risk groups. The interplay of these forces has resulted in substantial epidemics in several pockets of many Indian states that could potentially ignite subepidemics in other, currently low prevalence, parts of the country. The growth of HIV, unless contained, could have serious consequences for India’s development. India’s national response to HIV began in 1992 and has shown early success in some states. The priority is to build on those successes by increasing prevention coverage of high-risk groups to saturation level, enhancing access and uptake of care and treatment services, ensuring systems and capacity for evidence-based programming, and building in-country technical and managerial capacity.

Introduction

The first instance of HIV in India was detected in Chennai in the southern state of Tamil Nadu in 1986. The National AIDS Control Programme was started in 1987 and focused mainly on surveillance in perceived high-risk areas, blood screening, and health education. By 1990, a medium-term plan was formulated that focused on four high-risk cities. The first HIV/AIDS project with support from the World Bank began in 1992. Programming has since expanded with assistance from several bilateral donors and, most recently, the Bill & Melinda Gates Foundation through its Avahan—India AIDS Initiative. The National AIDS Control Organization (NACO) estimated that adult HIV prevalence in India was 0.88% in 2005, which translates into about 5.2 million people infected with HIV, or one in eight of worldwide HIV cases. This number, however, masks distinct regional and subregional variations (figure 1) in a country with a population of 1 billion across 31 states and 593 districts. This review will explore what is known and yet to be understood about the current extent and features of the various Indian subepidemics and discuss the status, challenges, and needs of a national response. Given the early stage of the epidemic in India, the emphasis of the discussion on national response will be on prevention, although the growing importance of the need for treatment is clear.

Data sources and limitations

Data related to the HIV epidemic in India come from: (1) routine sentinel HIV surveillance from antenatal and sexually transmitted disease (STD) clinics, and from interventions with populations at greatest risk (high-risk groups), including female sex workers, men who have sex with men, and injecting drug users; (2) mapping and size estimation exercises of high-risk groups; (3) some behavioural surveys in high-risk groups and the general population; (4) limited biological surveys in high-risk groups and the general population; and (5) facility-based studies. Depending upon the availability and extent of these data, it is possible to describe the epidemic drivers and suggest opportunities for programmatic response.

The Indian sentinel surveillance system

The main source of HIV prevalence data in India comes from the surveillance system of unlinked anonymous HIV testing in antenatal and STD clinics. The sentinel surveillance system has been expanding rapidly—from a total of 180 sites in 1998 to 393 antenatal clinics and 179 STD sites in 2005. About 295 districts had at least one antenatal sentinel surveillance site as of 2005. Prevalence estimated from antenatal surveillance sites has several limitations. Antenatal sites in India are largely located at government hospitals in urban areas, although 72% of the population is rural. Antenatal coverage of women varies from over 90% in some southern states to as low as 34% in the northern states, while use of public-health services for antenatal care is estimated at 60%. The low mean age for voluntary sterilisation of 25–7 years and the high proportion of women choosing this means of family planning—around 50% in the southern states— further skews antenatal clinic data.

Interpretating estimated HIV infection numbers in the country either as point prevalence or as a trend series poses problems because of three factors: (1) rapid site expansion leading to sites with differing characteristics from year to year; (2) changing assumptions in estimation procedures, and (3) variable patterns of antenatal clinic attendance, which means that the data is not representative of the general population. There is limited data on antenatal prevalence compared with general population HIV prevalence and no reported antenatal HIV validation studies. Where data do exist to compare antenatal and general population prevalence, the antenatal HIV prevalence was lower. For example, three studies in Tamil Nadu done in 1998, 1999–2000, and 2003–04 reported HIV prevalences of 2.1% in women, 1.4% in an urban sample of men and women.
and 0.3% and 1.4% among women and men, respectively.\textsuperscript{14,15} By contrast, the corresponding antenatal prevalence data from nearby sentinel sites for those periods were 0.8%, 0.75%, and 0.6%. Despite these limitations, antenatal clinic data over time can point clearly to certain areas with consistently higher prevalence that warrant programme focus.

Sentinel surveillance in STD clinics for general populations and interventions for high-risk groups offer more insight into HIV epidemics at their early stages.\textsuperscript{16} In India, roughly 30% of all districts have established sentinel surveillance sites at government STD clinics.\textsuperscript{17} Little is known about potential biases of people attending government STD clinics, but one survey shows that only 10–40% of respondents from the general population with STD symptoms reported seeking treatment at government STD clinics during their last episode.\textsuperscript{18} Anonymous HIV data is also collected annually from 132 out of 302 targeted interventions with high-risk groups as part of surveillance activities.\textsuperscript{19} This collection offers a simple and lower cost method of monitoring trends in high-risk groups over time, but is subject to all the potential biases of facility-based sampling.\textsuperscript{17,20} Surveillance through antenatal clinic sites can be a good late marker of trends once HIV enters the general population. However, for understanding drivers of an early stage epidemic, programme planning and measurement of programme effectiveness, mapping and size estimation of high-risk groups, periodic assessment of risk behaviours, and biomarker data are crucial.\textsuperscript{14,18–21} With some exceptions, such data are sparse in India. There are few systematic processes of data collection in these areas; public-health research output in India is low in general.\textsuperscript{22}

Grouping Indian states by data availability, epidemic stage, and response

For the purposes of this review, we categorised Indian states into four groups that broadly reflect differences in (1) extent and availability of data, (2) severity of the epidemic and its drivers, based on available data, and (3) status and comprehensiveness of response (table 1).

With a total population of 292 million, the states of Maharashtra, Karnataka, Andhra Pradesh, and Tamil Nadu (Group I) account for nearly 3.5 million HIV infections.\textsuperscript{16} Transmission is largely heterosexual.\textsuperscript{1} As a consequence of years of sustained large-scale prevention efforts, there are fairly comprehensive mapping and size estimations of some high-risk groups and some behavioural, biological, and facility-based studies.

Manipur, Nagaland, and Mizoram (Group II) have a combined population of 5.5 million and abut Burma, an important source of heroin.\textsuperscript{23} 50–75% of districts in Manipur and Nagaland report over 1% antenatal HIV prevalence, while Mizoram has shown consistent antenatal HIV prevalence of over 1% for 3 years in at least one district.\textsuperscript{22} Transmission in these states is primarily via injecting drug use, and there is reasonable to extensive mapping and size estimation data for some high-risk groups.\textsuperscript{2}

Delhi, Goa, Gujarat, Kerala, and West Bengal (Group III) form a loose grouping of states with a population of 187 million where on average, antenatal clinic sentinel surveillance covers 40–50% of districts, but no district shows over 1% prevalence consistently over 3 years.\textsuperscript{16} Transmission in these states appears to be heterosexual. There is also reasonable mapping and size estimation data for some high-risk groups, the comprehensiveness of the mapping varying across states, depending on the extent of programming.

The rest of India (Group IV), consisting of states adjoining those in the first, second, and third categories, has a combined population of 576 million.\textsuperscript{2} Typically, this group of states has antenatal clinic surveillance data in about 25% of the districts (with one or two exceptions), but no district covered under sentinel surveillance shows over 1% antenatal HIV prevalence consistently over 3 years.\textsuperscript{2} Transmission in these states is most likely heterosexual, although mapping of high-risk groups is probably not comprehensive, as evidenced from the limited extent of HIV programming.
Drivers of India’s subepidemics

In this section, we focus on what is known about (1) high-risk group presence, reported condom use, and HIV prevalence, (2) bridge and general population sexual networks, and (3) migration and mobility of both high-risk and bridge populations. The data reviewed came primarily from Group I, II, and to a lesser extent Group III states, since the states in Group IV are less studied and documented. The limited data indicates that India’s epidemics seem to be largely driven and maintained

<table>
<thead>
<tr>
<th>Selected characteristics</th>
<th>HIV prevalence</th>
<th>Current HIV sentinel surveillance$^{10}$</th>
<th>High-risk group data</th>
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</thead>
<tbody>
<tr>
<td><strong>Group I</strong></td>
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<tr>
<td>Four high prevalence</td>
<td>Population$^1$: 292 million</td>
<td>Regionally $&gt;1%$ median ANC HIV prevalence</td>
<td>Reasonable to high quality mapping and size estimation of FSWS, MSMs, IDUs</td>
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<tr>
<td>states in south and west</td>
<td>Predominant HIV risk behaviour$^2$: sexual</td>
<td>At least 25% districts with &gt;1% ANC HIV prevalence over 3 years$^3$</td>
<td>Some behavioural and STI/STIs HIV prevalence survey data$^{11,12}$</td>
</tr>
<tr>
<td>(Andhra Pradesh,</td>
<td>Number of estimated high-risk group</td>
<td>ANC HIV surveillance in some districts for over 7 years</td>
<td>Some facility-based studies$^{13,14}$</td>
</tr>
<tr>
<td>Karnataka, Maharashtra,</td>
<td>FSW: 338,000 (Avahan programme data), FSW as proportion of female urban population: 1.27%</td>
<td>ANC HIV surveillance in all districts for past 2 years</td>
<td></td>
</tr>
<tr>
<td>Tamil Nadu)</td>
<td>150,421–194,594 (NACO)$^{15}$ size estimation, coverage, FSWS as proportion of female urban population: 0.56–0.73%</td>
<td>Overall 25–40% of districts have HIV sentinel surveillance among STD patients in district STD clinics.</td>
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<td></td>
<td>869,000 (estimate)$^{16}$</td>
<td>By state, 5–25% of districts have facility-based sentinel surveillance for high-risk groups—FSW, IDU, and MSM</td>
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<td></td>
<td>MSM: 115,000 (Avahan programme data)$^{17}$</td>
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<td>37,548–58,196 (NACO)$^{18}$</td>
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<td>IDU: 8760 to 9938 (NACO)$^{19}$</td>
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<td></td>
<td>Prevention programming history$^{20}$</td>
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<td></td>
<td>From 7 to 12 years of FSW and high-risk male prevention programming</td>
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<td></td>
<td>IDU and MSM prevention programming more recent and limited</td>
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<td><strong>Group II</strong></td>
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<tr>
<td>Three northeast states</td>
<td>Population$^1$: 5.7 million</td>
<td>Regionally $&gt;1%$ median ANC HIV prevalence</td>
<td>Good quality mapping and size estimation of IDUs/sex workers</td>
</tr>
<tr>
<td>(Nagaland, Manipur,</td>
<td>Predominant HIV risk behaviour: IDU</td>
<td>(except Mizoram)$^{21}$</td>
<td>Some facility and population-based studies$^{11,12}$</td>
</tr>
<tr>
<td>Mizoram)</td>
<td>Number of estimated high-risk group</td>
<td>At least 25% districts with &gt;1% ANC HIV prevalence</td>
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<td></td>
<td>FSW: 793,898 (NACO)$^{22}$, FSWS as proportion of female adult urban population: 1.28%</td>
<td>(except Mizoram)$^{21}$</td>
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<tr>
<td></td>
<td>MSM: 1058–2700 (NACO)$^{23}$</td>
<td>FSW: 4–297$^{24,25,26}$</td>
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<td></td>
<td>IDU: 54,000 (Avahan program data, excludes Mizoram)</td>
<td>MSM: 15–65$^{26}$</td>
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<tr>
<td></td>
<td>45,926–53,552 (NACO)$^{19}$, IDUs as proportion of adult population: 1.9–2.7%</td>
<td>IDUs: 0.4–33.6$^{26}$</td>
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<td></td>
<td>Prevention programming history$^{20}$</td>
<td>STD: 3.5–15.6$^{26}$</td>
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<td>Over 8 years of IDU prevention programming</td>
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<td>Sex worker and MSM prevention programming more recent and limited</td>
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<td><strong>Group III</strong></td>
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<tr>
<td>A loose grouping of</td>
<td>Population$^1$: 187 million</td>
<td>Regionally $&lt;1%$ median ANC HIV prevalence</td>
<td>Reasonable to good quality mapping and size estimation of sex workers</td>
</tr>
<tr>
<td>states (Kerala, Goan,</td>
<td>Predominant HIV risk behaviour: largely sexual (presumed)</td>
<td>$&lt;1%$ consistently over 3 years$^{27}$</td>
<td>Some behaviour/prevalence data$^{28,29}$</td>
</tr>
<tr>
<td>Goa, West Bengal,</td>
<td>Number of estimated high-risk group</td>
<td>FSW: 0.5–434$^{30,31}$</td>
<td>Few facility-based studies$^{11,12}$</td>
</tr>
<tr>
<td>Pondicherry, Delhi)</td>
<td>FSW: 413,000–500,000 (estimate)$^{24}$</td>
<td>MSM: 0.5–39.6$^{26}$</td>
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<td></td>
<td>104,217–125,907 (NACO)$^{32}$</td>
<td>IDU: 0.8–22.8$^{26}$</td>
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<td>size estimation, coverage, FSWS as proportion of female urban population: 0.60–0.73%</td>
<td>STD: 0.0–16.5$^{26}$</td>
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<td>26,166–76,074 (NACO)$^{26}$</td>
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<td>IDU: 15,364–24,787 (NACO)$^{19}$</td>
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<td>Prevention programming history$^{20}$</td>
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<td>From 7 to 12 years of FSW and high-risk male prevention programming</td>
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<td>IDU and MSM prevention programming more recent and limited</td>
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<td><strong>Group IV</strong></td>
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<tr>
<td>Rest of India (north,</td>
<td>Population$^1$: 5.7 million</td>
<td>As in Group III</td>
<td>Limited availability of mapping and size estimation data</td>
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<tr>
<td>central, parts of the</td>
<td>Predominant HIV risk behaviour: largely sexual (presumed)</td>
<td></td>
<td>Little or no behavioural/biological survey data$^{33,34}$</td>
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<tr>
<td>northeast)</td>
<td>Number of estimated high-risk group</td>
<td></td>
<td>Few facility-based studies$^{11,12}$</td>
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<td></td>
<td>FSW: 307,000–1000,000 (estimate)</td>
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<td></td>
<td>29,422–85,376 (NACO)$^{35}$, limited size estimation exercises, coverage numbers, FSWS as proportion of female urban population: 0.09–0.27%</td>
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<td>MSM: 2655–12,53 (NACO)$^{35}$</td>
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<td></td>
<td>IDU: 8260–35,958 (NACO)$^{35}$</td>
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<td></td>
<td>Prevention programming history$^{20}$</td>
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<td></td>
<td>7 to 12 years of limited high-risk group prevention programming</td>
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</tbody>
</table>

ANC = antenatal clinic, FSW = female sex worker, IDU = injecting drug user, MSM = men who have sex with men, STD = sexually transmitted disease, TG = transgender. “Avahan is working in six states: Tamil Nadu, Andhra Pradesh, Karnataka, Maharashtra, Nagaland, and Manipur. In these states Avahan has invested in mapping and size estimation exercises in uncovered districts or parts of districts to gain a comprehensive denominator of high-risk groups for programming purposes. In Tamil Nadu, Andhra Pradesh, Karnataka, and Maharashtra mapping and size estimation exercises were done for FSW and MSM populations. In Nagaland and Manipur they were done for IDUs alone. Where size estimation or coverage data is cited as “Avahan programme” this refers to all data available in states on estimated size and coverage of interventions from both Avahan and state AIDS control societies of NACO.

Table 1: Summary of selected characteristics, HIV prevalence, surveillance populations and surveillance coverage, data availability, and prevention programme history by groups of states.
through contact between high-risk subpopulations and bridge populations with onward transmission to spouses/girlfriends but without further spread—a so-called truncated epidemic. There may be some exceptions in coastal Andhra Pradesh, southern Maharashtra, and northern Karnataka, where local networks might sustain ongoing transmission. Consequently, this discussion focuses on high-risk populations and key bridge populations, mainly clients of sex workers.

**High-risk group presence and transmission risk**

**Female sex workers**

Non-governmental organisations and social research organisations have done mapping and size estimation for female sex workers in urban areas in the Group I and II states and for most states in Group III over the past few years. Mapping and size estimation in Group IV states remain limited to large cities. A simple comparison of estimated female sex worker population per urban adult female population suggests female sex worker numbers in Group IV states have been substantially underestimated (eg, 0.56–0.73% in Group I states compared with 0.09–0.27% in Group IV states; table 1).

Transmission risk varies considerably by typology of sex work in the Group I states, both in the number of commercial transactions per day and, to some extent, by social norms regarding condom use. According to data from the Avahan programme, only about 5–10% of sex work solicitation in the southern states occurs in brothel settings (figure 2), compared with 55–65% street-based and 20–30% home-based solicitation. In certain cities other typologies of sex work have been documented, including bar-based and cell phone-based, although the relative numbers of partners and risk behaviour in these types is not well described. Typologies of female sex workers are fluid, in response to economic and other environmental pressures. This dynamic situation complicates HIV prevention responses.

HIV prevalence in female sex workers varies widely across Group I states. In studies where reported condom use is high, HIV prevalence is relatively low in female sex workers. The comparatively low 9.5% HIV prevalence in population-based samples of female sex workers in Tamil Nadu correlates with high rates (80–90%) of self-reported condom use. In the other three Group I states, HIV prevalence in female sex workers ranging between 4% and 49% have been documented. Recent reports of higher HIV prevalence in young female sex workers in long standing prevention programmes suggest that prevention programmes need to address new entrants into the trade. STD prevalence rates in female sex workers are variable but high. For example, reactive syphilis serology has been documented to range between 4% and 31%. 

**Men who have sex with men**

Quantifying male-male sexual activity in India requires in-depth understanding of a complex tapestry of self-categorisation (kothis: mainly anal receptive; doubledecker: both anal insertive and receptive; panthi: anal insertive; and transgenders) related to sexual behaviour and varying levels of risk. Size estimation and HIV prevalence data for men who have sex with men are difficult to interpret, since eligibility criteria for inclusion are not always clear. Male to male sexual activity seems common in both urban and rural India. One population-based study of five rural districts found that 10% of single men and 3% of married men reported anal sex with a man in the previous year. State-wide mapping exercises from urban areas of Tamil Nadu, Andhra Pradesh, and Karnataka in 2003–04 estimate the population of male sex workers, including transgenders, to be as high as 25% of the female sex worker population.

Limited reports suggest that men who have sex with men, particularly transgender men and male sex workers, have high HIV and STD prevalence levels and are at substantial risk for acquiring HIV. These data are consistent with findings elsewhere in Asia. In India, large proportions of men who have sex with men have regular female sex partners, comprising an important bridge group. A large study of men who have sex with men in Andhra Pradesh found that 51% reported sex with a woman in the past 3 months; reported condom use was 44% and 16%, respectively with last male and female partner. Much more needs to be understood regarding men who have sex with men typologies, sexual networks, and risk behaviours to determine their role in the epidemic and develop effective prevention responses.

**Injecting drug users**

Injection drug use is a major driver of the epidemic in the northeast states. Recent size estimation data show that injecting drug users could constitute 1.9–2.7% of the adult population in Manipur and Nagaland (table 1). In addition to the known risks of HIV transmission...
through sharing injection equipment, sexual transmission is also important. In a sample of injecting drug users in the northeast, 75% were HIV positive, most were under the age of 19 years, two-thirds were sexually active, and 3% reported using condoms. The risk of HIV transmission to sexual partners and wives of injecting drug users has been documented across India.13,62,63

Monitoring the intersection and overlap of injecting drug user and sex worker networks is important for programming responses and tracking spread to the general population.64,65 Mapping exercises of the three northeast states show substantial numbers of female sex workers in urban/valley areas where injecting drug users are also in higher numbers.66 Data from one voluntary counselling testing centre suggests increasing HIV prevalence in female sex workers in Manipur.67 Although population mobility between the northeast and the rest of India is limited, most goods travel to the northeast by road. Therefore, more understanding is needed of the sexual and injection networks between truckers, female sex workers, and injecting drug users in the northeast as a potential driver of epidemic spread to other parts of the country.68

Injecting drug users are also found in most of the major cities in India outside the northeast (table 1) and HIV prevalence rates ranging between 2% and 44% have been documented among them.69,70,71,72,73,74 Little is known about injecting drug user overlap with other risk groups in states outside the northeast. 80% of NACO-supported prevention interventions for injecting drug users are in Group II states.

Bridge populations, sexual partnerships, and mixing
The key bridge populations in India are clients of sex workers but also include men who have both male and female partners, and regular partners of sex workers. Compared with information on female sex workers, few studies exist to quantify these men or to understand their patterns of risk behaviour. Behavioural surveys from Tamil Nadu and Karnataka suggest 11–18% of rural men, 10% of factory workers and men in urban slums, and 2% of rural workers report commercial sex partners.75,76,77 A national sample of male clients of female sex workers found that 3% had sex with a male partner in the previous year.78 Studies also indicate that about 50–70% of clients of female sex workers are either married or have a regular female partner.79,80,81,82

Non-regular partnership (including commercial sex partners) in the general population was reported by 11% of men and 2% of women overall in the 15–49 year age group in a nationally representative behavioural survey.83 However, substantial regional differences exist. In Andhra Pradesh and Maharashtra, 15–19% of men and 7% of women reported having non-regular partners in the past year compared with 4–5% of men and 0.5–1% of women in Orissa, Rajasthan, and West Bengal.84 More in-depth study of partnership patterns in India is needed, particularly of partner concurrency in the context of heightened infectivity during acute stages of HIV infection and the effect on spread in the general population.85–87 Truckers are another important bridge population recognised early in India.

Mobility and migration
Data from the region and in Africa suggest mobility and migration separates people from their social support structures, creating a social milieu in which they are more likely to engage in risky behaviour, in turn leading to their having a key role in spreading the HIV epidemic in other areas.88–91 Large scale population mobility occurs in India, primarily in the form of male migrant labour. Although interstate migration reflects only 15% of all migrants, the absolute magnitude of interstate migration is still large.92

Mumbai (formerly Bombay), a key destination for single male migrants, assumes special importance for the spread of HIV in India. The percentage contribution of migration to the population growth of Mumbai between 1951 and 2001 has averaged 50%, with migrant men coming from as far as Uttar Pradesh, Bihar, and southern Tamil Nadu.93 A 1999–2000 study estimated net inter-state out-migration to be 3.9 million people from Bihar and Uttar Pradesh combined, with Mumbai as the single largest destination. HIV prevalence rates of 40% or more have been documented in the female sex worker population in Mumbai for over a decade; other studies point to Mumbai as the source of HIV for returning migrants to Nepal.94–96

Truckers are a special case of mobile men with a well-defined mobility pattern due to their organisation by
specific routes. There are about 3 million trucks, often with both a driver and younger male helper, plying the roads in India (figure 3). Approximately 40–50% of truckers work on long distance routes, staying away from home for a month or more. Surveys in truckers indicate that they are more likely to be clients of female sex workers than men in the general population, with 24–34% reporting commercial sex in the previous year. Estimates of HIV prevalence in truckers range from 4% to 11%. Some studies suggest that male to male sexual activity between truck drivers and helpers also occurs.

There are limited formal studies of the patterns of sex worker mobility and migration. However, programme experience suggests female sex workers are highly mobile within and between districts and states. Drivers of female sex worker mobility include both a historical reputation for sex work in women in certain source districts and their consequent demand elsewhere (eg, from certain coastal districts in Andhra Pradesh to Mumbai and Goa), and more recently, poverty and economic opportunity (eg, from northern Karnataka to southern Maharashtra or from West Bengal to Mumbai).

The magnitude and general patterns of mobility and migration in India indicate potential for HIV spread, particularly in the north and central states. However, without coincident presence of local high-risk sexual networks in the source communities, returning migrants might not be sufficient to spark locally self-sustaining HIV transmission. This situation underscores the need for detailed mapping and understanding of risk behaviours of high-risk and bridge groups in these states.

Current national response to the epidemic

Table 2 provides a snapshot of select data related to HIV/AIDS programming in India. In 1992, the first Indian National AIDS Control Project (NACP-I) was launched under World Bank funding. The project succeeded in establishing state AIDS control cells in all states and union territories but, due to substantial variations in state capacity and commitment, the resources were spent disproportionately by a few states—eg, Tamil Nadu, Maharashtra, and West Bengal. Over the next few years, more state and national level programmes were launched under funding from other major donors. NACP-2 was launched in 1999. Tamil Nadu and West Bengal have shown clear, early success, although the record is less clear for other states.

The estimated total amount spent on HIV/AIDS in India in 2004 was US$79 million (including Avahan funds) or about $0.15 per capita of the adult population. This spending compares with an estimated $1.74 per capita for Thailand or $0.28 per capita for China during the same period, but must be seen against the backdrop...
of overall low general government expenditure on health in India of $7 per capita.\(^{142-144}\) This allocation was not uniform across the state categories and more importantly, use of funds as evidenced from expenditure versus allocation of funds under NACP-2 is distinctly variable across different regions—from 51% to over 90% (figure 4).\(^{139,140}\)

**Status of existing HIV prevention programmes**

Under NACP-2, the Indian government has been supporting interventions that focus on high-risk groups appropriate to the epidemiology of HIV in India. The package, called targeted interventions, has five basic elements shown globally to be effective: behaviour change communication/peer education, STD treatment, condom promotion/provision, enabling environment, and community mobilisation (figure 5).\(^{145,146}\)

In August 2005 there were 965 targeted interventions covering female sex workers, men who have sex with men (including transgenders), and injecting drug users as well as migrant workers in slums, street children, prisoners, truckers, and mixtures of the target groups in all but two states.\(^6\) Of these, only 31% focused on female sex workers, men who have sex with men, or injecting drug users. Independent assessments of these programmes done in 2002 and 2003 identified some shortcomings.\(^{24,34}\) These shortcomings included rigidity of financing mechanisms and flow of funding that limited flexibility on the ground, resulting in under-use of funds in some regions, lack of a coordinated state-level strategy, limited focus on coverage, and diffused programming with substantial interventions in non-priority groups. With respect to targeted interventions, the reports identified the current primary focus on behaviour change communication and free condom distribution with limited options for quality STD treatment, especially for women, as areas for improvement. In particular, the reports noted a need to mount structural interventions that could substantially change environmental factors increasing risk (eg, violence faced by sex workers) to organically foster a strong community-led response.\(^6\) The reports also suggested that there was inadequate focus on male clients, and limited evaluation of effectiveness.

Large-scale programmes covering high-risk groups in more than four or five districts per state are no more than 7 years old, even in some Group I states.\(^8\) In 2003, at the inception of the Avahan programme, coverage of female sex workers by current programmes was 12% in Karnataka and 40% in Andhra Pradesh.\(^4\) Even a state as mature as Tamil Nadu had about 40% coverage, with low coverage in its western districts despite large numbers of high-risk group members. Programming for men who have sex with men was also limited—31 of 965 targeted interventions in August 2005 were for such individuals.\(^6\) Given that mapping and size estimation data is not comprehensive for many of the states in the rest of India, it is difficult to make estimates of coverage in those states but it is likely to be much lower than the high prevalence states in Groups I and II where most interventions have been mounted.

Finally, sales of socially marketed condoms, which can help corroborate the impact of HIV interventions, has grown slowly at an annual rate of 6% between 1999 and 2004 (figure 6).\(^{111,112}\) This is in the context of an already low use of condoms as a family planning method.\(^7\)

**Status of current care and treatment programming**

Against a background of an estimated 5-2 million HIV infections in 2005, between 600 000 to 700 000 people were projected to have AIDS in India.\(^{29,144}\) Officially, 17716 AIDS cases were reported to NACO at the end of 2005.\(^145\) NACO had supported a limited number of testing centres since 1997 but began scaling up substantially from 2002. By the end of 2005, over 1100 were operational.\(^138\) These testing centres served over 970 000 clients in 2005.\(^145\)
At the end of 2005 there were 52 NACO supported antiretroviral therapy centres providing care to 24 301 AIDS patients. An additional 10 333 patients received care through centres supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria through government hospitals, non-governmental organisations, intersectoral partners, and private hospitals. The initial establishment of antiretroviral therapy services focused on tertiary care centres and was not linked to on-going prevention efforts. Group I states with the greatest HIV burden have a disproportionately low number of centres (table 2). In addition to antiretroviral therapy service expansion, more support is planned for management of opportunistic infections, home-based and palliative care, and addressing children.

**Potential impact of the epidemic**

The epidemic in India is difficult to classify given its scale and geographic diversity. Moreover, given the limited sources of systematic data, it is difficult to assess either the big picture or local epidemic patterns accurately. Minimum data required to realistically estimate past and current HIV infections, AIDS cases and deaths, or to project epidemic trends, are typically not available in most places in India. A recent analysis of aggregated antenatal clinic data across sites suggests that HIV incidence in Group I states might be declining, as measured by trends in HIV prevalence in young women aged 15–24 years. However, the same study also shows that, when disaggregated by state, the possible pattern of declining incidence does not hold in at least two of the four states in the analysis, Andhra Pradesh and Karnataka. The hypothesis of declining incidence in these states needs much closer scrutiny given the limitations of the antenatal clinic data upon which the analysis is based, and the obscuring of local patterns resulting from aggregation of data over epidemiologically diverse areas. Ideally these data should be reanalysed in light of geographic variation and varied intervention responses. Such analyses could help to better explain the continuing high levels of HIV infection in female sex workers reported by some studies, and possible stabilisation where there have been long-standing interventions.

Studies suggest that even a low level epidemic in perhaps one-eighth of India’s 593 districts would have a disproportionate socioeconomic impact. About 80% of India’s health-care spending is private spending, and a single catastrophic illness puts a household into debt for perpetuity. The social fallout and the devastation to an already fragile public-health system would be huge, even if AIDS were to affect only a few sections of some states. Finally, because AIDS in India affects the poor disproportionately, there could be a major impact on the Millennium Development Goals. An Asian Development Bank/UNAIDS report estimates that AIDS could slow poverty reduction goals by 23% between 2003–15.

Ultimately the most obvious impact will be on mortality. WHO estimated that in 2002 AIDS accounted for 3% of all deaths and 9% of all infectious disease deaths in India. AIDS is projected to account for 17% of all deaths and 40% of all infectious disease deaths by 2033, making it the largest killer among infectious diseases in India. The incidence of tuberculosis in India, the source of 20% of all new tuberculosis cases globally, is projected to increase by 12% between 1990 and 2015 as a result of HIV.

**Ensuring an effective national response**

Implementing an effective response to HIV in India presents extraordinarily complex challenges, due to the country’s scale; the diversity, size, and mobility of the populations at risk; and the highly stigmatised nature of HIV. To mount a response capable of bringing HIV under control, India must address high-priority gaps in national HIV efforts, by (1) increasing prevention coverage of high-risk populations; (2) enhancing access and uptake of care and treatment services linked to these prevention services, (3) ensuring commitment to evidence-based HIV programming and investing in strategic knowledge building, and (4) building technical and managerial capacity.

In mid-2005, NACO and an advisory committee embarked on a nationwide, participative process to develop the NACP-3 strategy and implementation plan. NACP-3 implementation is scheduled to begin in 2006 and will continue to place appropriate and substantial resources into prevention through focused programmes for high-risk and bridge groups, as well as decentralising and expanding infrastructure for care and support. The strategic collection, synthesis, and use of data to inform programme planning, and the need for state level capacity building have also gained increased attention in the design of NACP-3. India’s challenge is to ensure that this programme is rapidly brought to scale and implemented with quality, which will require strategic knowledge building, scalable approaches to prevention, and resources for capacity building.

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*Figure 6: Socially marketed condom sales for all India, 2001-05*
Strategic knowledge building
Given India’s scale, and the diversity and mobility of the populations at risk, combining prioritised data collection with active programme management is critical for staging an effective response to the evolving HIV epidemic.80 Knowledge building and data gathering efforts will need to be tailored to the epidemic and programme needs on a state or regional level. The concentrated and truncated nature of the epidemic, in most areas of the country, suggests sentinel surveillance of high-risk groups—eg, female sex workers, men who have sex with men, and injecting drug users—might be more informative about the epidemic’s progress and programme effectiveness than reliance primarily on antenatal clinic data.81 Such surveillance ultimately requires comprehensive mapping and size estimation of populations of female sex workers, men who have sex with men, and injecting drug users, at least in urban centres across India and in particular in the northern and central states, although for areas with little experience or data, rapid assessments followed by interventions would be a first step.82

Beyond better mapping, size estimation, and surveillance, research is needed to understand the profile of recent infections in different regions and the social contexts and patterns of sexual networking between female sex workers, injecting drug users, men who have sex with men, and male clients. This research will provide insight into transmission dynamics and the proximate determinants of infection that can be addressed through prevention programmes.83 The ability to profile and segment high-risk groups by degree of risk and focusing efforts on its most vulnerable members will enhance the effectiveness of programmes with limited resources.

Scalable approaches to prevention with high-risk groups
Saturated coverage of high-risk groups with focused prevention programmes remains a key strategy for the Group I and II states and must now be comprehensively implemented in the rest of India. Given the sheer size and scale of India, it is essential to supplement the one-to-one service delivery approaches that characterise current models of targeted interventions with more efficient, scalable methods. Such methods should include (1) leveraging existing social networks and community structures for reaching large numbers of individuals, (2) reducing vulnerability of marginalised groups by addressing structural barriers, and (3) catalysing changes in social norms and environmental conditions.84-87

Explicit attention should be paid towards facilitating the use of peers to access communities, and to fostering community identity and cohesion in marginalised groups to help create social norm change around safe behaviour and self-efficacy in collectively handling barriers related to power structures. Enabling marginalised groups to access existing government health services and schemes such as ration cards and micro loans, appropriate sensitisation and training of health-care personnel, and advocacy leading to legal and policy changes can reduce vulnerability, raise self-efficacy, address sex inequities, and also extend prevention programme resources.88 High-level advocacy with police, media, and celebrity advocates to create a prevention-friendly environment and address HIV and sexual health-related stigmatisation is essential.89 Finally, aggressive condom promotion campaigns to normalise condom use to supplement social marketing and targeting to high-risk groups should be an essential part of the intervention package in every state.

Prevention programmes gain effectiveness and sustainability when implemented in the context of a strong public-health system and linkages to other programmes. Government services for STDs and basic HIV care require more resources for training and sensitisation of personnel to meet the needs of female sex workers, men who have sex with men, injecting drug users, and people living with HIV/AIDS. In certain settings, providing specialised STD and HIV testing services customised to meet the specific needs of communities may be warranted. In a context of limited, affordable antiretroviral treatment, improving access and ensuring marginalised groups are not discriminated against becomes critical. Ensuring HIV and tuberculosis programming receives attention from broad efforts to strengthen and integrate public sector health services—eg, the National Rural Health Mission in India and the Revised National TB Programme—requires strong national leadership.90,97,176
Human capacity building
Management and technical capacity within government and the non-governmental organisation sector to implement effective programmes remains an area that requires renewed focus for India to execute the scaled effort required to contain the country’s epidemic. Enhanced management skills are required to prioritise action, optimise service delivery mechanisms, and to use data to monitor achievements towards set objectives. Limited technical expertise in general, and in data analysis in particular, especially at state and local levels, restricts the country’s ability to adjust programming and anticipate emerging areas of need. Building these capabilities will entail flexible recruitment, a network approach to training and on-site support, and tapping resources outside the government sector.

Looking ahead
India’s national political leadership has made a strong commitment to a robust HIV/AIDS response. The process for developing NACP-3 has been transparent and collaborative, and the strategy appropriately puts prevention programmes for high-risk populations at the forefront. There are, however, substantial hurdles ahead for India if it is to mount a truly effective response. Rallying political will at the state and district level to address the challenges, especially in the northern states, remains one of the biggest obstacles to a nationwide response. Ensuring adequate resources and efficient use and flow of funds is critical. Technical and especially management capabilities and systems must be enhanced at all levels. As India’s epidemic matures there will be increasing demands on HIV/AIDS money to address the widening needs from prevention to care to treatment. India must keep the focus on the unfinished HIV prevention agenda in the country. 177,178

Conflicts of interest
We declare that we have no conflicts of interest.

Acknowledgments
We thank the National AIDS Control Organization of India for providing data on antenatal clinic, STD, and high-risk group sentinel surveillance, HIV infections, targeted interventions, voluntary counselling and testing and antiretroviral programmes, and funding sources and use for the year 2005. We also thank various individuals associated with implementation of HIV prevention programmes under funding from the Avalan—India AIDS Initiative program of the Bill & Melinda Gates Foundation for sharing data on mapping and size estimation of high-risk groups. The views expressed in this review are solely those of the authors and do not necessarily reflect the official views of the Government of India or the Bill & Melinda Gates Foundation.

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Introduction to Evidence-based Advocacy

**Background Notes**

An evidence-based approach to advocacy means using data to provide evidence about the nature of a problem and to make the case for a recommended policy action or solution.

When we think of data, we often think of quantitative data, such as HIV prevalence or percentage of sex workers who access STI services or who use condoms. Epidemiological and behavioral data are only two types of data that can be used for advocacy purposes.

Data: facts or information to be used as a basis for discussing, reasoning, or deciding something (The Oxford Dictionary)

To be an effective advocate, it is essential to understand and accurately represent the dynamics and impact of the HIV/AIDS epidemic and the needs, priorities, and interests of their constituencies. Many different types of data help us to do this:

**Good quality epidemiological and behavioral data** interpreted together can provide a coherent picture of the epidemic, and these data can be used to produce estimates of the current epidemic or its future course.
Any effective HIV/AIDS plan needs to be based on reliable information about:

- People infected and affected by HIV
- Conditions and behaviors that put people at risk of HIV infection
- Resources available for the response
- Current efforts to intervene with prevention, treatment, care and support
- The results of those efforts

This is, however, often not the case. There are challenges in India, as in many other countries, in ensuring that necessary data is available to inform decision making, but considerable efforts are going on to improve collection and analysis of data. Better data, well used, can and should be used to improve the effectiveness of efforts to respond to HIV/AIDS.

Mainstream society disapproves of, and sometimes harshly punishes, illicit drug use, sex between men, and sex work. This societal disapproval often means that IDUs, MSM and sex workers are ignored in surveillance systems, or inadequate data is collected, even though they are often at high risk of HIV infection.

So, sometimes advocacy efforts need to focus on ensuring that the right kind of data are collected regularly over time, analyzed and used to inform decision making: where the resources should be directed; what types of programs are required and what alterations to existing programs are needed to ensure they are effective in reducing HIV transmission.

Data is not just about numbers. **Qualitative data**, information that is descriptive, records peoples’ perceptions, attitudes and experiences -- such as case studies that document the experiences of communities affected by HIV/AIDS-- are also essential tools for advocacy.

Advocates need to know how current HIV/AIDS policies and programs affect individuals and communities, particularly the key populations with whom you work. Much of this work is already happening in your programs. For example, many of you will know that laws and the practices of police, pressure groups and gatekeepers impact on key populations' access to prevention, care and legal services.
Understanding what policies or programs key populations think are needed or what changes are needed to existing policies, practices and programs is essential.

**Example: Understanding the sexual health needs of men who have sex with men:** Naz Foundation (India) Trust recognized that MSM were not accessing STI clinics, and were advocating for specific services to meet their needs. However, as this work involved more members of the MSM communities, it became clearer that MSM specific services alone would not meet the needs of all MSM. Some MSM were concerned about being identified through accessing such services, and feared being stigmatized. Many men who have sex with men do not identify as MSM, and so they would be unlikely to access such services. So, advocacy efforts began to focus on both developing MSM-specific services as well as making mainstream STI services more accessible and appropriate for MSM. This included educating health care workers about sexuality and sexual health issues relevant to MSM, efforts to enable workers to reflect on their own values and attitudes to reduce discrimination against MSM, and to improve confidentiality policies and practices, so that MSM would have greater confidence in accessing such services. One approach used was to place counselors from Naz in mainstream services, both to build skills and capacities of health care workers and provide services for MSM as a transitional strategy.

As advocates you should consider your own information needs as well as the information needs of policy makers.

Advocates need to be strategic in the data they collect and in how they analyze and use data. What data will help you to persuade policy makers about the need for policy changes? What data will best strengthen communities’ and policymakers’ ability to design and implement better programs and policies?

Efforts to collect data with key populations should be part of a long-term relationship to ensure key populations are supported to understand and use data in their advocacy.

**Data are tools that can be used in a wide variety of ways as part of the advocacy process:**

- Assist in identifying the right advocacy issues to focus on
- Highlight the needs, experiences and concerns of key populations
- Provide evidence of the need for changes to policies and practices and persuade decision makers to a specific course of action
- Assist in understanding the perspectives of our target audiences for advocacy and therefore to craft our advocacy messages more effectively
- Show whether or not advocacy efforts are making a difference.

The more relevant, reliable and appropriate the data that advocates possess the more realistic, representative and credible their policy demands will be.
Data Sources

Understanding the HIV epidemic, its impact and the effectiveness of responses may require collecting different kinds of data. Some data may already be available and other data may need to be collected for the first time. If data are available, advocates can get access to it in order to do secondary data analyses. If data are not available, advocates may need to obtain the data, or do primary data collection.

Primary data are collected directly by individuals, organizations or government agencies through the use of a survey, focus group or interviews. The information collected through these methods is then compiled, entered into data bases, analyzed and used in reports and documents.

Secondary data are data that have already been collected and are available as a file, database or document for others to re-analyze or review. The Behavioral Surveillance Survey (BSS) and UNAIDS periodic reports are examples of secondary data that are available to advocates, policy makers and others to use. Organizations also often have data they may have collected that advocates can obtain and use for secondary data analysis.
Qualitative/Soft and Quantitative/Hard Data

Data can be collected by using qualitative or quantitative methods or a combination of both. Each kind of data must be collected using specific methods that are closely followed. Each method has its strengths and weaknesses; data are often most comprehensive when a combination of both methods have been used.

Qualitative data, or Soft data, are descriptive or narrative texts that describe behavior and institutions by conveying impressions, opinions, values, rituals, beliefs and emotions. They provide information on what people think, feel, and do in their own words. For example, what does the national AIDS program mean to people in the community, how did people feel when they had to undergo compulsory testing, what do sex workers feel when health care workers treat them rudely? What impact does this have on whether they use health services in future?

Qualitative data also describe processes and often answer questions about how or why something happened. For example, how do MSM in a rural community obtain information about their specific health needs and concerns? Qualitative data are collected through various ways including interviews, observations, or by using direct quotes or discussions.

- One of the advantages of qualitative data is that they offer detailed, rich, in-depth information.

- However, qualitative data are usually collected on a small number of individuals and therefore cannot be used to make generalizations about entire populations or large groups of people.

Quantitative data measure amount or degree. They tell us information in terms of numbers, such as the number of children under five who are orphans or otherwise vulnerable to HIV/AIDS in a certain region, or the average number of years of education of members of a support group. They also provide numeric estimates of what segment of a population would have a specific characteristic, for example, the percentage of PLWHA among the adult population aged 15-49.

- When large amounts of quantitative data are collected they can be used to make comparisons between groups to do more complex data analyses.

- However, one of the disadvantages of quantitative data is that important nuances can be missed. A survey, for example, can reveal the number or
percentage of those interviewed who have been tested for HIV but these figures do not indicate how people felt during the test and after they were tested, or the details of how and why certain people did or did not go for testing.

<table>
<thead>
<tr>
<th>Example of data</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users</td>
<td>quantitative/hard</td>
</tr>
<tr>
<td>Positive speaking: voices of women living with HIV/AIDS</td>
<td>qualitative/soft</td>
</tr>
<tr>
<td>Participatory site assessment report</td>
<td>Can be both qualitative and quantitative</td>
</tr>
<tr>
<td>Key indicators for Frontiers Prevention Program: Report on Baseline study in Andhra Pradesh</td>
<td>qualitative/soft</td>
</tr>
<tr>
<td>Case studies report derived from focus groups with MSM and their experiences in accessing sexual health services</td>
<td>qualitative/soft</td>
</tr>
</tbody>
</table>

Data Quality

For data to help advocates and policymakers understand a situation, and to be persuasive, the data needs to be of good quality. It is important to evaluate data that are collected and analyzed to assure that they are valid, reliable, and unbiased. Policies or programs that use data that are not reliable, not valid, are biased, or have important gaps are unlikely to improve HIV/AIDS prevention, care or support services and interventions.
**Reliability** - Refers to whether a measurement (or method for collecting data) gives the same result when repeated over time for the same situation.

For example, at a presentation of a country's recent maternal and child health survey data, network members were shown data of HIV infection in all children 18 months of age tested at the national pediatric hospital outpatient clinic: at baseline the percent of all children infected with HIV was 12%, at three months the percentage was 25% and at six months the percentage was 6%. Given the broad fluctuations in percent of children infected, the testing methodology is likely not being done correctly or reliably.

**Validity** - Refers to how well a measurement (or method for collecting data) actually reflects what you are hoping to understand.

For example, an advocacy group wants to focus on decreasing the number of new HIV infections among adolescent girls aged 15-21 whose boyfriends or husbands are using injection drugs. It locates a survey on adolescent girls' knowledge and attitudes about reproductive health. While the survey does focus on girl's reproductive health, it does not include information specific to HIV transmission. The general adolescent health survey would not be a valid measure of specific knowledge and attitudes about HIV and IDU risk behavior.

**Bias** - Refers to a systematic distortion in the measurement (or method for collecting data).

For example, an advocacy group wants to understand the HIV needs of MSM in their country. They have been able to access recent surveillance data for MSM. However, the surveillance was carried out only in the capital city. The information collected would be biased towards the experiences of men living in urban areas, and thus would not be representative of all MSM in the country.
## Data Quality Scenarios: Participant Worksheet

### Scenario #1:

An advocacy network decided to focus its advocacy efforts to decrease the number of new HIV infections that are occurring among adolescent girls 15-21 years of age whose boyfriends or husbands were using injection drugs. The network wanted to address this issue in its advocacy messages and strategy and needed more information about these adolescents to make sure their advocacy approach was appropriate. The network locates a survey on adolescent girls’ knowledge and attitudes about reproductive health and decided to use that survey to gather information they could use for their advocacy strategy.

**What is the data quality issue?**

### Scenario #2:

At a presentation of country’s recent maternal and child health survey data, network members were shown data of HIV infection in all children 18 months of age tested at the national pediatric hospital outpatient clinic: at baseline the percent of all children infected with HIV was 12%, at three months the percentage was 25% and at six months the percentage was 6%.

**What is the data quality issue?**

### Scenario #3:

An advocacy group wants to understand the HIV needs of MSM in their country. They have been able to access recent surveillance data for MSM. However, the surveillance was carried out only in the capital city, and thus might not be valid for the whole country. They thus decided to find out more about the behaviors of MSM in rural areas. To gather this information, the advocacy group had providers of STI services for men ask their male patients who consented to be interviewed about their sexual behaviors; the service providers found very few men who reported sexual relations with other men and thus the data collected seemed to indicate that there were few men engaged in sexual relations with other men in rural areas.

**What is the data quality issue?**
Examples: Policy Process Map and Specific Policy Process Example

Country X: Policy Process Map

1. Agenda Setting
   - President
   - Prime Minister
   - Ministers

2. Committee of Parliament

3. Entire Parliament
   - Not Approved

4. Back to ministry for implementation
   - Approved

President
Prime Minister
Ministers
Policy Formulation and Implementation: The process

What is a policy?

A policy is a plan of action of an organization or government which guides their decisions and actions towards achieving a strategic goal. Public policy is a course of action or inaction chosen by public authorities to address a problem and is expressed in the form of laws, regulations and decisions of the government. Public policies are usually distributive (which extend services/goods to people at shared costs e.g. education policy) or regulatory (which limit discretions of individuals and organizations in decision making and impose sanctions e.g. Foreign Contribution Regulation Act), in nature.

Common features of public policies are:

- The policy is made in the name of the "public"
- Policy is generally made or initiated by government
- Policy is interpreted and implemented by public and private actors
- Policy is what the government intends to do
- Policy is what the government chooses not to do

Different forms of policies:

- Official government policy (legislation, guidelines that govern how laws should be put into operation)
- Broad ideas and goals in political manifestos and pamphlets
- A company or organization's policy, e.g. equal opportunity policy

Public Policy Process

Not all policies of the government have to go through the same process. Policies that have a budgetary requirement above a certain level, or whose impact is beyond a single ministry or requires change in legislation go through the process of Cabinet and Parliament approval (e.g. Immoral Trafficking Prevention Act or ITPA). Other policies that have sole bearing on one department/ ministry and have budgetary implications that fall within the limit permitted for the department/ministry are usually approved by the concerned minister and implemented by the department/ ministry (e.g. Policy for mainstreaming HIV within the training programs of the Border Security Force, BSF)
The policy process can be segregated into three interlinked stages:

- policy formulation
- policy adoption and
- policy implementation

The section below analyses these steps in some detail:

1. **Policy formulation:**

   Policy formulation begins with the diagnosis of a problem and identification of issues followed by the actual drafting of the policy. It may include both policy reforms and new policies.

   1.1 **Diagnosis of issue/problem:** The process of policy change or policy formulation begins with a trigger which could include any one or more of the following:

      i. Public Interest Litigation;
      
      ii. News/media reports;
      
      iii. A new global development (e.g. Trade Related Intellectual Property Rights or TRIPS);
      
      iv. Lessons from an ongoing programme;
      
      v. Recommendation by the standing committee of Planning Commission;
      
      vi. UN or other global report;
      
      vii. New data from surveillance/projections/scenarios
      
      viii. Issues raised in Parliament/Legislative Assembly;
      
      ix. Research and analysis;
      
      x. Qualitative/quantitative studies

   1.2 **Identification of core issues:** This process involves asking the question- why is the reform/new policy needed? What problem does it aim to address? What is the end objective to be achieved?

   Policy data/information is collected from case studies, interviews or literature reviews. Consultations may also be organized to seek inputs from experts and other stakeholders (e.g. The formulation of legislation for HIV/AIDS).
1.3 Drafting: This includes a problem statement; goals and objectives of the policy; proposed actions to achieve those targets; constraints; resource needs. Policies are usually drafted by a team of experts belonging to the organization. Inputs/feedback may be sought through various groups.

Public/stakeholder participation in policy formulation is sought through:

i. Public notification through newspaper or websites (e.g. FCRA Bill was put on the official website of the Ministry of Health and Family Welfare to seek Inputs from all interested),

ii. National consultative seminars involving stakeholders (e.g. for a national AIDS policy)

iii. Online discussions and feedback (e.g. The proposed legislation for HIV/AIDS)

iv. Engagement of Think Tanks

2 Policy Adoption:

As explained policies that have limited/no budgetary and inter-ministerial implications are usually approved by the concerned Minister. All other policies undergo a journey that passes through the Cabinet, both Houses of Parliament, in some cases a Standing Committee, until finally approved by the President. Not all bills/policies are eventually approved.

2.1 Cabinet approval: Joint Secretary of the concerned ministry prepares a cabinet note which the Minister presents before the Cabinet. Cabinet is divided into sub-committees (e.g. Cabinet Committee on political affairs). Cabinet as well as cabinet sub-committees are headed by the Prime Minister. Not all policies need to be presented before the entire Cabinet.

After presentation, the Cabinet may take any of the following actions:

- Accept it fully or partially;
- Defer it to a more appropriate time in case of any sensitivities or other stakes;
Referring the Bill

Refer it to group of ministers (e.g. Disaster Management Bill). Group of ministers will deliberate and may request ministry to revise, drop or defer the proposal. Ministry will respond and then after review and alterations will present to the Cabinet again; Reject it in which case the ministry may revise and present it again with a strong case.

2.2 Presentation in Parliament: If it is a bill it will go to Parliament; if only a policy it need not go to the Parliament. Cabinet's approval of policy will be followed by an executive order issued by the concerned ministry.

Non-financial Bill (which does not have impact on the exchequer) can be presented in either House, but a financial bill is mandatorily presented first in the Lok Sabha.

The concerned house will debate the bill and may take any one of the following steps:

Approve it in which case it goes to the second house of Parliament;
Reject it, in which case it goes back to the ministry and if re-introduced, it has to go through all stages;
Request amendments;
Refer it to the Departmental Standing Committee.

2.3 Departmental Standing Committee consists of members of Lok Sabha and Rajya Sabha from all parties and is chaired by a Member of Parliament (MP) of the opposition party. Concerned Secretary makes presentations before the Standing Committee which deliberates on the subject, seeks clarifications and may take any one of the following actions:

Approve in toto;
Request ministry to reconsider/ or modify in light of observations. If there are minor changes, it comes to the house for voting. If there are major changes then the ministry has to again submit a note to the cabinet and go through the entire cycle again.
Reject it. If rejected, the ministry can still go back to the cabinet with a stronger case and/or modifications. If approved by the cabinet, it will not need to be referred to a standing committee but will be deliberated in the House.
Opportunities for community participation

Standing Committee can request ministry to also engage stakeholders in consultation and review of the proposed policy.

Pressure groups may lobby with the members of the Standing Committee, sharing their concerns and suggestions

2.4 Presentation in Parliament: After being passed in either the Lok Sabha or Rajya Sabha, the Bill/policy in question is presented in the other house. The steps for the process in the second house are the same as the first house.

2.5 Voting in Parliament: After deliberations on the modified proposal approved by both the houses and the Standing Committee, the Parliament members vote. Voting takes place on every single clause separately (E.g. FCRA Bill has 52 clauses, requiring a show of hands 52 times)

2.6 Presidential approval: After clearance by both houses, the government sends the bill/policy to the president. The President may:
   - Approve it
   - Send it to the Supreme Court for review, or
   - Send it back to government for revision

If revised then it has to go through the cabinet again and follow the entire cycle, receiving the President’s approval. In some cases the President may "pocket" a bill, meaning it may delay response.

2.7 Public Notification: After the President’s approval, the bill is notified in the official gazette of India. State bills are notified in the state gazette. It becomes operational from the date of notification. This becomes an Act and forms part of the statute.

3. Policy operationalization:

A policy is the intention of the legislature as to how the executive will work. Whether a national or a departmental policy, it cannot be enforced by itself. The process of operationalization involves the following:

- In the case of an act the concerned ministry has to make rules or subordinate legislation to operationalize it. The rules are vetted by the
Ministry of Law and Justice. Rules are placed before the Parliament at least for 30 days. MPs may suggest modification of rules.

- Executive orders are issued to break down the policy/act to specifics including strategy and action plan. Usually a steering committee draws short and long term plans as well as roles and responsibilities.

- Evaluation and impact assessment: Concerned ministry may conduct an evaluation or an impact assessment study. The recommendations may result in policy reform or revision.

Table above demonstrates opportunities for public engagement in policy process

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What can local leaders do to influence policies?

1. **Develop local level policies using discretionary powers:** it is often felt that policies are developed at state or national levels. However, leaders at the village, block, and district levels enjoy the right to develop local policies as long as these do not contradict state regulations. Success of such local policies may be brought to the attention of policy makers for a broad-based policy.

2. **Act as a pressure group using their constituency:** local leaders have the duty to bring the concerns of their constituency to policy making forums. At the same time, they have the capacity to generate local discussions around priority concerns so as to activate the constituency around a subject, contributing not only to preference assertion but also preference formation on a topic.

3. **Be a vocal activist in the party discussion forums:** If committed to a certain issue, local leaders may raise this within party cadres, sensitize members and mobilize support to generate policy action.
The first two steps in any advocacy campaign are selecting the advocacy issue and developing the goal and objective. These pieces of the advocacy process make up some of the most challenging, analytic work facing a country or group of people. Completing these steps requires an ability to analyze complex environments and inter-related problems, discern a policy solution for a selected problem, envision a long-term result, and articulate a short-term objective. The quality of the network’s efforts will have an important bearing on the success of the steps that follow. These elements provide the foundation for an effective advocacy campaign. Without a clear, articulated issue and well-defined goal and objective, the remaining steps of the campaign will lose focus.

An advocacy issue is the problem or situation that an advocacy group seeks to rectify. Some global advocacy issues that have attracted international attention are the use of antipersonnel landmines; universal, safe working conditions; and widespread sexual exploitation of women and girls. In this unit, participants will select an HIV issue that is widely felt by their constituency and begin to build an advocacy campaign around that issue.
In various settings, the terms goal and objective are used interchangeably. In some instances, an objective is broad and a goal is narrow; in others, the meanings are reversed. For the purpose of the advocacy workshop, an advocacy goal is the long-term result (3-5 years) that the network is seeking. Participants should envision how the policy environment will be changed as a result of their advocacy efforts. Will all PLWHA have access to ARVs? Will the government draft, approve, and implement a national HIV/AIDS policy using a transparent, participatory approach? These examples represent a long-term vision for policy change. A particular organization may not be capable of achieving its goal single-handedly, but the goal statement can orient an advocacy network over the long term.

**Advocacy Goal:**

The goal is what you hope to achieve over the next 3-5 years. The policy goal is your vision. It is also the subject of your advocacy efforts. Goals can be general.

An advocacy objective is a short-term target (1-2 years) that contributes toward achievement of the long-term goal. A sound objective is specific, measurable, realistic, and time-bound. Often, groups work on two or more objectives simultaneously in their efforts to achieve a single goal. It is important that an advocacy objective identify the specific policy body with the authority to fulfill the objective as well as the policy decision or action that is desired. Two examples of sound advocacy objectives follow: to secure a commitment from the Ministry of Health and Family Welfare (MOHFW) by a certain timeframe that it will provide quality services to PLWHA; and that the District AIDS Program Control Units (DAPCUS) will draft and submit a District HIV/AIDS Policy and Operational Plan for approval by a specific date, such as December 2007.

**Advocacy Objective:**

The objective is a smaller and realistic step towards the achievement of your goal. It is usually what you hope to achieve in the next 1-3 years. Advocacy objectives need to be:

- specific
- measurable
- action oriented
- realistic
- time-bound
A good advocacy issue is one that meets most of these criteria. Rank your three priority issues against the questions as high, medium, or low.

**HIGH = XXX**  **MEDIUM = XX**  **LOW = X**

<table>
<thead>
<tr>
<th>Issue 1:</th>
<th>Issue 2:</th>
<th>Issue 3:</th>
<th>Will advocating on this issue...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Have an impact on HIV prevention efforts?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Be supported by strong evidence, including data that will support your case for a more effective HIV response?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Promote awareness of and support for the rights of key populations?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. Be easily understood by key decision makers?</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>5. Build leadership in responding to HIV at the national, state or local level?</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>6. Be supported by your organization’s current skills and resources?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7. Have the support of other groups to enable joint action?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8. Offer a clear policy solution?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9. Be supported by clear and measurable steps within a specific timeframe?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10. Be supported by opportunities for policy change, in the current environment?</td>
</tr>
</tbody>
</table>
Advocacy objectives should include three parts:

- **What Change You Want**
  (In policy or support for an issue)

- **By Whom**
  (The person or institution)

- **By When**

Example:

“By X (2 years from now), a standing committee of X (name specific institution) on issue X (name specific advocacy issue) will be formed and function with joint representation of the government and the affected group.”
Identifying and Analyzing Target Audiences

Background Notes

To increase the chances of success, advocacy groups must identify and study all the individuals and groups that may support the group’s issue and goal as well as those that may oppose it. The advocacy campaign's target audiences must be determined for each advocacy objective to be achieved and include the primary target audience, persons and/or institutional bodies that themselves have decision-making authority as well as the secondary target audience, persons and/or institutional bodies that can influence the decision makers. Documenting information on these audiences helps the group target its advocacy activities, develop effective messages, and select appropriate channels of communication.

While the categories of people in the target audience are not identical in every setting, the HIV/AIDS policy target audience is likely to include political leaders, national and local government officials, private and public sector service providers, PLWHA groups, and groups representing other populations vulnerable to HIV (i.e. sex workers, MSM, IDUs) the media, religious and traditional leaders, NGOs, women's organizations, professional associations, and business and civic groups. In some places and for some issues, the range of audiences is even wider and may encompass groups that are unlikely ever to meet each other, such as foreign donors or traditional healers.
Once the audiences are identified, the group must determine the level of support or opposition to be expected from those in the primary and secondary target audiences. For many reasons-religious, cultural, and historical — HIV/AIDS related issues are often controversial. People on both sides of the issue feel strongly that their position is the right one; therefore, they are willing to devote considerable resources to supporting that position.

Whether opposition is mild or strong, advocacy groups should be prepared to address it in ways that are most beneficial to their own efforts. The best advice is to be as informed as possible about the opposition's specific issues and base of support and to preempt oppositional efforts with messages that anticipate and refute opponents' arguments.

On the other side of the coin, advocacy networks often dedicate themselves to broadening their base of support. The larger the number of persons or groups working to achieve the advocacy objective, the greater is the chance of success. Groups can create coalitions with other groups or formal networks, expand their own membership, create alliances with commercial or private sector entities, and/or generate public and community support to enlarge their support base.

Finally, advocacy groups cannot afford to forget the “undecided” or neutral parties. In some cases, the best investment of time and energy is to appeal to the neutral public. Public opinion can exert powerful pressure on decision makers. In other cases, the group may find policymakers and public officials who appear neutral but in fact hesitate to voice an opinion due to the controversial nature of the HIV/AIDS issue; they may support the advocacy efforts in private but prefer to appear neutral. The group may decide to direct its efforts to convincing these influential “neutrals” to join and publicly support the campaign.
Power Map for Audience Analysis
<table>
<thead>
<tr>
<th>PRIMARY AUDIENCE: The individuals and/or body with decision-making authority (re: advocacy objective)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of knowledge about the issue (Rank 1 - 5)</td>
</tr>
<tr>
<td>Low; 5 - high</td>
</tr>
<tr>
<td>Level of Previous Support Demonstrated</td>
</tr>
<tr>
<td>1 - low, 5 - high</td>
</tr>
<tr>
<td>Level of Previous Opposition Demonstrated</td>
</tr>
<tr>
<td>1 - low, 5 - high</td>
</tr>
<tr>
<td>Undecided or Position Unknown</td>
</tr>
<tr>
<td>Potential Benefits to Audience Related to the Issue</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>SECONDARY AUDIENCE: The individuals and/or body that can influence the primary audience</td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
Monitoring and Evaluating Advocacy

PowerPoint presentation on advocacy action plans is on the CD provided.

**Why is monitoring and evaluating advocacy important?**

Advocacy for policy change is an incremental process, often taking years to achieve impact of a substantive nature. Advocacy takes places in a dynamic and ever-changing environment, where external factors can affect whether or not you are able to achieve your goal. Given the long-term nature of advocacy work and the complex and dynamic environment in which it takes place, it is as important to be able to measure your progress as you work toward your goal. Tracking the impact of your efforts over time will contribute to a better focused programme and one which has measurable success.

Sharing the results of evaluation with communities, donors and others stakeholders creates a culture of continuous learning that can be motivating at every level.
Plan for monitoring and evaluation at the beginning

To monitor progress and evaluate the impact of advocacy you should start by defining the change you want to bring about and carefully plan the steps towards achieving that goal.

The goal is your vision, it is what you hope to achieve in the long term (3–5 years). Objectives are the smaller steps towards the achieving the goal (usually 1–2 years). Setting objectives that are SMART at the outset - Specific, Measurable, Action-orientated, Realistic and Time-bound makes monitoring and evaluation of advocacy possible.

An advocacy action plan defines these goals and objectives. Below are some considerations to make when making this plan:

- Who is the primary target audience for advocacy?
- Who are the decision makers that can bring about the policy solution?
- What activities need to be undertaken to achieve the specific objectives?
- Who will be responsible for these activities?
- What resources will be needed to undertake the activities?
- When will the activities be undertaken?
- What indicators will be used to measure progress, outcome and impact?
- What information will need to be documented or collected to measure whether you have fulfilled the indicators you have set?

The next two sections look in more detail at how to:

- develop indicators to monitor progress, outcome and evaluate impact and
- use different types of data or information to document or show the progress, outcomes and impact of your advocacy efforts.
Indicators for monitoring and evaluation

Indicators are predetermined milestones, “check in” points, used to monitor and evaluate your advocacy efforts. An advocacy action plan should include indicators that enable you to review progress, record outcomes and assess impact. Different kinds of indicators can be used to help you do this. Review the example table of different indicators, types of documentation and data for monitoring and evaluating advocacy in relation to advocacy with police outlined below before proceeding further.

Progress indicators

Progress indicators, sometimes called ‘process indicators’, measure the smaller incremental steps towards achieving specific objectives and ultimately your goal, as well as to help record, understand and explain what happened and why and when unexpected events occur.

In a dynamic environment over the long term, circumstances change and unplanned events occur that affect what you should do. For example, you may be on track to plan training for police, and then the senior officer is transferred and you need to develop a relationship with a different officer to move forward. In this way, advocacy action plans are not static documents, prepared at the outset and then forgotten, but help you to take into account these changes and adjust your approach. Understanding these challenges and changes provide important opportunities to learn about what works and does not work so that you can improve your advocacy efforts over time. Flexibility is often the key to successful advocacy.

Monitoring your progress along the way, also highlights smaller successes that contribute to achieving the goal show results that can be encouraging for advocates, communities and donors and that will assist in keeping them engaged in the long term work of advocacy. When developing progress indicators it is important to monitor your external progress as well as your own advocacy capacity (which could be seen as ‘internal progress’).

Examples: Progress indicators for monitoring external progress:

- obtained a face-to-face meeting with the head of the district police
- established an on-going working relationship with senior police
- secured police agreement to bring out a circular
While these achievements have not yet produced an outcome, it is likely that they have been hard-won. So it is important to know how to document these successes along the way, show how they contribute to achieving your goal and understand what contributed to achieving these successes.

**Example:** Progress indicators for monitoring progress in developing your own advocacy capacity:

- coalitions function effectively through regular, well chaired meetings, clear communication during meetings and agreed activities undertaken within agreed time frame
- expanded number of champions involved in contributing to addressing your advocacy issue.

The kind of documentation you could develop or collect to monitor whether you are meeting these two types of progress indicators are highlighted below.

**Outcome indicators**

Outcome indicators are concrete results that you want to generate as a result of your advocacy activities.

**Examples:**

- Police circular is developed and distributed to all police stations
- Police training is developed and conducted in collaboration with NGOs and key populations.

**Impact indicators**

Impact indicators are used to show what positive change there has been in the lives of the people you want to benefit from your advocacy efforts.

For example, if the goal is to protect the rights of sex workers and ensure their access to condoms and HIV prevention services. Specific objectives might be:

- that the Police issue a circular within twelve months to all units making clear that arrest of sex workers and HIV outreach workers for carrying condoms is not consistent with the Immoral Trafficking Prevention Act, and hampers effective HIV prevention efforts
that Police carry out in collaboration with sex workers and NGOs, police training to increase their understanding of HIV prevention and ensure compliance with the circular within eighteen months.

The impact you would want to be able to show is not just that the circular was produced or that the training was undertaken, but that the impact of the circular and the training was to reduce harassment and arrest of sex workers and outreach workers by the police.

**Data for monitoring and evaluation**

There are many different tools that you can use to record the incremental steps in moving towards your advocacy goal and to assess the impact of your advocacy efforts. But monitoring and evaluation does not need to lead to wasted effort and endless paper work!

Far too often, too much information is collected and much of it not used. Think carefully about what you want to collect or document, so that it is useful for monitoring your progress, outcomes and impact. See the examples of data and documentation that could be used to show whether each of the indicators set out in the example below were achieved.

Data for monitoring and evaluation can be quantitative or qualitative. Qualitative data include reports from focus groups, case studies and interviews, for example, with outreach staff and key populations. These can be used to document the problems you are seeking to address, as well as to measure the progress and impact of your advocacy efforts. Quantitative data can be collected through surveys, by collecting the number of media releases distributed, recording the numbers of people that attend events. However, it is important to remember that quantitative data often simply tracks outputs while qualitative data often reveals more about their effects. However, quantitative data can lead to asking the right questions to improve your advocacy efforts. For example, recording the numbers of police trained does not tell you anything about the effect of the training. But if the numbers attending are low, this should prompt you to ask why and think about how you can work with senior police to ensure better attendance at the training.

Monitoring media coverage of your advocacy issue, recording minutes of meetings, conducting interviews and surveys can all help to track your progress and outcomes. One to one interviews are particularly useful to develop deeper insight into both whether and how your advocacy efforts are
influencing decision makers and measuring the impact that your advocacy is having on peoples’ lives. For example, when your progress is slow or you are facing particular challenges, you might decide to interview political advisors or community leaders with whom you have developed a relationship and who understand the issues you are seeking to address, to identify different ways you could approach the problem or persuade the decision maker. Interviews with key populations and field workers about their experiences can be used to develop case studies, stories, and quotations about the impact of your advocacy efforts. This is essential to explore whether the outcomes you may have achieved along the way are producing real benefits in people’s lives.

**Evaluation report**

It is not easy to clearly show that the impact, such as reduced harassment and arrests of sex workers, is the direct result of your advocacy efforts. Advocacy is complex, long term, and there are often many players involved. Rather than trying to show that the impact was the result of your advocacy efforts, it is often more credible to show how your efforts have contributed to that impact. By monitoring progress and outcomes along the way, and documenting the impact that your advocacy efforts on the lives of the people you wanted to benefit, you should be in a strong position to determine what you have achieved.

The more your evaluation report tells the story about what happened during the course of your advocacy campaign, the more it will be useful for your own organisational learning, and for advocacy partners, communities and donors.

In preparing an evaluation report consider and answer the following questions:

- What did we set out to achieve: set out your goal, objectives, what policy change did you seek and why?
- What did we do and how did we go about it?
- What incremental successes did we achieve that moved us towards achieving your goal, how and why were these steps successful?
- What challenges did you face along the way? How did you respond? What worked and what did not? What would you do differently?
What positive changes have there been in the lives of the people we sought to benefit by our advocacy efforts?

How have our advocacy efforts contributed to these changes?

**Example: Indicators and documentation for monitoring and evaluating advocacy with police**

**Goal:** Protect the rights of sex workers and ensure their access to condoms and HIV prevention services.

**Advocacy Objective:**

That the Police:

- Issue a circular to all units of the force within twelve months making it clear that arrest of sex workers and HIV outreach workers for carrying condoms is not consistent with the Immoral Trafficking Prevention Act, and hampers effective HIV prevention efforts.

- Carry out in collaboration with sex workers and NGOs, police training to increase their understanding of HIV prevention and ensure compliance with the circular within eighteen months.
<table>
<thead>
<tr>
<th>Activities</th>
<th>Monitoring &amp; Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document the problem; gather data to show the problems</td>
<td>Problem clearly documented</td>
</tr>
<tr>
<td>Explore allies who have relationship with police &amp; could influence police</td>
<td>Allies identified and involved in advocacy efforts</td>
</tr>
<tr>
<td>Research senior police attitudes to the issues</td>
<td>Meetings obtained</td>
</tr>
<tr>
<td>Identify and contact key police personnel to arrange meeting(s) to seek</td>
<td></td>
</tr>
<tr>
<td>policy solution: circular &amp; training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expected Outcome                                                                      Impact Indicator</td>
</tr>
<tr>
<td></td>
<td>Increased number of champions working on issue</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities</td>
<td>Progress Indicators</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Prepare for meetings with the police to secure commitment to obtain circular for trainings</td>
<td>Advocates well prepared for meetings (assess capacity)</td>
</tr>
<tr>
<td>Contribute to development of circular and training including involving sex workers in developing an implementation of training</td>
<td>Sex workers involved in circular and training development</td>
</tr>
<tr>
<td>Use documentation to review progress and amend plan</td>
<td>Plan monitored and plans adjusted (assess capacity)</td>
</tr>
<tr>
<td>Evaluate advocacy impact</td>
<td>Evaluation report prepared</td>
</tr>
</tbody>
</table>
## Advocacy Action Plan

### Advocacy Objective:

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Activities</th>
<th>Person Responsible</th>
<th>Resources Needed</th>
<th>Time-frame</th>
<th>Monitoring &amp; Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Expected Outcome, Indicator, Documentation</td>
</tr>
</tbody>
</table>
Advocacy Communication: Messages and Methods

Background Notes

In today's society, we are bombarded by messages every day. The intent of the message may be to sell us a product, inform or educate us in some way, or change our opinion about an issue. An advocacy communication strategy follows many of the same principles as an advertising or social marketing campaign. It is essential to know your audience thoroughly and to deliver a concise, consistent message that is tailored to your audience's interests.

Most people shape their messages to the needs and interests of a particular audience as a matter of common sense. In other words, the message communicated to a parents' group about providing family planning services to adolescents would differ from the message transmitted to officials in the Ministry of Health and Family Welfare.

Audience research, particularly qualitative research such as focus group discussions and in-depth interviews, helps identify appropriate messages for various policy audiences. Whoever the target audience may be, it is important to remember three other points about advocacy message development.

First, there should ideally be only one main point communicated or, if that is not possible, two or three at the most. It is better to leave people with a clear idea of one message than to confuse or overwhelm them with too many.

Second, messages should always be pre-tested with representatives of the target audience to ensure that the message sent is the one received. When a
network develops an advocacy message directed toward the Minister of Health and Family Welfare for example, it is always useful to practice delivering the message to a supportive ministry official as a test run. The ministry official may offer valuable feedback about how the message is interpreted.

Third, the message should not only persuade through valid data and sound logic, but it should also describe the action the audience is being encouraged to take. The audience needs to know clearly what it is you want it to do, e.g., include reproductive health in the national health insurance package, and support an advocacy campaign by attending a rally on the steps of Parliament.

This unit addresses the essential components of a message: content, language, messenger/source, format, and time/place of delivery. Participants are asked to apply what they know about advocacy message development through role-play scenarios with decision makers.

### Five Key Elements of an Advocacy Message

1. **Content**
2. **Language (words, images)**
3. **Medium (mass media, one-on-one meeting, demonstration, street theater)**
4. **Messenger or spokesperson (members of the affected group, an expert, colleague)**
5. **Time/place**

### How to Choose Appropriate Advocacy Methods

There are no simple rules for choosing the best advocacy methods. Your choice will depend on many factors: a) the target person/group/institution; b) the advocacy issue; c) your advocacy objective; d) the evidence to support your objective; e) the skills and resources of your coalition; and, f) timing, for example, external political events, when a law is still in draft form, immediately before a budgeting process, time of year, stage of advocacy process. Below is an example of the strengths and weaknesses of some methods for a particular advocacy objective and targets. Remember that every case is different.
**Advocacy objective:** To persuade managers of the 10 largest companies in Andhra Pradesh to end compulsory testing of workers and dismissal of HIV+ workers.

**Direct targets:** General managers of companies.

**Indirect targets:** Labor unions, boards of directors, personnel managers.

<table>
<thead>
<tr>
<th>Method</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analyzing and influencing legislation and policies or their Implementation</strong></td>
<td>If analysis shows that a company's current practices are costing them money, this can be powerful evidence. Beneficiaries can provide expertise.</td>
<td>Criticism of policies could anger managers. Not useful for managers who dislike formal policies.</td>
</tr>
<tr>
<td><strong>Position paper or briefing note</strong></td>
<td>Suitable for presenting to senior directors and managers.</td>
<td>Can easily be lost among other paperwork. Some managers do not like reading papers. Difficult to involve beneficiaries.</td>
</tr>
<tr>
<td></td>
<td>Useful background briefing for journalists.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensures that public statements by allies always agree.</td>
<td></td>
</tr>
<tr>
<td><strong>Working from inside</strong></td>
<td>Some managers will listen more closely to people they know.</td>
<td>Limited opportunities in companies where all policies are made by managers and directors.</td>
</tr>
<tr>
<td></td>
<td>Many opportunities within labor unions.</td>
<td></td>
</tr>
<tr>
<td><strong>Lobbying or face-to-face meetings</strong></td>
<td>Opportunity to present ‘human face’ of the issue and to build a personal relationship. Beneficiaries can explain their case directly.</td>
<td>Managers often too busy to attend. Board members not interested in the issue, discriminatory to HIV+ people.</td>
</tr>
</tbody>
</table>
**Advocacy objective:** To persuade managers of the 10 largest companies in Andhra Pradesh to end compulsory testing of workers and dismissal of HIV+ workers.

**Direct targets:** General managers of companies.

**Indirect targets:** Labor unions, boards of directors, personnel managers.

<table>
<thead>
<tr>
<th>Method</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presentation</strong></td>
<td>Opportunity to present the issue in a controlled way, direct to decision-makers.</td>
<td>Managers often too busy.</td>
</tr>
<tr>
<td></td>
<td>Beneficiaries can speak directly</td>
<td>Difficult to gain permission for presentation to board of directors.</td>
</tr>
<tr>
<td><strong>Drama</strong></td>
<td>Emotional appeal works with some managers.</td>
<td>Some decision-makers will feel that drama is only for the illiterate.</td>
</tr>
<tr>
<td></td>
<td>Suitable for mass meetings of labor unions.</td>
<td>Difficult to find opportunity to perform to managers or directors.</td>
</tr>
<tr>
<td></td>
<td>Beneficiaries can advise on story, or perform.</td>
<td></td>
</tr>
<tr>
<td><strong>Press release</strong></td>
<td>Useful for organizations needing public support.</td>
<td>No use for companies who do not need/want public support.</td>
</tr>
<tr>
<td></td>
<td>Useful to launch a campaign or for quick reaction to opposition or new developments.</td>
<td>Difficult to involve beneficiaries.</td>
</tr>
<tr>
<td></td>
<td>Inexpensive</td>
<td></td>
</tr>
<tr>
<td><strong>Media interview</strong></td>
<td>Same as for press release.</td>
<td>Can have negative impact if the interviewee is not prepared or does not deliver message well.</td>
</tr>
<tr>
<td></td>
<td>Useful at times when the advocacy issue needs ‘a human face’.</td>
<td>Can be manipulated by journalists.</td>
</tr>
<tr>
<td></td>
<td>Inexpensive</td>
<td></td>
</tr>
</tbody>
</table>
### Press conference

**Strengths**
- Same as for press release.
- Good for presenting evidence, especially case studies/examples.
- Useful to launch a major campaign or for reaction to serious opposition or major new developments.
- Easy to involve beneficiaries and allies, and give them public recognition.

**Weaknesses**
- Same as for press release.
- Requires high level of organization.
- Expensive.

### Public demonstration

**Strengths**
- Draws public attention and media attention.
- Mobilizes beneficiaries.
- Creates pressure.

**Weaknesses**
- May require permission from government/local authorities.
- Can cause target to change, but can also anger target and cause to react depending on timing.

---

**The One-Minute Message**

- **Statement**
- **Evidence**
- **Example**
- **Action Desired**

---

<table>
<thead>
<tr>
<th><strong>Message Development Worksheet</strong>&lt;sup&gt;*&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Audience</strong></td>
</tr>
<tr>
<td><strong>Audience Background</strong></td>
</tr>
<tr>
<td>Knowledge?</td>
</tr>
<tr>
<td>Support?</td>
</tr>
<tr>
<td>Opposition?</td>
</tr>
<tr>
<td>Benefit from issue?</td>
</tr>
<tr>
<td><strong>Message Purpose</strong></td>
</tr>
<tr>
<td>What do you want the audience to know, to</td>
</tr>
<tr>
<td>support, or to do?</td>
</tr>
<tr>
<td><strong>Message Content</strong></td>
</tr>
<tr>
<td><strong>Possible Format(s)</strong></td>
</tr>
<tr>
<td><strong>Messengers</strong></td>
</tr>
<tr>
<td><strong>Time and Place for Delivery</strong></td>
</tr>
</tbody>
</table>

* This worksheet is adapted from Ritu R. Sharma. 1997. Advocacy Training Guide, Academy for Educational Development, Washington, DC
Sample policy briefs are on the CD provided as well as in the “Facilitators’ Resources”:

- MRC Policy Brief: What are the leading causes of death among South African children?


- Social Science Research Policy Brief: Men in Nepal ignoring risk from unprotected casual sex.


These can be copied and distributed to the participants as handouts.
Preparing a policy brief

Introduction

A briefing note and a position paper are both documents that clearly state the position or opinion of an organization (or a coalition of organizations) about a particular issue. The message of these documents is:

‘This is what we think about this topic, and this is what we recommend’. They are different from a press release, which is written specifically for a media audience.

There are different definitions, but this toolkit makes the following distinction between the two, based on who the audience is:

A **position paper** is written to be read by a target, not an ally. It is a formal written record of the position (opinion) of an organisation or coalition, for an external audience. Position papers can:

- Be left with an individual decision-maker at the end of a face-to-face meeting, to summarise the main points of your message
- Be sent to local and national governments during consultation exercises
- Be sent to people of influence, in response to a policy or action, to explain an alternative or supporting position
- Summarise the resolutions of a conference or workshop
- Show that a coalition of many different allies supports your advocacy objective
- Be given to delegates or members of a committee at the beginning of a meeting or conference whether or not you are allowed to speak at the meeting.

A **briefing note** is written for an ally, not a target. It is similar to speaker’s notes, to help someone who is speaking publicly in support of your advocacy objective. Often a briefing note is a position paper with additional advice to the speaker — for example, how to answer questions, or key points to emphasise. A briefing note can:

- Be written by a program officer involved in advocacy work, to assist the executive director in supporting the advocacy objective at a high-level meeting
- Summarize the agreed advocacy objectives and messages of a coalition, to ensure that all members of the coalition give a consistent message
### Advantages

- Briefing notes and position papers are a good way to provide clear documentation of our points for external audiences.
- They reduce distortion or misinterpretation of our position.
- They are a way of contributing to decision-making processes for example, as a way of delivering your analysis of policies or legislation to people in positions of influence.
- They help to identify allies based on the reaction to your position paper/briefing note.
- They can build consensus on policies inside the organization.

### Disadvantages

- Briefing notes and position papers commit the organization to a certain position; an organization can change its mind but it cannot deny what its position was in the past.
- They are only as up-to-date as the last time they were edited/written, but they may still be in use long after you have changed your position.
- It is sometimes difficult and time-consuming to involve beneficiaries in writing position papers but not doing so can make our work less representative.
- They can be misinterpreted if you are not there to explain them.
- They can be ignored.
A face-to-face meeting with a targeted decision-maker (also known as 'lobbying') is one of the most frequently used advocacy methods and is often the starting point for a series of activities.

Personal contact provides the opportunity to build relationships with decision makers, make the person aware of the work of your network, bring your issue to their attention for future action, assess their views and information needs on your advocacy issue, determine what more they need to know for follow-up meetings. Try to set up a channel for regular contacts.

Choose the right time

It is important to choose the right time to meet decision-makers. For example, you might want to try and arrange a meeting when your issue or problems are already on their agenda or most likely to be taken up, such as in the lead up to budget sessions or an important meeting.

Know your target audience

Try to imagine how the issue or problem looks from the decision-maker's point of view. Consider: Why should they support your advocacy objective? How can they benefit from taking the action you are requesting? These questions can be answered more easily if you have researched the 'target person' you are meeting. (See hand out materials on Target Audiences). Try and collect information about their views or likely approach. Ask people who you think may know. Have they made public comments on similar or related issues?

Build the case for change

Be realistic about the options for action you propose. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message (use briefing notes to ensure the message is the same).
Do not be satisfied with vague expressions of support. Return to two basic questions:

- Do the decision-makers agree things need to change?
- What are they willing to do to make change happen?

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Scenarios for 'lobbying' activity

Scenario 1: Access to services for MSM and transgenders

Roles:
- Policy maker: Head of the State AIDS Control Society
- Advocates: Representative of the MSM/Transgender advocacy group, “Hamare Haq” (Our rights) and Director of NGO, Akash.

Issues:
Akash, an NGO, provides a range of HIV prevention services. As part of their outreach activity, Akash staff is becoming increasingly aware that men who have sex with men (MSM) and transgenders are at particular risk of HIV infection. Yet, many MSM and transgenders report a lack of access to condoms and lubricant and report discrimination when attempting to access sexual health and HIV services. With Akash's support, some MSM and transgenders formed an advocacy group called ‘Hamare Haq’.

SACS has developed a state HIV/AIDS policy about five years ago. The policy does not address the needs of MSM and transgenders. They want the State HIV plan to address the HIV prevention needs of MSM and transgender and ensure access to non-discriminatory and good quality HIV prevention, sexual health, HIV treatment and care services.

Instructions:
Prepare for a face-to-face meeting with the influential person outlined in the scenario below. Identify two people to act as advocates and one person to act as the influential person.

Prepare for a face-to-face meeting considering the following:
- What are the advocacy issues you want to raise?
- What action do you want from the policy maker?
- What will both say (who is best placed to say what?)
- What facts and evidence will you use to support what you will say?
- What more information do you need, if any?
What will the decision-maker say about the issue?

What will your responses be?

Consider how you want to behave during the meeting and why?

Decide what, if anything, you should take to the meeting

You will have 10 minutes to present your role-play.

**Scenario 2: Police raids hamper effective HIV prevention among sex workers**

**Roles:**

- Policy maker: Head of District Police.
- Advocates: Representative of the sex worker collective, Mahila Sangha and Director of NGO, Prajal Foundation

**Issues:**

In the last two months, police have been regularly rounding up street sex workers and conducting random raids on brothels, arresting sex workers, in a particular district.

The sex worker collective, Mahila Sangha, knows that many sex workers are being fined and unable to pay the fine. In their experience, many men demand, and are willing to pay more for, sex without condoms. Many sex workers are being forced to do so, just to make more money to pay back these fines. They report that sex workers are increasingly worried about carrying condoms or being identified as sex workers.

The NGO, Prajal Foundation runs a number of sexual health clinics for sex workers in these districts. They work in partnership with Mahila Sangha providing outreach to brothels and street sex workers, to ensure their access to condoms, HIV prevention information and sexual health services. In the last two months, staff have noticed a sharp drop in the numbers of sex workers attending their clinic.

The Prajal Foundation and Mahila Sangha want police to understand the impact of these raids, how they violate the rights of sex workers and the impact they are having on effective HIV prevention efforts.
**Instructions:**

Prepare for a face-to-face meeting with the influential person outlined in the scenario below. Identify two people to act as advocates and one person to act as the influential person.

Prepare for a face-to-face meeting considering the following:

- What are the advocacy issues you want to raise?
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- What more information do you need, if any?
- What will the decision-maker say about the issue?
- What will your responses be?
- Consider how you want to behave during the meeting and why
- Decide what, if anything, you should take to the meeting

You will have 10 minutes to present your role-play.

**Scenario 3: Resistance to harm reduction and a changing epidemic**

**Roles:**

- Policy maker: Head of Manipur SACS
- Advocates: Director of NGO, Ukhzul Foundation and a representative of Manipur Advocacy Coalition.

**Issues:**

There is high HIV prevalence among injecting drug users (IDUs) in Manipur. The Ukhzul Foundation is an NGO that provides a range of services including Needle and Syringe Programs (NSPs), peer outreach, IEC. They work with an IDU network, of current and ex-users that they have been training as peer educators. Together they have documented that IDUs have poor access to appropriate drug treatment programs including drug
substitution programs. There is also considerable community resistance to the harm reduction work of NGOs. This is creating a climate of fear and violence against IDUs. Increasingly, IDUs are not carrying injecting equipment because they fear this will lead to their arrest by police or violence from ‘pressure groups’.

Ukhzul and the IDU network members have formed an advocacy group, called the Manipur Action Coalition (MAC) to take action together to:

- increase understanding of harm reduction and how it contributes to preventing the spread of HIV;
- improve access to appropriate drug treatment, HIV related prevention, treatment and care of IDUs and their partners.

**Instructions:**

Prepare for a face-to-face meeting with the influential person outlined in the scenario below. Identify two people to act as the advocates and one person to act as the policy maker.

Prepare for a face-to-face meeting considering the following:

- What are the advocacy issues you want to raise?
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- What will both say (who is best placed to say what?)
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- What will your responses be?
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- Decide what, if anything, you should take to the meeting

You will have 10 minutes to present your role-play.
Preparation for face-to-face meetings

**Introduction**

A face-to-face meeting with a targeted decision-maker (also known as ‘lobbying’) is one of the most frequently used advocacy methodologies and is often the starting point in a series of activities.

Personal contact provides the opportunity to build relationships with decision-makers, which could prove very useful in future. Try to set up a channel for regular contacts.

It is important to choose the right time for meeting decision-makers, when your issue or problem is already on their agenda or most likely to be taken up, for example, before an important vote or when they are able to take action in support of your advocacy like during the budget-setting process, or at the time of an annual meeting.

Try to imagine how the issue or problem looks from the decision-maker’s point of view. Why should they support your advocacy objective? How can they benefit from taking the action you are requesting? This can be answered more easily if you have fully researched the ‘target person’ you are meeting.

Make realistic requests. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message (use briefing notes to ensure the message is the same, see Advocacy in Action Card 2). It is difficult for officials to ignore large numbers of advocates.

Do not be satisfied with vague expressions of support. Return to two basic questions:

- Does the decision-maker agree that things need to change?
- What are they willing to do to make change happen?
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Sample Policy Briefs

Copies of the samples briefs used in this session can be found in the section- Advocacy Communication: Messages and Methods.

Scenarios: Using Evidence for Advocacy

Scenario 1: Access to services for MSM and trans-genders

Akash, an NGO in Bangalore, provides a range of HIV prevention services. As part of their outreach activity, Akash staff is becoming increasingly aware that men who have sex with men (MSM) and trans-genders are at particular risk of HIV infection and that many in the city are already living with HIV. Yet, there seem to be barriers to access to mainstream health services. There is very little information available about sexual behavior and HIV/STI risk among MSM and transgenders, and the impact of HIV on PLWHA.

With Akash’s support, some MSM and transgenders formed an advocacy group called ‘Hamare Haq’ (Our rights). Members of Hamare Haq and Akash outreach workers have been talking to MSM and transgenders and documenting their experience such as their access to condoms, lubricants, HIV prevention information and services to meet their HIV treatment and care
and/or sexual health needs. Together Akash and Hamare Haq have run four focus groups, in all seventy people attended these group discussions. They also conducted thirty individual interviews. A total of 100 people reported their experiences.

They found that many MSM and transgenders report a lack of access to condoms and lubricants. Forty percent report having had the symptoms of one or more sexually transmitted infections (STIs) in the last twelve months. Of these forty people only eight (20%), sought treatment for the infection. Fifteen people reported that the staff at the OPD of one of the city’s largest public hospital’s Out Patients’ Department are known to be dismissive of MSM and transgenders and often have no experience in handling oral and anal STIs affecting the community. There is also evidence about breach of confidentiality about clients’ sexual orientation and HIV status by health workers, leading to family and community harassment or rejection. As a result many people say that they will not go there.

Together Akash and Hamare Haq discuss what action they could take to improve the situation for MSM and transgenders. They build partnerships with other NGOs who want to work on these issues and agree to set up a coalition, Transgender and MSM Advocacy Coalition (TRAM), to work together on an advocacy agenda. The coalition meets and agrees to focus its advocacy efforts on:

- access to condoms and lubricants, and
- access to non-discriminatory and good quality HIV prevention, sexual health, HIV treatment and care services

In addition to their own research, there is also some data that can be used to make the case for their advocacy goals.

Target audience for policy brief: SACS

Scenario 2: Police raids hamper effective HIV prevention among sex workers

There is a district election coming up in the north-west of Karnataka and there has been considerable community pressure about cracking down on sex work in a number of blocks in the area. In the last two months, police have been regularly rounding up street sex workers and conducting random
raids on brothels, arresting sex workers. In 2004, the Director General of Police in Karnataka issued a circular explaining what the police powers are under the Immoral Trafficking Prevention Act (ITPA). These raids do not comply with the circular and therefore with ITPA.

The sex worker collective, Mahila Sangha, is spending much of their time trying to assist sex workers who have been arrested and charged with soliciting. They report that many sex workers are being fined and are unable to pay the fine. In their experience, many men demand, and are willing to pay more for sex without condoms. Many sex workers are being forced to do so, just to make more money to pay back these fines. They report that sex workers are increasingly worried about carrying condoms or being identified as sex workers.

The NGO, Prajal Foundation runs a number of sexual health clinics for sex workers in the north-west of Karnataka. They work in partnership with Mahila Sangha providing outreach to brothels and street sex workers, to ensure their access to condoms, HIV prevention information and sexual health services. In the last two months, staff have noticed a sharp drop in the numbers of sex workers attending their clinic.

Brothel madams in the area are increasingly worried about these raids, and their effect on their businesses. Prajal Foundation and Mahila Sangha are finding that their working relationships with many madams have deteriorated as a result. Some madams refuse to provide condoms and safer sex resources, because they will be used as evidence that the premises are being used as a brothel.

It is more difficult to locate brothels and street sex workers. A number of brothels have moved premises to avoid police exposure. Some madams are colluding with the police offering them sex with their workers in exchange for agreeing not to raid their brothels. Frequently police insist on not using condoms and the sex workers are powerless to refuse, exposing both workers and officers to the increased risk of HIV infection.

The Karnataka Health Promotion Trust, Prajal Foundation and Mahila Sangha meet to discuss how to take action to address these issues. They want to advocate for the police to comply with the Police circular and the ITPA and to improve understanding about how the raids impede effective HIV prevention efforts.

Target audience for policy brief: Police Department of Karnataka
Scenario 3: Resistance to harm reduction and a changing epidemic

There is high HIV prevalence among injecting drug users (IDUs) in Manipur. There are a number of NGOs working to implement a range of strategies to reduce HIV infection among IDUs and address the treatment and care needs of those living with HIV. Ukhzul Foundation is an NGO that provides Needle and Syringe Programs (NSPs), peer outreach, IEC, advocates for access to appropriate and non-discriminatory drug treatment and HIV treatment and care services, as well as increases community awareness about the effectiveness of harm reduction approaches to injecting drug use and the contribution that this makes to reduce HIV transmission.

Ukhzul also works with an IDU network of current and ex-users that they have been trained as peer educators. Through the network’s work with their peers, they want to take action about the many challenges that IDUs are facing. Together they have started to document the challenges through focus group discussions and one on one interviews. Eighty people participate. The work reveals that most IDUs have poor access to appropriate drug treatment services such as drug substitution programs. While 50% of those surveyed had been detained and forced into detoxification programs, with no support or follow up upon release. The survey also found that 45% of those surveyed were HIV-positive. Of these, 90% had experienced discrimination in accessing HIV-related health care.

There is also considerable community resistance to the harm reduction work of NGOs, particularly by a vocal womens’ group that is advocating that the NSP will increase injecting drug use. This is building community resistance, and this has created a climate of fear and violence against IDUs. Increasingly, IDUs are not carrying injecting equipment because they fear this will lead to their arrest by police or violence from ‘pressure groups’.

Data in Manipur also shows a trend of increasing STIs among women, which suggests that they are increasingly exposed to HIV, likely through their male IDU partners. There is inadequate evidence to confirm this trend, but Ukhzul is aware that few programs exist that address the HIV prevention needs of partners of IDUs or HIV/AIDS treatment and care needs of IDUs, partners and others living with HIV/AIDS. Existing programs and services do not necessarily have the capacity to expand their work without additional funding and support to meet these emerging needs.

Ukhzul and the Network find other allies and form an advocacy group, called the Manipur Action Coalition (MAC) to take action together. MAC
meets to discuss what action they could take to address these issues. They want to:

- increase understanding of harm reduction and how it contributes to preventing the spread of HIV;
- ensure access to appropriate drug treatment, HIV-related treatment and care for IDUs and their partners;
- address stigma and discrimination by pressure groups, and
- address programs gaps, particularly the needs of women partners of male IDUs.

In addition to their own research, there is also some other data that can be used to make the case for their advocacy efforts.

Target audience for policy brief: SACS

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**Policy Brief template**

**Summary of main recommendations**

**Background**

Explain why position paper has been written: E.g., This paper recommends a course of action that can be considered by the taskforce examining policy issues related to HIV testing in India.

**Key issues and evidence**

What are the key issues of concern and what evidence is there that support the recommendations you will make? Use subheadings if there are different issues. Focus on only two to three key issues.

Evidence can include:

- facts and figures, such as behavioral data, case studies, that demonstrates and illustrates the issues of concern, and
facts and figures, program evaluations, best practice research that persuade decision makers about the best course of action, that are reflected in your recommendations below.

Consider how your evidence could address questions or objections the target audience may have.

**Recommendations for action**

Specific, realistic policy actions that decision makers can take

**Contact**

Contact organization/ network
Contact person's name and contact details

**Date**
Suggested Core Program (3 days)

Modules and sessions

**DAY 1**

**A. Introduction to HIV/AIDS Advocacy**
- A.1 Introduction to the Workshop
- A.2 About the EAP and a Rights-based Approach to Advocacy
- A.3 What is Advocacy?
- A.4 Advocacy and Related Concepts
- A.5 Examples of Advocacy leading to Policy Change
- A.6 Steps in the Advocacy Process

**B. Introduction to Evidence-based Advocacy**
- B.1 Understanding the Epidemic: HIV/AIDS in India
- B.2 Introduction to Evidence-based Advocacy
- B.3 Introduction to Data Analysis

**DAY 2**

**C. Understanding the Policy Process**
- C.1 Policy Processes in Government (guest panel)

**D. Advocating change**
- D.1 Identifying Advocacy Issues
- D.2 Advocacy Issue Prioritization
- D.3 Identifying Policy Solutions
- D.4 Developing Advocacy Goals and Objectives
- D.5 Target Audiences: Identifying Opposition and Support
- D.6 Analyzing Target Audiences

**DAY 3**

**E. Implementation - Advocacy Action Plans**
- E.1 Introduction to Advocacy Action Plans
- E.2 Developing an Advocacy Action Plan

**F. Advocacy Messages and Methods**
- E.1 Introduction to Advocacy Communication
- E.4 Face-to-face Communication
Suggested Advanced Program (4.5 days)

Modules and sessions

**Day 1**

A. **Introduction to HIV/AIDS Advocacy**
   A.1 Introduction to Workshop
   A.2 About the EAP and a Rights-based Approach to Advocacy
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   A.5 Examples of Advocacy Leading to Policy Change
   A.6 Steps in the Advocacy Process

B. **Introduction to Evidence-based Advocacy**
   B.1 Understanding the Epidemic: HIV/AIDS in India
   B.2 Introduction to Evidence-based advocacy
   B.3 Introduction to Data Analysis

**Day 2**

B. **Introduction to Evidence-based Advocacy**
   B.4 Analyzing Behavioral and Epidemiological Data

C. **Understanding the Policy Process**
   C.1 Policy Processes in Government (guest panel)

D. **Advocating Change**
   D.1 Identifying Advocacy Issues
   D.2 Advocacy Issue Prioritization
   D.3 Identifying Policy Solutions
   D.4 Developing Advocacy Goals and Objectives
D. Advocating Change
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D.6 Analyzing Target Audiences

E. Implementation - Advocacy Action Plans
E.1 Introduction to Advocacy Action Plans
E.2 Developing an Advocacy Action Plan

F. Advocacy Messages and Methods
F.1 Introduction to Advocacy Communication

G. Evidence for Action: Using Data for Advocacy
G.1 Written Communication. Using Data in a Policy Brief
G.2 Face-to-face Communication. Using Data for 'Lobbying'

G. Evidence for Action: Using data for Advocacy
G.2 Face-to-face Communication Using data for 'lobbying'
With support from

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India AIDS Initiative