Unit 2 – Socio-political Factors Contributing to Successful Programmes

Introduction

Welcome to Unit 2 of this module. We hope that Unit 1 provided you with an overview of the global nutrition situation and introduced you to some of the features of successful nutrition programmes. In the final session of Unit 1, we touched on the influence of socio-political factors like political will and community participation. In this Unit we will discuss these socio-political factors in greater depth, focusing on the political will of decision-makers, community participation and advocacy.

Unit 2 contains four Study Sessions:

Study Session 1:	Nutrition Promotion
Study Session 2:	Socio-political Factors, Political Will and Community Participation
Study Session 3:	Community Participation
Study Session 4:	Advocacy Strategies

Learning outcomes of Unit 2

By the end of Unit 2, you should be able to:
▪ Identify the main features, advantages and drawbacks of three approaches to nutrition education and promotion. ▪ Identify the features of a Nutrition Promotion Approach ▪ Design a nutrition communication framework for your programme. ▪ Describe the nature of *political will* and the factors that influence it. ▪ Analyse the relationship between political will and other key social and political factors, including community participation and mobilisation, and organised advocacy. ▪ Describe the concept of *community participation*. ▪ Determine how to assess the degree of community participation in nutrition programmes. ▪ Explain why community participation is important for the success of nutrition programmes. ▪ Suggest an approach to community participation, which can make it a reality within nutrition programmes.

Once again, remind yourself of the requirements of the assignment, and select relevant information as you study. In addition, it is always useful to try to apply new ideas and approaches to your own context while you study, analysing whether they exist or can be nurtured in your own programme situation.

Unit 2 - Session 1
Nutrition Promotion

Introduction

Welcome to this session on Nutrition Promotion. In this session, we will try to illustrate how social-political action, community participation, effective communication and advocacy are all essential components of improving nutrition.

This session will introduce the different approaches towards nutrition education and take you through how approaches have changed over time, to the point where we now recommend a Nutrition Promotion Approach.

Contents

Timing of this session

This session contains six readings and eight tasks. It should take you about four hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:
▪ Identify the main features, advantages and drawbacks of three approaches to nutrition education and promotion. ▪ Identify the features of a Nutrition Promotion Approach ▪ Design a nutrition communication framework for your programme.

2 READINGS

Author/s	Publication details
Alnwick, D.J.	(1987). Nutrition Education and UNICEF. New York: UNICEF.1-15.
Favin, M. & Griffiths, M.	(1996). *Using Communication to Improve Nutrition*. World Bank, Washington DC.
Verzosa, C.C. & Brown, K. H.	(1994). *Beyond Creative Concepts: The Dietary Management of Diarrhea Project*. (Eds) Koniz-Booher, P. Cornell University, Ithaca, NY.
Miller, R.	(1993). *The Iringa Project. Proceedings of an International Conference on Communication Strategies to Support Infant and Young Child Nutrition*. (Eds) Koniz-Booher, P. Cornell University, Ithaca, NY.
de Boer, F.	International Agricultural Center. The Netherlands. Unpublished paper.
Stuart T.H. & Achterberg, C.	(1995). Education and communication strategies for different groups and settings. *Nutrition Education for the Public. Discussion papers of the FAO expert consultation on nutrition education for the public.* FAO, Rome Italy.

3 APPROACHES TO NUTRITION PROMOTION

For quite some time, nutrition education and promotion has been thought of as a transfer of knowledge from the health worker to the client. Some forms that this has taken are health talks, posters, pamphlets and instructions to or counseling of mothers. Let us start by exploring the traditional approach to nutrition education. Those of you who have studied *Health Promotion I* or *II* will be able to see that the issues in Public Health nutrition are very similar. While you read about it, consider whether this traditional approach is still being practised in your context.

3.1 The Traditional Approach to Nutrition Education

Reading:
Alnwick, D.J. (1987). Nutrition Education and UNICEF. (1987). Nutrition Education and UNICEF. New York: UNICEF.1-15.

This reading provides a critique of the traditional approach to nutrition education.

TASK 1 – A critical analysis of the traditional approach to nutrition education

As you read this extract of Alnwick's article *Nutrition Education and UNICEF*, list the advantages and drawbacks of the traditional approach to nutrition education.

FEEDBACK

It is important to recognise that the traditional approach to nutrition education has the advantage of requiring fewer resources than other Health Education and Health Promotion approaches. This is because the health worker can

select the content to be delivered, and organise and package it well ahead of time. The health worker's job is further made easier because the information has already been prescribed by professionals, and is assumed to be appropriate for all groups of people. Evaluation is also simplified because it simply sets out to test whether clients can correctly recall the information. Since the method is similar to those used in traditional school teaching, health workers do not need training on how to use this method.

However, evaluations of this method have consistently shown that knowledge alone is not enough to change behaviour. The broader constraints to behaviour change such as self-efficacy, powerlessness, resource constraints and social norms also need to be addressed. The traditional approach has limited reach, and is biased towards relying solely on interpersonal communication.

As a result of these evaluations, a new strategy for nutrition education has been developed. This approach is known as Social Marketing.

3.2 Social Marketing

An important response to the shortcomings of the traditional approach to nutrition education is an approach known as Social Marketing. Favin and Griffiths explore how this approach addresses some of the shortcomings of the traditional approach.

Reading:
Favin, M. & Griffiths, M. (1996). *Using Communication to Improve Nutrition*. World Bank, Washington DC.1-18.

TASK 2 – Summarise the improvements made by the Social Marketing Approach

How has the Social Marketing Approach addressed the shortcomings of the traditional approach to nutrition education?

FEEDBACK

In addition to what Favin and Griffiths mention, you should note the following:

- A Social Marketing approach tries to find out what people's knowledge and behaviour is on a particular nutrition practice, by performing formative research.
- Social Marketing also takes into account the idea that it is not just a lack of knowledge which is a barrier towards changing behaviour, but that other influences, such as culture, may present an obstacle to change.
- Social Marketing uses many different channels, such as radio and television to pass information.

Now that you have learned about what Social Marketing is and how it works, let's find out more about why a Social Marketing approach may not work.

Reading:
Verzosa, C.C. & Brown, K. H. (1994). *Beyond Creative Concepts: The Dietary Management of Diarrhea Project*. (Eds) Koniz-Booher, P. Cornell University, Ithaca, NY. 43-51.

Read the case study in the above reading – "Beyond Creative Concepts: The Dietary Management of Diarrhea Project". It describes a Social Marketing Approach. You should note, however, that even though the DMD project was well executed, only 16% of the mothers tried the new product which was being advocated. The key question is *why*?

TASK 3 – A critique of the Social Marketing Approach

After reading the case study answer the following two questions:

a) What evidence is there that this project was not completely successful?
b) List all the reasons why you think a Social Marketing approach may not have worked in this context.

FEEDBACK

a) It is evident that the project was not entirely successful because, although most of the target group gained knowledge of *sanquito,* very low numbers adopted it. Hearing about the product over the radio was not sufficient to result in adopting the product, while demonstrations at Mothers' Clubs and hearing about it from more than one source resulted in a stronger likelihood of mothers adopting the product.

b) Check your listing to see whether you have included the following reasons for why the Social Marketing strategy might have failed:

- Social Marketing may not work because it assumes that individuals make decisions based on reasoned action. In other words, they act after reflecting on the costs and benefits of the action for themselves. Social Marketing further assumes that individuals act mainly in their own interests. While this may be true in Western societies, in many African societies, it is the influence of the family and collective decision-making of the community or clan which is more important than the individual's decision.
- Although Social Marketing attempts to engage people in discussion about their behaviour, this is often not undertaken in the context of real life situations.
- Social Marketing assumes that the message which is delivered is the correct one for <u>all</u> audiences without considering the individual's socio-cultural setting. For example, parents are expected to develop a new understanding of the causes of poor nutrition through effective messages and appropriate communication channels, regardless of their past experiences, cultural norms or education level.
- Social Marketing is based on the belief that individuals are passive recipients of messages and therefore it does not address the broader causes of malnutrition.

With these reservations in mind, we move on to the third approach to Nutrition Promotion.

3.3 The Community Empowerment Approach

The community empowerment approach is demonstrated through the Iringa Case Study (Tanzania), which shows how different nutrition education strategies can be combined in a nutrition programme.

Reading:
Miller, R. (1993). *The Iringa Project. Proceedings of an International Conference on Communication Strategies to Support Infant and Young Child Nutrition*. (Eds) Koniz-Booher, P. Cornell University, Ithaca, NY. 186-193.

TASK 4 – Explain the potential of the Community Empowerment Approach

Review the Iringa case study. Describe the nutrition education and promotion approach used. Explain how this approach addresses the drawbacks of the Traditional Nutrition Education approach and the Social Marketing Approach.

FEEDBACK

In this reading, Roy Miller thoroughly evaluated the Iringa Project. In summary, here are some of the ways in which the Iringa Project addresses the drawbacks of the traditional nutrition education approach and the Social Marketing Approach:

- Information is not extracted from the community but generated and punctually analysed in a participatory way by both outsiders and community members.
- Through a problem-posing methodology, local people are encouraged to analyse and devise programme interventions themselves.
- By using the conceptual framework, the analysis is not restricted to the immediate causes such as ignorance or cultural barriers, but starts to identify and address the contextual and environmental barriers to change.
- Community empowerment through capacity building and social mobilisation is considered to be just as important as the nutrition and health objectives and both goals are pursued simultaneously.

These three approaches represent a transition which parallels the shift from Health Education to Health Promotion in the late 1970's. Health Education was at that time most actively centred on providing learning opportunities for individuals and communities, so that they were able to voluntarily change their behaviour. In other words, they were expected to acquire information and skills to help them initiate changes that would enhance their well-being and their health. Health Education activities range from individual counselling and self-development to the use of mass media and communication campaigns.

Health Promotion on the other hand is much broader and includes both Health Education and

- The provision of preventive health services.
- Measures to protect the physical environment and make it conducive to health.
- The mobilisation of community resources.
- The implementation of organisational policies which promote health.
- Economic and regulatory activities (Schaay et al, 2002:57).

In the next section, we focus on this transition in the field of Public Health Nutrition.

4 CHANGES IN APPROACH TO NUTRITION PROMOTION

The next reading summarises the shift in thinking from Nutrition Education to Nutrition Promotion.

Reading:
De Boer, F. *The Transition from Nutrition Education to Nutrition Promotion.* The International Agricultural Center, The Netherlands. Unpublished paper. 1-4.

TASK 5 – Identifying key shifts in Nutrition Promotion strategies

What are the most important components of the new Nutrition Promotion?

FEEDBACK

The crucial components of the new nutrition promotion include:
- Creating an enabling environment through social and political actions.
- Empowering communities through enabling them to participate in programmes.
- Effective communication strategies.
- Effective advocacy.

The rest of this unit will focus on these key components. We will start with designing an effective communication strategy.

5 DESIGNING AN EFFECTIVE COMMUNICATION STRATEGY

As you have seen, designing a communication strategy is an important part of a Nutrition Promotion strategy. In this section, we will focus on developing a communication strategy and suggest a framework which could help you to plan a nutrition education and communication strategy. The strategy will consider all of the following:

- Different settings.
- Target groups.

- Message development.
- Channels of communication.

We will use the next reading to guide you in this process.

Reading:
Stuart T.H. & Achterberg, C. (1995). Education and communication strategies for different groups and settings. *Nutrition Education for the Public. Discussion papers of the FAO expert consultation on nutrition education for the public.* FAO, Rome Italy. 71-102.

TASK 6 – Describe the setting in which you work

This reading is quite long, so we will read it in several parts. To begin, please read pages 71- 79. Use the structure used in this paper to describe the setting in which you are working. Use the same headings as in the reading and describe the different key settings in your own programme.

FEEDBACK

You have probably noted that there is a great deal of information that needs to be collected before designing a nutrition communication strategy. You should also have noted there is a need to do a situational assessment. We shall re-visit this point in the next unit.

TASK 7 – Select target groups for your communication strategy

Now study pages 79-80 of Stuart and Achterberg (1995). This section describes how to select target groups. Use this information to identify the target groups for your own programme.

FEEDBACK

You should have noted that there are many ways to do audience segmentation. Based on your programme's objectives and the settings assessment, you need to decide who is the most important audience for your communication intervention.

TASK 8 – Develop your message

a) Pages 80-84 of the reading focus on message development. After reading this section, summarise its key points (in your own words).
b) Read the remaining pages - 85-102, which describe different channels of communication. Refer to the target groups (audiences) you have identified and list the channels that would be most appropriate for reaching each of the target groups in your programme.
c) You should now be able to fill in the following table to guide you in designing your communication strategy.

DESIGNING A COMMUNICATION STRATEGY

Target group/ audience	
Presentation content	
Action you want the audience to take	
Format(s)	
Messengers	
Time and place for delivery	

6 SESSION SUMMARY

This was a substantial session. Hopefully you have developed a clear sense of the changes of approach in Nutrition Promotion and why these developments have taken place. You should also have had a chance to start developing an effective communication strategy for an actual nutrition setting.

At this stage, you will only be able to complete a first draft of your communication strategy. You have probably noted that you need more information to assist you to define your audience more precisely, and to

develop the key messages and channels of communication. Session 4 will build on these aspects of this session.

In the next session, we focus in more detail on socio-political factors which affect nutrition programmes.

7 REFERENCES

- Schaay, N. *et al.* (2002). *Health Promotion I* Module Guide. SOPH, UWC, Bellville.

Unit 2 - Session 2
Socio-political Factors, Political Will and Community Participation

Introduction

Welcome to the second session of Unit 2. In it, we will review key socio-political factors that influence nutrition programming and policy. The argument is made that such factors not only have a significant impact on health programming, but also that a concrete implementation approach which supports participatory democracy is essential to ensure successful programming. The session encourages you to read critically and to apply the views put forward by different authors to your own context in order to evaluate their validity. Use this opportunity to practise a critical approach to reading.

Contents

Timing of this session

This session contains four readings and four tasks. It should take you about three hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Describe the nature of *political will* and the factors that influence it.
- Analyse the relationship between political will and other key social and political factors, including community participation and mobilisation, and organised advocacy.

2 READINGS

Author/s	Publication details
Sanders, D.	(1999). Success factors in community-based nutrition programmes. *Food & Nutrition Bulletin,* 20(3).
Rosenfield, P. L.	(1985).In Scott, B., Halstead, S.B., Walsh, J.A. & Warren, K. S. The Contribution of Social and Political Factors to Good Health*. Good Health at Low Cost.* Switzerland: Rockefeller Foundation.
Piyaratn, P.	(1992). Ch 6: Basic Minimum Needs: Concepts and Practice. Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K. (eds.), *Integrating Food and Nutrition into Development: Thailand's Experiences and Future Visions.* Mahidol University, Nakhon Pathom, Thailand.
Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K.	(1992). Ch 21: Reflections on Thailand's Food and Nutrition Situation. Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K. (eds.), *Integrating Food and Nutrition into Development: Thailand's Experiences and Future Visions.* Mahidol University, Nakhon Pathom, Thailand.

3 THE IMPORTANCE OF PARTICIPATORY DEMOCRACY IN IMPROVING HEALTH

In the ACC/SCN publication *How Nutrition Improves*, it is stated that: *"Successful community-based nutrition programmes have tended to have combinations of political will at central level, middle-level district (and more decentralized) administrative support, in addition to community-level organizational capacity. This reinforces the potentially synergistic relationship between the community and the government. Once bottom-up processes with their associated demands are facilitated, and communities empowered, the government has to provide more relevant, timely and appropriate support"* (Gillespie S. et al, 1996: 81).

3.1 Participatory democracy

In this section, we clarify what is meant by a participatory democracy. As you read, try to analyse critically how this model of governance influences health. You may find these critical questions helpful:

- On what assumptions is the author's argument based?
- Where does the information come from, and could it be biased?
- What opposing views could there be?
- In what way could the information be inaccurate?

READING:
Sanders, D. (1999). Success factors in community-based nutrition programmes. *Food & Nutrition Bulletin,* 20(3): 307-311.

TASK 1 – Explore the links between participatory democracy and nutrition programming

Review the section "Factors Influencing Success" on pages 308-310 of the above reading. Make notes on Sanders' argument about the link between participatory democracy and its influence on nutrition programming.

FEEDBACK

In the reading it is suggested that genuine community participation implies participatory democracy and that a process of participatory democracy is essential to achieve and sustain the political will to meet all people's basic needs.

Do you have a clear idea of what participatory democracy implies, and is it practised in your own country or region? Make sure you understand how it differs from representative democracy by doing the next task and checking your answer against the feedback.

TASK 2 – Distinguishing two kinds of democracy

What do you understand by the term "participatory democracy" and how does it differ from "representative democracy"?

FEEDBACK

The main differences between direct or participatory and indirect or representative democracy are illustrated in the following excerpt from a chapter written about community participation in health in the newly-independent Zimbabwe of the early 1980s.

> *"… One of the major gains of this revolutionary experience was the practice of direct democracy, where peasants and workers for the*

first time participated directly in the formulation of policies, and their day-to-day implementation and evaluation. Furthermore, the ability of the peasants and workers to control, reject, and re-elect representatives became a reality – a far cry not only from their previous experience, where they had no vote, but even from the experience of those living in western 'democracies', where representatives are elected infrequently to parliament, or local government bodies, without any day-to-day control over their actions being exercised by the electorate who voted them in. This gain has persisted, to some extent, in certain parts of the country, but has been progressively eroded with the passage of time" (Sanders, 1992: 185).

The gains are two-fold – first of all a participatory democracy enables more direct influence on governance by those affected by it, and secondly it enables the populace to hold the elected government accountable.

3.2 Lessons from poorer countries

The importance of strong political and popular commitment in achieving impressive improvements in health has been recorded for a number of poor countries. The best known of these countries have been studied and their characteristics analysed in an attempt to provide lessons for other poor countries faced with similar challenges.

Read the following extract from Werner et al in *Questioning the Solution: The Politics of Primary Health Care and Child Survival* (1997:114-115).

Good Health at Low Cost

"Despite the dismal and deteriorating living conditions and health situation in many poor countries, a few poor states have succeeded in making impressive strides in improving their people's health. In 1985 the Rockefeller Foundation sponsored a study titled 'Good Health at Low Cost'. Its purpose was to explore 'the reasons why certain poor countries have achieved acceptable health statistics in spite of very low national incomes.' Specifically, the study sought to 'verify whether China, the state of Kerala in India, Sri Lanka, and Costa Rica did indeed attain life expectancies of 65-70 years with gross national products per capita of only $300-$1 300,' and, if so, to discover why.

On completing the study, its authors concluded that 'the four states did achieve good health at low cost.' Specifically, the states had dramatically reduced their infant and child mortality rates, and as a result increased their life expectancies to near-First World levels. The reductions in mortality attained by the four states were substantially greater than those registered by Third World countries that pursued conventional child survival strategies. Moreover, these reductions were accompanied by declines in malnutrition and, in some cases, the incidence of disease."

The authors of the study attributed these remarkable improvements in the health of entire populations to four key factors which are:

1. Political and social commitment to equity i.e. to meeting all people's basic needs.
2. Education for all with emphasis on the primary level.
3. Equitable distribution throughout the urban and rural populations of Public Health measures and Primary Health Care.
4. Assurance of adequate caloric intake [enough food] at all levels of society in a manner that does not inhibit indigenous agricultural activity.

The importance of a strong "political and social commitment to equity" – although pursued in different ways – cannot be over-emphasised. Henry Mosley, director of Johns Hopkins University's International Institute of Health and Population, points to the social and political factors underlying the improvements in health achieved in these four states:

> *"[To] guarantee access [to services] there must be an aggressive effort to break down the social and economic barriers that can exist between the disadvantaged subgroup and the medical services."*
> *"This may be approached with a top-down strategy as illustrated by Costa Rica, or it may be gained through a bottom-up strategy where demand is generated by the organized poor as in Kerala … A passive approach of only making services available will not succeed in most situations unless the population has a heightened consciousness of their political rights."*

Mosley further notes that:

> *"The fundamental underpinnings of any mortality reduction effort involves the political commitment to equity as well as policies and strategies to provide essential services to all. Judging by the historical experiences of the case studies, this stage may be reached through a long history of egalitarian principles and democracy (Costa Rica), through agitation by disadvantaged political groups (Kerala), or through social revolution (China)"* (Mosley, 1985: 243).

In the Rockefeller Foundation's publication, *Good Health at Low Cost*, Patricia Rosenfield *et al* identify a number of key social and political factors contributing to the remarkable improvements in health in the above four low-income countries. They also suggest that these factors can be measured through a variety of indicators.

READING:
Rosenfield, P. L. (1985). In Scott, B., Halstead, S.B., Walsh, J.A. & Warren, K. S. The Contribution of Social and Political Factors to Good Health. *Good Health at Low Cost.* Switzerland: Rockefeller Foundation. 173-180.

TASK 3 – Critically evaluate "factors which contribute to good health"

Study the reading by Patricia L. Rosenfield *et al*, pages 173-180.

a) Reflect on the five common social and political factors identified by Rosenfield as key to the achievement of good health.
b) Do you think that these are both useful and measurable factors?
c) Do you think that they could be helpful in analysing success factors in nutrition programmes?

FEEDBACK

Rosenfield's framework assists us in analysing some key social and political factors influencing health and nutrition programmes. Clearly a number of these are themselves a reflection of "political will", such as a "social welfare orientation to development" and "equality of coverage for all social groups".

While Rosenfield's framework is a useful one for understanding social and political factors influencing successful programmes, it does not in itself provide a strategy for developing a facilitative political and social environment. It does not identify key approaches to secure political will.

As indicated earlier in this study session, political will may be brought about by a process of participatory democracy or strong community participation. Such processes are seen in periods of profound political change, where large sections of a country's population mobilise to achieve a particular political objective. It is important, however, to identify mechanisms which can be used to secure political support for health and nutrition programmes in the much more common situation of low levels of political activity. In another session of this module, you will learn about the Triple A Approach to nutrition programme development. This approach, if successfully applied, can result in a number of outcomes, including greater political commitment to nutrition programmes. Another, similar, approach has been used in Thailand: this has been called the Basic Minimum Needs Approach. We will explore and evaluate this approach in the next section.

4 THE BASIC MINIMUM NEEDS APPROACH

In these two readings, you are introduced to the Basic Minimum Needs Approach. Once again, you are asked to study the approach and to analyse it critically.

READINGS:
Piyaratn, P. (1992). Ch 6: Basic Minimum Needs: Concepts and Practice. Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K. (eds.), *Integrating Food and Nutrition into Development: Thailand's Experiences and Future Visions.* 63-70.

Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K. (1992). Ch 21: Reflections on Thailand's Food and Nutrition Situation. Kachondham, Y., Winichagoon, P., Attig, G. A. & Tontisirin, K. (eds.), *Integrating Food and Nutrition into Development: Thailand's Experiences and Future Visions.* 227-231.

TASK 4 – Evaluate the potential of the Basic Minimum Needs Approach

Study the readings by Piyaratn (1992) and Kachondham *et al* and while you read, try to answer these questions:

a) Do you think that the Basic Minimum Needs Approach offers other countries a possible mechanism for gaining government commitment to health and nutrition development?
b) What kind of preparation would be needed in your own country to launch a similar initiative?

5 SESSION SUMMARY

Well done – you have completed another study session and have hopefully gained a sense of the importance of considering socio-political factors when planning health and in particular, nutrition programmes.

We have placed particular importance on community mobilisation and participation in this process. But as you will have realised, these processes must be coupled with the government's political will to ensure that the whole population's basic needs are met. This poses some real challenges to health workers and professionals. In the next session, we will explore principles and strategies to ensure community participation. Take a break before embarking on the third session of Unit 2.

6 REFERENCES

- Gillespie, S., Mason, J. & Martorell, R. (1996). *How Nutrition Improves.* ACC/SCN State-of-the-Art Series, Nutrition Policy Discussion paper No 15. 1-88.

- Mosley, W. H. (1985). Remarks. Halstead, S. B. Good Health at Low Cost. New York: The Rockefeller Foundation.

- Sanders, D. (1992). The State and Democratisation in Primary Health Care: Community Participation in Zimbabwe's Village Health Workers' Programme. Frankel, S. (ed.). *The Community Health Worker.* Oxford: Oxford University Press.

- Werner, D. & Sanders, D. (1997). *Questioning the Solution: The Politics of Primary Health Care and Child Survival.* Palo Alto, California: Health Wrights.

Unit 2 - Session 3
Community Participation

Introduction

Welcome to this session on community participation. In it, we will explore the concept of community participation and different ways in which community participation can be achieved. Community participation is like home baked bread – it is something that everybody likes very much but only a few actually fully understand how it is achieved. We hope that by the end of this session, you will have learnt a few secrets!

Contents

Timing of this session

This session contains twelve readings (four of which you have already summarised). There are also eleven tasks which are designed to help you engage with readings critically and to apply their content to your own situation. It should take you about five hours to complete. It would be logical to take a break after sections 5 and 6.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Describe the concept of *community participation*.
- Determine how to assess the degree of community participation in nutrition programmes.
- Explain why community participation is important for the success of nutrition programmes.
- Suggest an approach to community participation, which can make it a reality within nutrition programmes.

2 READINGS

Author/s	Publication details
Asthana, S.	(1994). Primary Health Care and Selective PHC: Community Participation in Health and Development. Phillips, D. & Verhasselt, Y. (eds.). *Health and Development*, London: Routledge.
Oakley, P. Kahssay & H. M.	*Community Involvement in Health Development: a Review of the Concept and Practice.* Geneva: WHO.
Kachondham, Y., Winichagoon. P., Tontisirin, K.	(1992). *Nutrition and Health in Thailand: Trends and Actions.* UN ACC/SCN country case study supported by UNICEF. Institute of Nutrition, Mahidol University.
Soekirman, I.T., Jus'at, I., Sumodiningrat, G. & Jalal, F.	(1992). *Economic Growth, Equity and Nutritional Improvement in Indonesia.* UN ACC/SCN country case study supported by UNICEF, UN Administrative Committee on Coordination, Subcommittee on Nutrition.
Reddy, V., Shekar, M., Rao, P. & Gillespie, S.	(1992). Nutrition in India. National Institute of Nutrition, Hyderabad, India. UN ACC/SCN country case study supported by UNICEF**.**
Kavishe, F. P.	*Nutrition-Relevant Actions in Tanzania.* UN ACC/SCN country case study supported by UNICEF. Tanzania Food and Nutrition Centre.
Shrimpton, R.	(1996). Community Participation in Food and Nutrition Programs: An Analysis of Recent Governmental Experiences. (Ed). Pelletier, D. Nutrition Actions. New York State: Cornell University Press.
Jennings, J., Gillespie, S., Mason, J., Lotfi, M. & Scialfa, T.	(1991). Ch 3 - Community Participation & Ch 4 - Management Information Systems. *Managing Successful Nutrition Programmes*. ACC/SCN State-of-the-Art Series, Nutrition Policy Discussion paper No 8. UN ACC/SCN.
Baum, F.	(1998). Communities, participation and social capital. *The New Public Health: An Australian Perspective*. Melbourne: Oxford University Press.
Baum, F. & Kahssay, H. M.	(1999). Health development structures: an untapped resource. Oakley, P.& Kahssay, H. M. *Community Involvement in Health Development: a Review of the Concept and Practice.* Geneva: WHO.

3 WHAT IS COMMUNITY PARTICIPATION?

In this section, we will explore the concept of *community participation* before discussing how to facilitate it.

TASK 1 – Define community participation

Begin this session by thinking about and writing down your own definition of community participation in health. When you have completed it, compare your definition to the ones outlined in the reading below.

READING:
Asthana*, S.* Primary Health Care and Selective PHC: Community Participation in Health and Development. Phillips, D. & Verhasselt, Y. (eds.). (1994). *Health and Development*, London: Routledge. 182-196.

After you have read this chapter, ask yourself the following questions:

a) Do you now want to change your definition of community participation?
b) What changes do you want to make and why?

FEEDBACK

From the reading, it should be clear to you that since the 1970's, the approach to development and therefore health, which emphasises building western health infrastructures and introducing western health practices, has been fundamentally re-appraised. *Participation* has been a central concept in this reappraisal.

Participation has taken a high profile and is regarded as a key concept in Primary Health Care because it is seen as the major way of ensuring effectiveness in health improvement.

This reading places the concept of participation in health in its historical and current political context. The centrality of participation in health arose as part of the revision of health in development, but was launched, as part of WHO's Primary Health Care approach, at a time of deepening worldwide economic recession and structural adjustment policies.

However, participation has also been the most controversial of PHC principles. It challenges the traditional notions of professional expert knowledge and roles. It clearly gives a place to local people, the lay person, in planning, implementing and evaluating health services and programmes. It attempts to enable people to gain the power to take political and individual control over factors that affect their health and their lives.

Finally you may be aware that quite often, community participation has been restricted to a process of consulting community members and gaining their permission to sanction development projects.

It is important to note that as we begin to explore the concept of participation, like Primary Health Care itself, we cannot identify or prescribe a model or even several possible models, for participation in health. The contexts of Primary Health Care in developing countries differ greatly. Political differences, with their different philosophies and the different relationships they imply with their citizens and their communities, have implications for working in health in these countries. What is needed, then, in our discussion of participation in health, is that you are able to identify and ask the critical questions that will guide you towards what will work best in your own context. This session cannot give you that answer since local conditions vary too dramatically. However it can provide you with the analytical skills to incorporate such analyses into your health and nutrition practice.

4 EXPLORING COMMUNITY PARTICIPATION

In this section, we look at the benefits of community participation and the different kinds of community participation that are possible.

4.1 The benefits of community participation

Think back to Session 2 where you encountered arguments promoting the idea of community participation, then try this task.

TASK 3 - Summarise your understanding of the benefits of community participation for nutrition programmes

Write down the possible benefits of community participation for nutrition programmes.

FEEDBACK

The World Health Organization has declared the benefits of participation thus: Coverage: Participatory projects involve more people than non-participatory projects and increase the number of beneficiaries of any development.

Efficiency: Participation promotes better co-ordination of resources, thus increasing the efficiency of their use.

Effectiveness: Goals, objectives, plans and strategies are more relevant as a result of participation.

Equity: Participation helps to promote the notion of providing benefits for those in greatest need.

Self reliance: Participation at community level increases people's control over their lives and so promotes a sense of self-reliance (WHO, 1991).

4.2 Different levels of community participation

There are, however, different kinds and levels of community participation. Now let's learn about the ways in which participation can be classified.

READING:
Oakley, P. & Kahssay , H. M. *Community Involvement in Health Development: a Review of the Concept and Practice.* Geneva: WHO. 3-19.

TASK 5 - Summarise different levels of community participation

Use this reading to complete the following table.

MODE OF PARTICIPATION	INVOLVEMENT OF LOCAL PEOPLE	RELATIONSHIP OF RESEARCH/ACTION TO LOCAL PEOPLE
Co-option		On local people
Compliance	Tasks are assigned with incentives; outsiders decide the agenda and direct the process.	
Consultation		For or with local people
Co-operation	Local people work together with outsiders to determine local priorities; responsibility remains with outsiders for directing the process.	With local people
Co-learning		With or by local people
Collective action		By local people

FEEDBACK

How did you do? We hope you found the activity easy. Check your table against the one below.

Types of Community Participation

Mode of Participation	Involvement of Local People	Relationship of Research/Action to Local People
Cooption	token, representatives are chosen but no real input or power	ON local people
Compliance	tasks are assigned with incentives; outsiders decide the agenda and direct the process.	FOR local people
Consultation	locals opinions are asked; outsiders analyze and decide on a course of action	FOR/WITH local people
Cooperation	local people work together with outsiders to determine local priorities; responsibility	WITH local people

	remains with outsiders for directing the process	
Co-learning	local people and outsiders share their knowledge to create new understanding and work together to form action plans, with outsider facilitation	WITH/BY local people
Collective action	local people set their own agenda and mobilize to carry it out in the absence of outsider initiators and facilitators	BY local people

4.3 Perspectives on community participation

Now let's consider different views or perspectives on participation in health development. At the broadest level of analysis, participation can fit into one of two views regarding its contribution to health and to health care in developing countries.

The first view, which is that imposed by western medicine, is that there is really very little wrong with the way health care has been delivered. It merely needs some fine-tuning. Participation fills some gaps, provides more information to local people, and enables people to commit themselves to the current health system, and in so doing ensure its success.

There have been serious criticisms of the first view of health care in developing countries. These include:

- It has not enabled people to think and act for themselves, and so it has kept them reliant and dependent on external knowledge and skills for solving health problems.
- It has failed to train a sufficient number of local people, and so many health care efforts have not been sustainable.
- It has often encouraged people to contribute resources to programmes and services, including cash payments, but it has not provided opportunities for those same people to participate in planning, implementing or evaluating the programmes and services.
- There has been a conflict and an incompatibility between health care needs that have been professionally determined and health-related needs, such as housing, water, and other structural issues, as determined by local people. This has caused local people to have little interest, involvement or sense of ownership of health services.

The second view argues that the direction of health development has been fundamentally flawed. Local people have been passive recipients of often inappropriate knowledge and methods. Participation, in this view, challenges the very core of the western medical approach to health development. Participation aims to ensure that people are active participants in their health care, acknowledging their knowledge as legitimate, and so producing new approaches, new knowledge, new directions, and new structures for health care in their communities.

The second view of participation has influenced the comprehensive PHC approach. It assumes that the knowledge for improving peoples' and communities' health status exists and that there is sufficient evidence of what perpetuates poverty. So, what is now imperative is to develop ways to involve local people, not only to support health efforts, but also to engage in the process of identifying needs, determining health priorities and deciding how to allocate scarce health resources.

5 FORMS OF COMMUNITY PARTICIPATION

By now you should be aware that *participation* is not a concept with a universally agreed-upon definition. It means different things to different people in different contexts. These differences have profound implications for health development and for health outcomes.

Another way of thinking about participation is whether it is regarded as a means or an end in itself. This is just one more useful line of thinking to appreciate the different, and very often competing and incompatible ways in which participation is conceived, and what assumptions and views of health provision each of these ways reflect.

- Participation as a means generally confers importance on something else such as the results of participation. Participation is seen as a more passive, static phenomenon and more of a temporary feature in the process of getting other things done.
- Participation, when regarded as an end in itself, is more akin to the notion of participation as a right. It is seen as a way of enabling participants to achieve power to participate and a process, which is enduring and sustained beyond a single programme or service. It is a built-up and bottom-up type of relationship.

There are other ways to view participation, for example, in terms of stages:

- Marginal participation: This means limited, temporary participation with little influence on outcomes or health development.
- Substantive participation: This is active involvement in determining priorities and implementing programmes, but with substantial external control and benefits that are generally limited to the programme itself.
- Structural participation: This is where participation is considered integral to health development activities and is part of the value base. Local people have enough power to ensure that their voices are heard, and they are able to influence the processes and outcomes.

We may also consider participation in relation to how it was initiated:

- Spontaneous and bottom-up.
- Induced by external factors and professionals.
- Compulsorily initiated by, say, a central government approach, as in many of the initiatives in China.

And one could also ask: in the long term, whose interests does this form of participation serve? Does the participation seek the co-operation of local people and does it intend to share power with them?

(Section adapted from Sanders *et al*, 2001)

6 ASSESSING COMMUNITY PARTICIPATION

Hopefully you have realised that there are many different ways of seeing community participation, but that the different levels of participation have a profound influence on the impact of a nutrition programme. It is therefore important to be able to assess the level and type of community participation that is taking place in a project. This task offers you to opportunity to apply your understanding to several case studies with which you are already familiar.

TASK 6 – Assess community participation in a range of programmes

Use the approach introduced in the table from Task 5 to complete an assessment for the countries as indicated in the table below. In this task, you are asked to assess the level of community participation achieved in each of the four case studies you studied in Unit 1, Session 3. They are listed below.

READINGS:

Kachondham, Y., Winichagoon. P., Tontisirin, K. (1992). *Nutrition and Health in Thailand: Trends and Actions.* UN ACC/SCN country case study supported by UNICEF. Institute of Nutrition, Mahidol University. 35-50.

Soekirman, I.T., Jus'at, I., Sumodiningrat, G. & Jalal, F. (1992). *Economic Growth, Equity and Nutritional Improvement in Indonesia.* UN ACC/SCN country case study supported by UNICEF, UN Administrative Committee on Coordination, Subcommittee on Nutrition.17-22.

Reddy, V., Shekar, M., Rao, P. & Gillespie, S. (1992). Nutrition in India. National Institute of Nutrition, Hyderabad, India. UN ACC/SCN country case study supported by UNICEF. 16-20.

Kavishe, F. P. *Nutrition-Relevant Actions in Tanzania.* UN ACC/SCN country case study supported by UNICEF. Tanzania Food and Nutrition Centre. 148-157.

CASE STUDY	LEVEL OF COMMUNITY PARTICIPATION
Thailand	
Indonesia	
Tamil Nadu, India	
Iringa, Tanzania	

FEEDBACK

How did you do? It wasn't very difficult was it? You will find more feedback in this reading by Shrimpton, where the author measures community participation in each of the projects mentioned above.

READING:
Shrimpton, R. (1996). Community Participation in Food and Nutrition Programs: An Analysis of Recent Governmental Experiences. (Ed). Pelletier, D. *Nutrition Actions*. New York State: Cornell University Press. 243-261.

Compare your table to Shrimpton's. How similar was your assessment? You should now be in a position to assess community participation in your own programme.

Further assistance for identifying participatory components of projects is contained in a Checklist on page 189 of the following reading.

READING:
Asthana, S. (1994). Primary Health Care and Selective PHC: Community participation in health and development. Phillips, D. & Verhasselt, Y. (eds.). *Health and Development*, London: Routledge. 189.

Study the reading and the checklist on page 189 of the reading before doing Task 8.

TASK 8 - Evaluate a checklist for assessing community participation

Evaluate the checklist on page 189 of Asthana (1994) in relation to a health programme or service with which you are familiar. Then ask yourself the following questions:

- How useful is this checklist in reaching a clear understanding of the form and extent of participation in the planning, implementation, control and evaluation aspects of the programme?
- How does this checklist inform your analysis?
- What are its shortcomings?
- What would you want to add to the checklist for it to be a more useful tool for your assessment and analysis?
- Do the points in the checklist really reflect the form and extent of participation?
- How would you rework the checklist?

FEEDBACK

Your evaluation and revision of this checklist may provide a useful tool for your assignment and for evaluation of nutrition programmes in the future. Now that you have familiarised yourself with community participation and how to assess it, we will focus on how to make community participation a reality.

7 MAKING COMMUNITY PARTICIPATION A REALITY

By now you should be aware that community participation has many benefits. However, there are a number of challenges to be faced in making it a reality. The next reading highlights some of these challenges.

7.1 Addressing the challenges of community participation

In this section, we offer two readings which address the challenge of community participation. The first one enumerates the challenges, while the second one offers the possibility of building social networks as an ongoing part of health work, in order to address some of these challenges.

READING:
Jennings, J., Gillespie, S., Mason, J., Lotfi, M. & Scialfa, T. (1991). Ch 3 – Community Participation & Ch 4 – Management Information Systems. *Managing Successful Nutrition Programmes*. ACC/SCN State-of-the-Art Series, Nutrition Policy Discussion paper No 8. UN ACC/SCN. 33-44 & 44-55.

TASK 9 – The challenges of incorporating community participation

As you work through the above reading, list the challenges of incorporating community participation into nutrition programmes. Add any points from your experience to those from the reading.

FEEDBACK

Here are some of the challenges that were identified:

- Community participation adds to the administrative complexity and cost of programmes as many more people and organisations now have to be consulted and involved in the programme.
- Community participation can add to the logistical costs of the project, as communities need to be reached in isolated areas.
- There is a danger that local elites can take over the process, as they are often the most well organised and powerful in small communities.
- Health professionals often assume they have more knowledge than community members with the knowledge of local people sometimes overlooked.
- Nutrition or health problems may not be perceived to be a priority for the community or they may demand food or monetary assistance instead of longer-term preventive interventions.
- Members of poorer communities may not be able to afford the time and resources necessary to contribute or participate in the programme.

One of your activities as a manager of a health programme is how to overcome these challenges. To help you think this through, here is a reading by Baum (1998).

READING:
Baum, F. (1998). Communities, participation and social capital. *The New Public Health: An Australian Perspective*. Melbourne: Oxford University Press. 93-99.

Baum points out that the odds have been stacked against the introduction of Primary Health Care and Health For All in this time of global economic recession and pressure exerted on developing nations by structural adjustment policies. However, in the reading, she suggests that, as we move into the new millennium, there is a backlash against the supremacy of wealth generation and the currently dominant economic paradigm. She suggests that one expression of this is the concept of *social capital* and the way it has captured the imagination of many policy makers, academics, researchers and practitioners.

Baum's description of social capital for Public Health is relevant to the debate on participation. She writes of opportunities for people to act collectively and to form networks. She also points to the need to focus on relationships between people rather than on individual behaviour.

What value can social capital add to your understanding of participation in health development and does it sharpen your tools of analysis in assessing the forms of participation that may be desirable and practicable in a particular cultural, social and political context?

You may want to follow up on some of the literature on social capital if you are interested in pursuing the role of trust, norms and networks in building

community. At the end of the Baum reading you are directed to some references to get you going in this direction.

7.2 The community participation potential of different forms of health structures

In making community participation a reality, different existing health structures will obviously play a role, offering more, or less potential. Baum and Kahssay (1999) conducted research from which they have extracted five potential health structures varying from formal to informal, which provide varying levels of community participation support.

READING:
Baum, F. & Kahssay, H. M. (1999). Health development structures: an untapped resource. Oakley, P.& Kahssay, H. M. *Community Involvement in Health Development: a Review of the Concept and Practice.* Geneva: WHO. 96-113.

TASK 10 – Survey existing health structures and their potential for community participation support

On page 97 of this reading, the authors identify different types of health development structures. In your own experience or current work setting, which of these structure types exist? What is their potential contribution to health development?

FEEDBACK

We hope that this discussion of forms of participation demonstrates that it is not possible to devise a one-size-fits-all model of participation. Determining the type, form and level of participation is an integral part of your work in health. You need to critically analyse the form that participation takes, and can take, in a particular context. It is obvious that the form of participation that is possible in a democracy may be very different from that which is possible, or even desirable, in an oppressive centralised political regime.

The final task in this session focuses on strategies for increasing community participation in health.

READING 25:
Oakley, P. & Kahssay , H. M. *Community Involvement in Health Development: a Review of the Concept and Practice.* Geneva: WHO. 124-137.

TASK 11 – Summarise strategies for increasing community involvement

As you work through Oakley and Kahssay, summarise the strategies that they recommend for increasing community involvement in health.

FEEDBACK

Which of these strategies can you use to improve community participation in your own programme?

8 SESSION SUMMARY

Congratulations on completing this substantial session. In the process of doing it, you have hopefully clarified that there are many interpretations and levels of community participation, and a range of structures to which you should look for building networks. It is also important to recognise that this is not an easy process, although a number of strategies have been suggested for strengthening networks. Revisit the intended outcomes of this session to be sure that you have achieved them all. Take a short break before starting the final session of this unit, the focus of which is advocacy for nutrition programming.

9 REFERENCES

- Sanders, D., Tesoriero, F. & Baum, F. (2001). Postgraduate Diploma in Public Health: *Health, Development and Primary Health Care.* SOPH, UWC.
- World Health Organisation. (1991).*Community Involvement In Health Development: Challenging Health Services*. WHO.

Unit 2 - Session 4
Advocacy Strategies

Introduction

Welcome to Session 4 which focuses on Advocacy Strategies. In this session you will clarify what is meant specifically by *advocacy*, who is regarded as an advocate and why you need to be an advocate for nutrition at the national, district and community levels. The session covers the eight basic elements of advocacy, and explores how to develop a strategy for advocacy. This is a very practical session and you are expected to develop your own strategy while you study. Enjoy the session.

Contents

Timing of this session

This session contains one reading which provides data to enable you to do one of the tasks. In this instance, the main reading is contained in the Study Session. There are also twenty tasks which are designed to help you engage with the process of designing an advocacy strategy. It should take you about three hours to complete.

1 LEARNING OUTCOMES OF THIS SESSION

By the end of this session, you should be able to:

- Explain the meaning of advocacy.
- Identify who can be termed an advocate.
- Describe the components of a conceptual framework for advocacy.
- Develop an advocacy strategy by undertaking the processes that follow:
- Write an advocacy goal and objectives.
- Explain how to do audience research and segmentation.
- Develop message content for a nutrition advocacy campaign.
- Determine approaches for delivering advocacy messages.
- Explain the decision making process in advocacy.
- Distinguish between networks and coalitions.
- Make effective presentations.
- Explain how to do fundraising for advocacy.

2 READINGS

Author	Publication details
Medical Research Council of SA.	(1998). *South African Demographic and Health Survey Data.* [Online]. Available: http://www.mrc.ac.za/bod/surveyfindings.htm: 6-12.

3 WHAT DO WE MEAN BY ADVOCACY AND WHO IS AN ADVOCATE?

Let's begin this session by clarifying the meaning of a number of key concepts.

TASK 1 – What is *advocacy*?

Read the following case study to help you answer the question, "What is advocacy?"

Case Study - Kenyan Advocates Succeed in Promoting Adolescent Health

One in four Kenyans is an adolescent and teens represent an ever-growing proportion of the population. Hospital treatment of teenagers for the consequences of unsafe abortion accounts for between 20% and 50% of all such cases. Teens aged 15-19 years also constitute approximately 40% of all reported cases of HIV and AIDS in

Kenya. Still the government of Kenya prohibits the distribution of contraceptives to adolescents.

In early 1990, the Center for the Study of Adolescence (CSA) was established to conduct research on adolescent health issues and to advocate for policies that promote the well-being of young people.

CSA encountered opposition to their advocacy efforts early on, but used this opposition to build a stronger and more creative force for adolescent reproductive health. Religious organizations that had attended several conferences on adolescent reproductive health in Kenya opposed CSA's work. They were so effective in their opposition to family life education in schools that the Ministry of Education threatened to eliminate the family life education programme from the curriculum.

Against this backdrop, youth serving organizations including CSA decided to develop a coalition to support adolescent reproductive health. In 1994, they established the Kenyan Association for the Promotion of Adolescent Health (KAPAH), conducted advocacy trainings and developed an advocacy strategy. KAPAH developed and distributed fact sheets on adolescent reproductive health that helped to dispel myths and misinformation about adolescent reproductive health and programmes such as family life education.

KAPAH also worked closely with the press to educate the public about the true content of family life education programmes and the extent of reproductive health problems facing Kenya's youth. In fact, KAPAH paid the newspaper to print an overview of the family life education curriculum and explain the contentious issues. KAPAH's media advocacy was so successful that they now regularly contribute views, opinions and advice to a column on adolescent health in a Kenyan newspaper. The column is sponsored and paid for by the Kenya Youth Initiative and funded by USAID.

Bravely, KAPAH also reached out to the opposition and engaged them in consultations in order to understand their concerns and to find common ground.

In addition, KAPAH met with individual policy makers and found that while these leaders supported adolescent health privately, it was difficult for some of them to take a public position on the subject. The Association made an effort to support these decision makers both publicly and "behind the scenes." As a result, KAPAH developed better relationships with several ministries including the Ministry of Education. In fact, KAPAH successfully advocated for pregnant schoolgirls to remain in school during pregnancy and to return to school after delivery.

KAPAH's success has more and more agencies requesting advocacy training and the debate over adolescent reproductive health in Kenya has intensified.

Now that you have read the case study, how would you explain what advocacy is?

FEEDBACK

I hope you mentioned some of the following points that describe advocacy:

- Advocacy is an action directed at changing the policies, positions or programmes of any type of institution.
- Advocacy is also pleading for, defending or recommending an idea ahead of other people.

From the case study, you might also have noted that:

- Advocacy is speaking up and drawing a community's attention to an important issue and directing decision makers towards a solution.
- Advocacy is working with other people and organizations to make a difference.
- Advocacy is putting a problem on the agenda, providing a solution to that problem and building support for acting on both the problem and the solution.

In the case of KAPAH, advocacy could also be described as involving many specific, short-term activities to reach a long-term version of change. Advocacy aims at changing an organisation internally or to alter an entire system.

- Advocacy consists of different strategies aimed at influencing decision-making at the organisational, local, provincial, national and international levels.
- Advocacy strategies can include lobbying, Social Marketing, information, education and communication (IEC), community organising, and many other "tactics".
- Advocacy is the process of people participating in decision-making processes that affect their lives.

As you can see, there is no one single definition of advocacy. It is a dynamic process involving an ever-changing set of actors, ideas, agendas and politics. Therefore as an effective advocate, you may succeed in influencing policy decision-making and implementation by educating leaders, policy makers or those who carry out policies; or by reforming existing policies, laws and budgets, and developing new programmes; and lastly by creating more democratic, open and accountable decision-making structures and procedures.

By now, it should be clear that there are many ways to define or explain advocacy. Advocacy is the act or process of supporting a cause or issue. Advocacy, like Information, Education and Communication (IEC), community mobilisation and public relations share a common goal - of influencing the attitudes or behaviours of a target audience. Advocacy aims to influence key leaders and decision makers to institute or change laws, policies, organisational practices and procedures or resource allocations.

TASK 2 – Describe an advocate

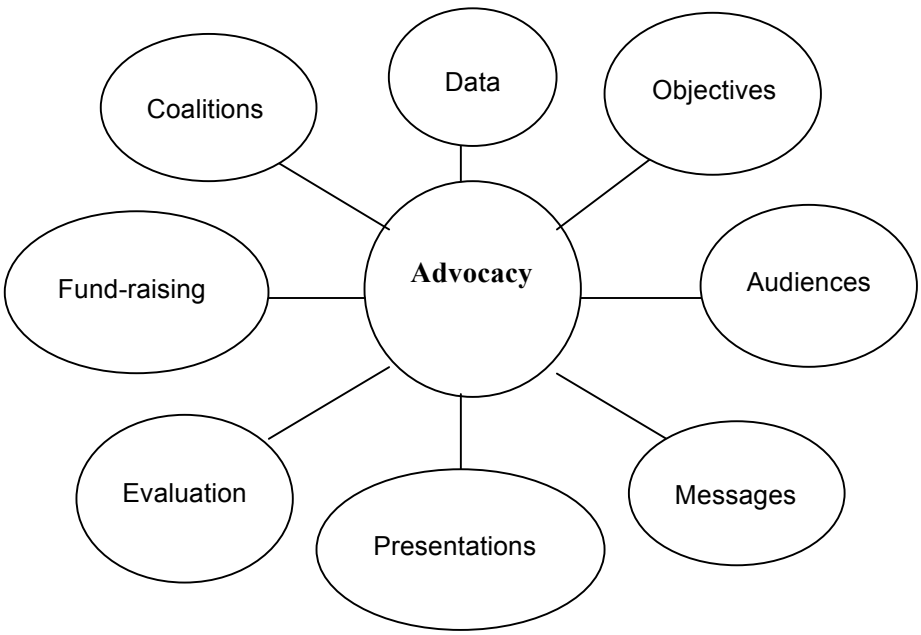
How would you describe an advocate?

FEEDBACK

An advocate is always someone with *passion and commitment.* Advocates are convinced believers in what they are trying to advocate. Advocates can also be satisfied users of a product or a service, such as family planning. Because they were assisted, they want to convince others about the benefits they have derived from such a service. Advocates are also persons with a vested interest in bringing about a change in policy or getting a law enacted. Advocates want to build support for a cause or issue, influence others to support it or try to influence or change legislation that affects that cause or issue. I hope you are an advocate for nutrition and nutrition related issues!

4 A CONCEPTUAL FRAMEWORK FOR ADVOCACY

You already know that advocacy is a dynamic process involving an ever-changing set of actors, ideas, agendas and politics. A useful conceptual diagram can be used to understand the advocacy more deeply: in it, eight key elements of advocacy are identified as shown in the following diagram. We will explore each of these processes in detail in the course of this session.



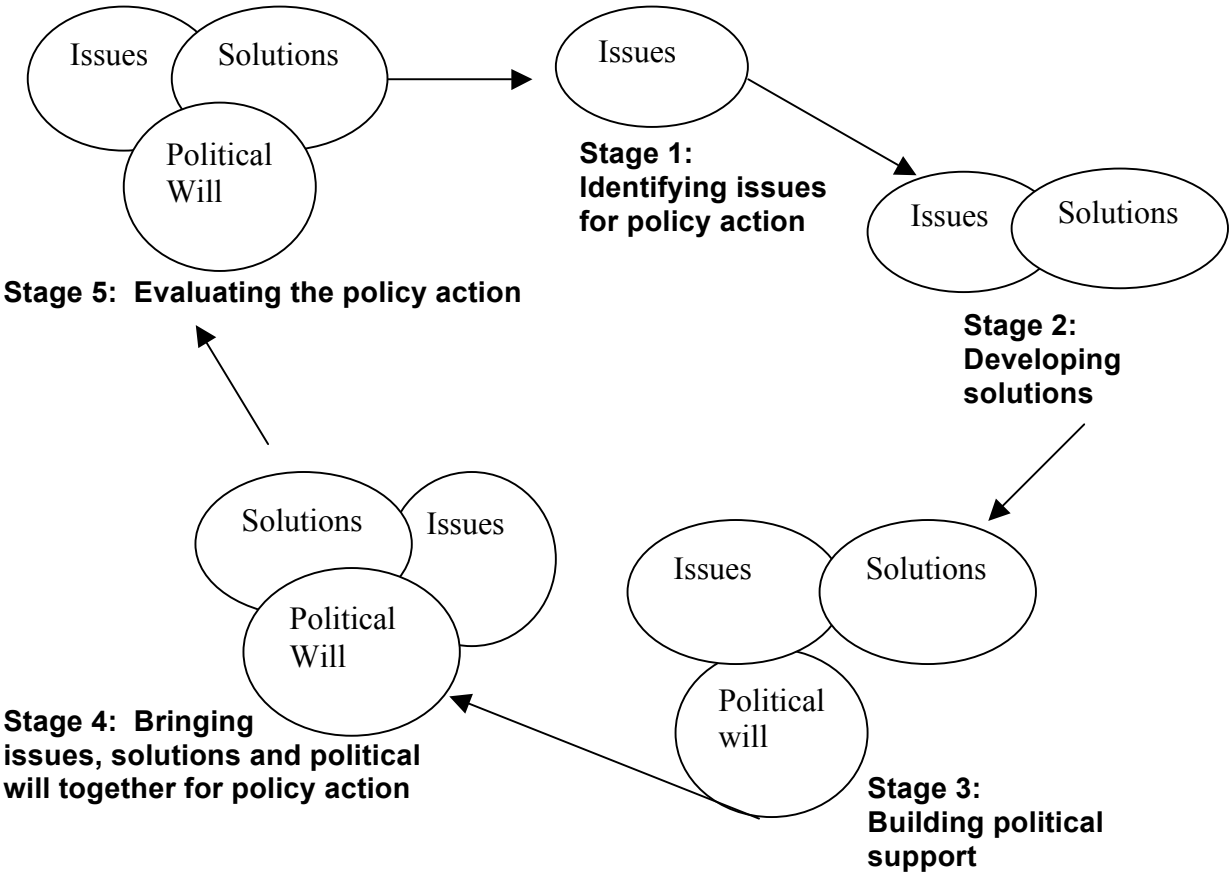
4.1 The stages of the advocacy process

Advocacy is a multifaceted process, and can also be divided into five stages. These are:

- Issue identification.
- Solution formulation and selection.
- Awareness building.
- Policy action.
- Evaluation.

These stages are fluid because they may occur simultaneously or progressively. You should also note that at times, the process might stall or reverse itself. The following diagram shows the advocacy process.

The Dynamic Advocacy Process



Here is a further explanation of these stages.

Stage 1 is the identification of an issue for policy action. This stage is also referred to as agenda setting. There are an unlimited number of problems that need attention, but not all can get a place on the action agenda. As an advocate you must decide which problem to address and attempt to get the target institution to recognise that the problem needs action.

Generally, Stage 2, solution formulation, follows rapidly. Advocates and other key actors propose solutions to the problem and select one that is politically, economically and socially feasible.

Stage 3, building the political will to act on the problem and its solution, is the centrepiece of advocacy. Actions during this stage include coalition building, meeting with decision makers, awareness building and delivering effective messages.

Stage 4, policy action, takes place when a problem is recognised, its solution is accepted and there is political will to act, all at the same time. This overlap is usually a short window of opportunity which advocates must seize. An understanding of the decision-making process and a solid advocacy strategy will increase the likelihood of creating windows of opportunity for action.

Stage 5, evaluation, which is the final stage, is often not reached, though it is important. Good advocates evaluate or assess the effectiveness of their past efforts and set new goals based on their experiences. Advocates and the institution that adopts the policy change should periodically evaluate the effectiveness of that change.

5 DEVELOP AN ADVOCACY PROCESS

As was noted in the diagram above, the eight elements of the advocacy process that we will discuss are:

- Identifying Policy Issues
- Selecting an Advocacy Objective
- Researching Policy Audiences
- Developing and Delivering Policy Messages
- Understanding the Decision Making Process
- Building Alliances
- Making Effective Presentations
- Fundraising for Advocacy

TASK 3 – Identify an opportunity for advocacy

As you proceed through the rest of the session, you are expected to develop your own advocacy strategy plan related to a nutrition issue which you consider important. Choose one nutrition advocacy objective, and develop an advocacy strategy based on the process to which you will be introduced. Your strategy will be written up as a plan and must include all of the following:

- An advocacy goal
- An advocacy objective
- Data and research findings about your objective
- Audiences
- Messages
- A list of key decision makers
- Networks and coalitions you will work with
- A plan for financial resources

You will be introduced to how to develop these sections in the rest of the session. Your outcome for Task 4 will consist of all the Tasks that follow.

Let's begin with the first element of the conceptual Framework for Advocacy: Identifying Policy Issues.

5.1 Identifying Policy Issues

In the previous section, you were introduced to a five stage process for an advocacy strategy. Do you remember what the first stage involved? If not, look back at the diagram and your answer to Task 3. The first stage involved identifying issues for policy action. The starting point for determining those issues is doing good research and having good data.

The policy process, that is, selecting one policy option from among several choices, is essentially a negotiation among various actors. In order to be included in the negotiation process, data and research must be translated into information and presented in formats that policy makers can understand and use. In this way, the facts can be made to "speak" the language of policy makers, community leaders, advocates, the public and the media. Thus the influence of data and research will be amplified.

You should remember that data could be both quantitative and qualitative information, gathered through an objective research process. Data can be used to identify issues for policy actions and to widen the range of possible solutions to a problem. Data can also be used to:

- affect what is considered changeable or do-able in a policy process;
- choose an advocacy goal;
- directly influence decision makers (the primary audience of an advocacy programme);
- inform the media, public or others (the secondary audience) who indirectly influence decision makers;
- support an existing advocacy position;
- counter oppositional positions and arguments;
- alter the perceptions about an issue or problem;
- challenge myths and assumptions;
- reconsider strategies that are now working.

TASK 4 – Ways of determining policy issues for advocacy

How do you determine policy issues for advocacy?

FEEDBACK

The process of determining policy issues for advocacy begins by identifying issues that require policy action, that is, problems that can be addressed by the actions of institutions and individuals representing these institutions.

A variety of policy actors identify issues for action, using techniques from the spontaneous generation of ideas to the cautious and deliberate study of issues. For example, breastfeeding interest groups may highlight a crisis and call for urgent policy action on breast milk substitutes, while economic research institutes might research a situation thoroughly before offering a policy proposal.

Research data can bring suspected or even unknown issues into focus and can provide a comparison among issues. Data may also uncover constraints that may signal potential difficulties in the advocacy process.

Reading:
Medical Research Council of SA. (1998). *South African Demographic and Health Survey Data*. [Online]. Available: http://www.mrc.ac.za/bod/surveyfindings.htm: 6-12.

Let's use the data provided in the *South African Demographic and Health Survey* from 1998 for the Eastern Cape to see how data can be used to identify issues for policy action.

TASK 5 – Using data to identify issues for advocacy

Look at the SADHS data. Come up with one idea from each chart about how the Eastern Cape's nutrition programme could be improved.

FEEDBACK

Did you come up with any ideas about how the Eastern Cape nutrition programme could be improved? Here are some other suggestions you might consider. These are all issues that institutional policies or resources could influence.

The data suggests:

Advocacy issue 1:	Exclusive breastfeeding practices are not very common.
Advocacy issue 2:	The infant mortality rate for the Eastern Cape is the highest in the country at 61.2.
Advocacy issue 3:	Immunisation coverage is lower in rural than in urban areas.

Now that you have identified several problems or issues that require action, the next step is to develop policy solutions for these problems.

Here are some policy solutions to the problems suggested by the data:

Advocacy issue/problem 1: Low prevalence of exclusive breastfeeding.

Policy Solution:	Direct breastfeeding education programmes to increase the duration of exclusive breastfeeding. Give attention to the optimal timing for such education of the mother-to-be. Also target significant others (or those who could exert an influence on mothers).
Advocacy issue/problem 2:	Infant mortality rate is very high.
Policy Solution:	Increase funding for water and sanitation programmes.
Advocacy issue/problem 3:	Immunisation coverage is low.
Policy Solution:	Empower rural people to participate in immunisation and growth monitoring programmes.

How did you do? I hope you were able to identify the problems and policy solutions that the data suggests. You should be aware that there are some factors that promote or hinder the use of data and research for advocacy and policy making.

Factors that promote the use of data and research for advocacy

Here are factors that *promote* the use of data and research:

- The information needs of the policy maker are taken into account when designing the study.
- Research is conducted by an organisation that policy makers perceive as credible and reliable.
- Research is focused on a few questions that can be answered.
- Findings are presented in multiple formats, tailored to each audience.
- Findings are disseminated to multiple audiences using a variety of channels.
- Audiences receive the same message from diverse sources.
- Presentations of findings to policy makers emphasise the important lessons that were learned, rather than the need for more research.

Factors that hinder the use of data and research for advocacy

Here are the factors that *hinder* the use of data and research:

- Research questions (and findings) are sometimes not relevant to policy decisions.
- The timing can be difficult: research may answer yesterday's questions or assess yesterday's programme.
- The research is conducted or presented by an organisation or individual that is not credible to policy makers.
- Findings are inconclusive or subject to widely differing interpretations.
- Findings are unwelcome because they are negative and/or not presented with policy relevant solutions.
- Findings are presented in lengthy, technical, or jargon-laden reports.
- Findings are not widely disseminated.

You have now come to the end of the section on identifying policy issues. Let's move on to the second element of the framework - selecting an advocacy objective.

5.2.1 Selecting an Advocacy Objective

In section 5.1, you identified issues for policy or programmatic action and corresponding solutions. Selecting one of these solutions to work on as an advocacy objective is the next step in planning your advocacy effort. When choosing an objective for advocacy you should consider

- the political climate;
- the probability of success;
- research and data on your issue;
- money available to support your advocacy efforts;
- your organisation's capabilities;
- your own capabilities.

What is an objective in the advocacy context? An objective is an incremental and realistic step toward a larger goal or your vision. In order to develop an objective, you must know the target institution and decision makers in order to create a persuasive communication plan and to discern how you can influence the institution's decision-making process. The advocacy objective should be specific and measurable so that you will know whether or not you have attained your objective in the time frame you have specified. From the objective, it should be possible to develop an effective strategy to reach your policy change goal. A goal can also be referred to as your vision.

Here are some examples of advocacy objectives

- Increase government funding for nutrition programmes by 25% in the next two years.
- Initiate a government-sponsored programme to fortify salt with iodine in the next 3 years.
- Start community nutrition education programmes in five selected districts in the Eastern and Northern Cape Provinces in the next year.

TASK 6 – Selecting an advocacy objective

In Task 5, you used data to determine your advocacy objective. But imagine that you do not have this data. Close your eyes and make a wish for what you would like to see in the next ten or twenty years as far as nutrition in South Africa is concerned. What did you wish for? If your wish is to see all South African children well nourished, and free from malnutrition, then this becomes your advocacy objective or goal. Link it to your own programme or a context that you know well in order to take this process further. Now clarify your advocacy goal by writing it down clearly and sharing it with your colleagues.

FEEDBACK

The objective or goal is the subject of your advocacy effort. It is what you hope to achieve over the next 10-20 years. Your advocacy goal can be general, for example, "to reduce childhood malnutrition" or "to eliminate Vitamin A deficiency".

An advocacy objective aims to change the policies, programmes or positions of governments, institutions or organisations. An advocacy objective is what you want to change, who will make the change, by how much and by when. Generally the time frame for an advocacy objective is 1-3 years.

TASK 7 – Refining your advocacy objective

Now check that your advocacy objective is specific, measurable, achievable, realistic and time bound i.e. SMART and complies with the following criteria. These criteria can help uncover potential obstacles or possible allies. The same criteria can be used to analyse and/or choose an overall advocacy goal or issue.

CHECKLIST FOR SELECTING AN ADVOCACY OBJECTIVE

- Do qualitative or quantitative data exist to show that achieving the objective will improve the situation?
- Is the objective achievable? Even with opposition?
- Will the goal/objective gain the support of many people?
- Do people care about the goal/objective deeply enough to take action?
- Will you be able to raise money or other resources to support your work on the goal/objective?
- Can you clearly identify the target decision makers?
- Is the goal/objective easy to explain/be understood?
- Does the objective have a clear time frame that is realistic?
- Do you have the necessary alliances with key individuals or organisations to reach your objective?
- How will the objective help build new alliances with other leaders, stakeholders or NGO's?
- Will working on the advocacy objective provide people with opportunities to learn about and become involved with the decision making process?

FEEDBACK

Does your advocacy objective satisfy the criteria in the checklist? Good!! Let's now think about how you can build the support you need to make your objective a reality.

First of all, it is generally advisable to focus only on as many objectives as you can realistically achieve. If you, as an advocate, attempt to fix everything, you run the risk of changing nothing in the process. You therefore need to focus on an advocacy objective that will give you more *credibility*, and therefore more enthusiasm and experience to conquer more ambitious objectives.

5.3 Policy audience analyses

The list of criteria above has already raised the issue of being aware of the stakeholders and decision-makers who will help you reach your objective. The key to effective advocacy is focusing on audiences that can have an impact on the decision-making process. In this task, analyse the audience/s of your advocacy strategy.

TASK 8 – Conduct an audience analysis

a) Make a list of people and organisations that can help you to reach your advocacy objective.
b) Who do you need to convince to take action to help you do this?

FEEDBACK

I hope your list included key decision and policy makers, influential leaders, NGO's and other professionals at the community, district, region, province and national levels.

To reach these people, you need to do some audience research. Let's find out more about researching policy audiences.

An audience-centred approach, based on Social Marketing techniques offers the necessary tools to distinguish, analyse, reach and motivate key policy players. These techniques can help you to target the institutions and people that are critical to your success, rather than attempting to reach all decision makers and sectors of society.

To understand the knowledge, attitudes and beliefs of your audience, you must do some audience research. The starting point of your research is *audience segmentation* which is a way of grouping key decision and policy makers, influential leaders, NGO's and other professionals at the community, district, region, province and national levels into sub-groups with similar characteristics. You can then learn more about the sub-groups and target your messages to the particular concerns of each sub-group.

In addition to being familiar with what any given audience knows and feels about your objective, it is also critical to learn about their internal norms, informal rules or codes of conduct.

Your audience can be divided into the primary and secondary audiences. The primary audience consists of the key decision makers with the authority to affect the outcome of your advocacy objective directly. These are the individuals who must actively approve the policy change and as decision makers, they are the primary targets of an advocacy strategy.

The secondary audiences are individuals and groups that can influence the decision makers or primary audiences. The opinions and actions of these influential people are important in achieving the advocacy objective in so far as they affect the opinions and actions of the decision makers.

TASK 9 - Identify your primary and secondary audiences

For your advocacy objective, write down all the members of the primary and secondary audiences. A useful tool to research your audiences is called policy mapping. Use this Policy Map tool to help you do this.

POLICY MAP 1: WHO ARE YOUR AUDIENCES?

ADVOCACY OBJECTIVE	
Primary audience - targets	**Secondary audience - influentials**
1.	1. 2. 3. 4. 5.
2.	1. 2. 3. 4. 5.
3.	1. 2. 3. 4. 5.
4.	1. 2. 3. 4. 5.

Using the Policy Map you have just completed, do this task with a colleague who is also familiar with the context in which you are working.

a) Check with your colleagues that all key decision makers and other influential players related to your advocacy objective have been included.
b) Decide who is in a position to and needs to take action, then rank the decision makers in order of importance.
c) Now determine who can influence these action-takers (decision makers). Don't forget to include spouses and partners!

FEEDBACK

I hope you were able to identify these important targets of your strategy. Note also that some members of a primary audience can also be a secondary Audience if they can influence other decision makers. For example, the Director of Nutrition might influence the Minister of Health or the Minister of Finance and influence one another's opinions. Therefore, the Director is both a primary audience (target) and a secondary audience (influential).

Furthermore, your secondary audience may contain oppositional forces to your advocacy objective. If so, it is extremely important to include these groups on your list, learn about them and address them as part of your strategy.

There are many kinds of policy audiences. Broad, loose groups such as parents can be targeted, or highly specified groups such as an individual parent organisation located in the province of a key parliamentarian.

5.3.1 Researching your audiences' views and attitudes

Once you have identified your primary and secondary audiences, you need to learn more about their opinions, attitudes and beliefs about your advocacy issue and objective. There are a number of techniques you can use for audience research.

The most common way to gather information about audiences cheaply and quickly is through observation. Therefore you should talk with people who are familiar with the group or organisation you are trying to advocate with. In addition, you should talk with other advocates and colleagues. This is especially helpful in learning what audiences really think about issues. It is important to realise that their true opinion may be different from their official position.

Other things you could do in the process of audience research are:

- Read speeches or other documents written by the key organisations or individuals.
- Review the results of recent polls, surveys or focus groups.
- Attend open meetings where the individual or group will be speaking or participating.
- Conduct surveys or polls to learn about large audiences such as "voters", "parents" or "youth".
- Organise focus group discussions to get an in-depth perspective on what people think and why.
- Conduct individual interviews with a representative if you cannot afford to do a survey, poll or focus group.

The second phase of policy mapping is to chart what audiences know, believe and feel about an issue. In addition, it can be useful to know what other issues an audience cares deeply about. If you can link your objective to one of these issues, the audience is much more likely to support your effort.

TASK 10 – Researching your audience's knowledge and values

a) Use the following tool to help you chart what your audiences know and think about your objective.
b) If you are unsure about how an audience feels or what they know, enter the words "research needed" in the appropriate box.

POLICY MAP 2: WHAT DO YOUR AUDIENCES KNOW AND THINK?

ADVOCACY OBJECTIVE:			
Audience	**Audience's knowledge about issue/objective**	**Audience beliefs and attitudes about issue/objective**	**Issues that the audience cares about (may be unrelated to your issue)**

FEEDBACK

Do you feel you better understand your audiences' attitudes, beliefs and knowledge about your objective? What are the gaps and what further research do you need to do?

In the next part of this study session, let's look at the fourth element in the advocacy process, that is, developing and delivering policy messages.

5.4.1 Developing and delivering policy messages

We are working through the eight elements of the Conceptual Framework for advocacy presented at the start of section 5. We will now focus on delivering your message.

One of the most effective ways to build awareness about your issue and to generate backing for your goal is to develop messages for the different sub-groups you have identified in your audience analysis.

TASK 11 – Guidelines for your message content

Before you start to develop your messages, write down five guidelines for the content of advocacy messages.

FEEDBACK

Did you write something like this:

- A message must be a concise and persuasive statement.
- It must relate to your advocacy goal and objective.
- It should capture what you want to achieve.
- It should say why and how this will be achieved.
- Since the underlying purpose of a message is to create action, your message should include the specific action you would like the audience to take.

There are five key elements of messages. Content is only one part of a message. Other non-verbal factors such as who delivers the message, where a message is delivered or the timing of the message can be as, or more, important than the content. In addition, sometimes *what is not* said delivers a louder message than *what is said*.

Here are some ideas for you to consider as you develop your messages.

GUIDING QUESTIONS FOR DEVELOPING MESSAGES

Content or ideas:	What ideas do you want to convey? What arguments will you use to persuade your audience? The key elements of message content therefore are *what* you want to achieve*,* *why* you want to achieve it (the positive result of taking action and/or the negative result of not taking action), *how* you propose to achieve it and *what action* you want the audience to take.
Language:	What words will you choose to get your message across clearly and effectively? Are there words you should or should not use? Successful messages often incorporate words, phrases or ideas that have positive connotations or that have particular significance to a target group.
Source/messenger:	Who will the audience respond to and find credible?
Format:	Which way(s) will you deliver your message for maximum impact, for example, in a meeting, letter, brochure or radio?
Time and place:	When is the best time to deliver the message? Is there a place to deliver your message that will enhance its credibility or give it more political impact?

TASK 12 – Develop different messages for different audiences

Look at your objective and what you know about your audiences. Use a form like this to write one message for your primary and one for your secondary audience.

POLICY ADVOCACY MESSAGES

Audience	
Action you want the audience to take	
Message Content	
Format(s)	
Messengers	
Time and place for delivery	

FEEDBACK

How did you do? Was this an easy task? Share your forms with your colleagues and see if they agree with your messages and the other details you have proposed.

5.5 Understanding the decision making process

By now you have identified your advocacy objective, you have segmented your audiences and you know how to develop and deliver a targeted message. As an advocate you must become extremely familiar with the decision-making process that you are attempting to influence. The more you know about this process, the more power you will have to influence it.

Decision making can be categorised as formal and informal. The formal decision making process is the official procedure as stated by the law or by

documented organisational policy. For example, within an institution or organisation, regulations for instituting policy changes may have to be voted on by a board of directors, or officially approved by an executive director.

In the informal decision making process, activities and procedures take place at the same time as the formal process but are not required by law or organisational policy. They are, however, also effective in influencing decision-making. For example, if the head of an organisation feels that a decision by her board of directors is not warranted for a minor policy change, she can discuss the change with key staff, make a decision and implement the change without "official" action.

There are five basic stages of decision-making. They are:

Stage 1: Generate ideas/proposals within the decision making body
An issue is added to the action agenda of an institution. The institution develops a policy proposal. Proposal ideas may come from outside or inside the organisation.

Stage 2: Formally introduce the proposal into the decision making process
The formal decision making process for the proposal begins. For example, an act is introduced into parliament, a proposal is sent to a board of directors for consideration, or an item is added to the agenda of a ministry meeting.

Stage 3: Deliberate
The proposal is discussed, debated and perhaps altered. For example, a group of decision makers has a discussion or the proposal is debated on the floor of the parliament.

Stage 4: Approve or reject
The proposal is formally approved or rejected. For example, a vote is taken or decision makers reach consensus or one or several decision makers reach a decision.

Stage 5: Advance to the next level, implement or return to a previous stage
If the proposal is approved, it may move to the next level of decision-making. If the proposal is accepted at the highest level, it will move to implementation. If rejected, it may return to a previous stage for alteration or reconsideration.

TASK 13 – Identify decision-making processes

a) For your advocacy objective, write down which decision making processes or institution are you trying to influence. Are there more formal or informal decision-making processes and why?

b) Use these questions to analyse decision making opportunities more accurately:

- What organisation or policy making body will make the decision you are trying to influence?
- What is the formal decision making process of this institution? What are the steps in the formal process?
- When will each step take place?
- What are the informal workings or "behind the scenes" actions for the decision making process?
- Who is/are the key decision makers at each stage?
- Which steps are open to outside input? Which stages in the process can you influence and how?

In order to really affect decision-making, plan the process in detail by matching the information generated in Task 13 with the five stages of the decision making process. It is useful to develop a grid or policy map for each stage. Here are the stages again:
Stage 1: Generate proposal
Stage 2: Introduce proposal
Stage 3: Deliberate
Stage 4: Reject
Stage 5: Advances to the next level.

TASK 14 – Plan a detailed strategy for influencing decisions

We have provided a policy map for Stage 1. Make copies of it and using your advocacy objective, fill in a map for Stages 1–5 for your advocacy strategy.

If possible, discuss the issue with your colleagues. Remember to determine which decision-making institution you are trying to influence. Is the official decision making process you are trying to influence more formal or informal?

POLICY PROCESS MAP: STAGE ONE – GENERATE PROPOSAL

Generate Proposal:	
Institution/Organisation	
Formal process	
Informal process	
Decision makers involved	
Approximate date of action	
How we can influence the process at this stage?	

FEEDBACK

I hope you have been able to fill in all the policy mapping forms.

Remember that when you are trying to advocate a strategy, do not give up on the formal process, even when you are going to try some alternative methods. Policy and programmatic changes made within formal structures have the benefit of being more permanent and providing a precedent for future actions. Therefore, keep working on the formal structure even as you expand into alternative arenas.

It is also important, however, to consider what to do if it is not possible to influence decisions either formally or informally.

If the formal and informal processes of influencing policy do not seem to be working, you may have to try an alternative process. Once you have ascertained whether your objective can be achieved through alternative means, the next questions to ask are:

- Who can effectively implement the policy/programme change without official action?
- How can you reach these people and help them to make the change?
- Would these people join your advocacy effort to change the official policy/programme?

Let's now discuss about another element in the advocacy process, that is, building alliances.

5.6 Building Alliances

As an advocate, you must constantly build networks among people and sometimes coalitions amongst organisations in order to bring about change. Often you can do together what no one can do alone.

Networks and coalitions take time and energy to develop and maintain because they involve building relationships of trust with other people. Many advocates find this aspect of their work to be both the most difficult as well as the most rewarding professionally and personally.

5.6.1 Networks

Think for a moment – what do you understand by the term *network*? We all have networks of friends, relatives, colleagues and acquaintances that we can call on for support from time to time. An advocacy network is similar, except that it is built consciously and deliberately to assist in reaching your advocacy objective. A network therefore consists of individuals or organizations, willing to assist one another or to collaborate to achieve an advocacy objective. Networks, because they are informal and fluid, are easy to create and maintain.

There are no rules for building networks because your style will be as unique as your personality and tailored to the relationship you have with each person in your network. Here are some steps you should follow to help you start your advocacy network.

GUIDELINES FOR BUILDING AN ADVOCACY NETWORK

- Identify individuals and organisations that are working toward the same objective as you are. You should also include people in your network who can influence decision makers and if possible, the decision makers, themselves. Keep your eyes and ears and mind open for anyone else who could help you.
- It is important to build an open and trusting relationship from the beginning. Here are a few suggestions for how you can do this:
  - Collaborate on projects of mutual interest.
  - Help bring attention to their work.
  - Assist them with special projects.
  - Share information with them.
  - Attend their meetings and invite them to yours.
- Get them interested in your advocacy objective by discussing your idea with them. Be open to their suggestions and ideas. This can help to ensure shared ownership of the idea.
- When you are ready, ask them to do something specific to help you reach your objective. For example, “Could you arrange for a meeting with the director and present our idea together?”

TASK 15 – List your advocacy network

Make a list of some of the people in your current network that could help you with advocacy. Who else should you network with?

FEEDBACK

I hope you have included people and organisations with whom you can network and those who are supportive of your idea.

5.6.2 Coalitions

Now that you know about networks, let’s discuss coalitions. What do you understand by the term *coalition*?

A coalition is a group of organisations working together in a coordinated fashion towards a common goal. Coalitions require far more wok than networks, but the results can also be much greater. Coalition building should augment, not replace,your existing networks.

There are advantages and disadvantages to working in coalitions. Look at the following table for some of these.

Advantages	Disadvantages
Enlarges your base of support; you can win together what you can't win alone. Provides safety for advocacy efforts and protection for members who may not be able to take action alone. Magnifies existing resources by pooling them and by delegating work to others in the coalition. Increases financial and programmatic resources for an advocacy campaign. Enhances the credibility and influence of an advocacy campaign, as well as that of coalition members. Helps develop new leadership. Assists in individual and organisational networking. Broadens the scope of your work.	Distracts you from other work. Can take too much time away from regular organisational tasks. May require you to compromise your position on issues or tactics. May require you to give in to more powerful organisations. Power is not always distributed equally among coalition members; larger or richer organizations can have more say. You may not always get credit for your work. Sometimes the coalition as a whole as a whole gets recognition rather than individual members. Well-run coalitions should strive to highlight their members as often as possible. If the coalition process breaks down, it can harm everyone's advocacy by damaging members' credibility.

There are many types of coalitions. They are not mutually exclusive and although each type serves a purpose. Different types of coalitions will attract different organisations.

Permanent coalitions are incorporated organisations with a staff and board of directors. Decision-making is structured and systematic. Members often pay yearly dues. Many coalitions start as temporary and informal groups and can take years to mature into a permanent coalition such as an association, trade union or federation.

Temporary coalitions come together for a specific purpose or goal. When the goal is achieved, the coalition disbands. Sometimes the coalition can remain intact if it takes on another goal or advocacy objective.

Formal coalitions are recognised because members join formally, pay dues, and are identified as coalition members on letterheads and statements.

An informal coalition is where there is no official membership and therefore the members constantly change. With membership turnover, the issues and tactics of the coalition may also shift.

A geographic coalition is based on a specific geographic area such as a school district or a region.

Multi-issue and single-issue coalitions work on a number of issues or advocacy objectives or on one issue at a time.

TASK 16 – Identify nutrition coalitions

Make a list of the coalitions you know of that are working to improve nutrition. Which one do you belong to? Which other ones would you join and why?

FEEDBACK

I hope you used the information above on the advantages and disadvantages of coalitions to help you answer the question "Which ones would you join?" Now let's think about how to participate in coalitions.

GUIDELINES FOR PARTICIPATING IN A COALITION

The following hints will help you benefit from any coalition you join.

- Understand clearly who is running the coalition, who the members are and what the goals and positions are before you join.
- Be sure you understand clearly the financial, programmatic and staff support you and your organisation will be expected to contribute.
- Make sure you and your organisation have the time and resources to participate.
- Find out exactly how your organisation will benefit by being involved. Learn what the coalition will offer you. Will you gain access to decision makers or the media?
- Do not miss meetings. A coalition will not be responsive to your needs and requests unless you are committed to participating. You need to be at the meeting to speak up and be heard.

Organising a coalition

If you plan to take on the responsibility and effort of organising a coalition, here are two different ways to do this:

- Have an open meeting: This is one of the most common ways to organise a coalition quickly. It is usually used for informal coalition building or if your advocacy objective is flexible. You can issue an invitation to a broad array of organisations or publish an announcement in a newsletter.
- Assemble the coalition by invitation only. This method is used to create more solid, long-term coalitions. The agenda and advocacy issue is more

likely to stay focused on your objective and you can select the groups that will bring prestige, power, resources and energy to your effort.

GUIDELINES FOR RUNNING AN EFFECTIVE COALITION

Lastly, here are some tips for running an effective coalition:

- At the first meeting of a new coalition, you should clearly state the purpose for forming the new coalition, the goals, what is expected of each member and the benefits of membership.
- Keep in personal contact with key coalition members and make sure that all members are informed regularly of developments on your issue or advocacy objective, actions taken or other items of interest.
- Get to know all the coalition members well so as to be properly informed about their positions and opinions.
- Achieve consensus among coalition members on short and long term goals.
- Involve powerful coalition members in all decision making.
- Keep coalition meetings brief and on a regular schedule.
- Develop sub-groups strategically to take on different tasks.
- Do not avoid troublesome issues. Difficult issues must be discussed openly at meetings or they will split apart your coalition.

Take a short break before studying the next section on the seventh element of advocacy - making effective presentations.

5.7 Making Effective Presentations

Meeting with decision makers or other important audiences is where preparation meets opportunity. Often, these opportunities are brief and you may have only one chance to make your case, so making a presentation that will persuade and inspire your audience requires solid preparation.

You will recall from an earlier study session on audience segmentation, we discussed the importance of relationships that you, as advocate, develop with decision makers, influentials and other key audiences. The stronger the ties of trust, mutual support and credibility between you and your audiences, the more effective you will be as an advocate.

TASK 17 - Ways of building good relationships

List the ways in which you build good relationships with key individuals.

FEEDBACK

Here are some suggestions for doing this. I hope your list includes these points.

- Offer to help with causes or issues about which your audience cares and which do not conflict with your interests.
- Find out how you can help them accomplish their job.
- Be a trustworthy, credible and reliable source of information.
- Be sociable. Develop personal friendships if you are able.
- Keep in regular contact and be patient. It takes time to create lasting friendships.

Good relationships go hand in hand with persuasive presentation techniques and preparing the ground for presentations. Here are some points to keep in mind. First, think creatively about how you can get a meeting with the audience you need to reach. Secondly, schedule a meeting with that decision maker or key audience by either sending them a letter of invitation or by inviting them to visit your project. If you have a friend or colleague who knows the decision maker, ask that person send the letter or make the phone call.

TASK 18 – Preparing for your presentation

Discuss with a colleague how you should prepare for meetings and presentations with key decision makers.

FEEDBACK

Here are four key points you should have mentioned.

- Know your audience. Try to learn what kinds of arguments will persuade this audience.
- Focus on your message. Plan what you would like to say at the meeting. First, present the issue that has led to the meeting, and then make two or three points about why the issue is worth addressing. Next, you may present your suggestions and tell the audience what you would like them to do to help. If you use charts or graphs, keep them clear and simple.
- Often the messenger is as important as the message. Always choose a messenger whom the decision maker will find credible and reliable.
- Practise! Rehearsing the presentation with friends and colleagues can help you get ready for your meeting.

I hope you are ready to go on to the last section of this study session which concerns the final element of the advocacy framework – fundraising for advocacy.

5.8 Fundraising for Advocacy

You have set your advocacy objective and developed your strategy. Only one element remains - the resources to put your plan into action. In many ways, fundraising parallels the advocacy process itself: you must set realistic goals, target audiences, develop persuasive messages to reach those audiences, build alliances and trusting relationships, and leverage decision-making at donor institutions. Without resources, your effort will not survive. Therefore seeking resources must be integrated into your strategy from the beginning.

You should work to diversify and expand your funding base. Do not become too dependent on one or a few sources, since this can confuse your agenda, lead to conflict of interests and leave you without funding when donor priorities change.

There is one important point to remember about fundraising: ***ALWAYS RAISE MORE MONEY THAN YOU SPEND.***

TASK 19 – Developing a fundraising strategy

Make a list of different fundraising methods that could be engaged in to raise funds for your campaign.

FEEDBACK

Does your list include the following?
- Charge membership dues.
- Solicit in-kind contributions.
- Hold fundraising events such as dinners, walks, and concerts.
- Look for corporate donations.
- Sell merchandise such as crafts, artwork.
- Seek grants from foundations and international donor agencies.
- Auction donated items.
- Raffle donated prizes.

There are many others you can add to your list.

Like any other activity that requires funds, you need to develop a budget. Here are four simple steps you should follow:

- Develop a budget.
- Divide the budget into fundraising goals by determining whom you will approach for funding and for what purpose.
- Develop a strategy to meet each goal.
- Follow up and be persistent!

TASK 20 – Develop a fundraising plan

Complete the following form, using your advocacy objective.

Funder	Strategy	Who will complete the task?	When will it be completed?

FEEDBACK

I hope you have enjoyed learning about the elements of advocacy. You should now be ready to go out and advocate for nutrition.

Take a well-deserved break before going on to Unit 3.

6 SESSION SUMMARY

Well done! You have come to the end of this study session. How did you do? In this session you learned about the need to select an advocacy objective and to ensure that it is SMART (specific, measurable, achievable, realistic and time bound). You also learned that an audience centred approach, based on social marketing techniques, offers the necessary tools to distinguish, analyse, reach and motivate key policy players. These decision makers may be your primary audience or they may be your secondary audience. You have also learned to develop and deliver policy messages. The information you obtained in this session on policy mapping will assist you in networking and forming of coalitions to influence the decision making process. Finally, you considered what makes presentations effective, and what should enable you to raise sufficient funds to achieve your advocacy goals and objectives.

Take a short break before you continue to the next Unit.