

ICPD+15 ADVOCACY PLANNING MEETING PROCEEDINGS REPORT



**GENTING VIEW RESORT, GENTING HIGHLANDS,
MALAYSIA
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**Report by
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1. Executive Summary

The International Conference on Population & Development (ICPD) Programme of Action (PoA) is the single international conference document agreed upon by states and is the single platform which sets forth the agenda of sexual and reproductive health and reproductive rights.

As a regional organization whose mission is stated as:

“ARROW is committed to advocating and protecting women’s health rights and needs, particularly in the area of women’s sexual and reproductive health. ARROW believes that good health and well-being and access to comprehensive and affordable gender-sensitive health services is a fundamental human right.

And whose “long-term objectives are:

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

A key ARROW strategy, to fulfill the long-term objectives, has been to monitor and generate evidence on ICPD implementation. And in turn, create advocacy around the evidence generation. This has been our way of holding governments in the region accountable to the commitments they made in Cairo. This key strategy has been implemented at the 5-year anniversary of ICPD - demonstrated by ARROW’s ICPD+5 monitoring and ICPD+10 monitoring. The ICPD+15 project incorporated a one-year review, during the year 2007, of the ICPD+10 project to ensure a more focused, and strategic approach to monitoring. A critical emphasis of the +15 project is to ensure that the key purpose of the monitoring, is advocacy. Hence the project was planned to have two equal components: monitoring research & advocacy.

In May 2008, the regional monitoring research planning workshop of the ICPD+15 project took place with an initial 21 partners across 12 countries in Asia. The April 2009, advocacy planning workshop of the ICPD+15 project was designed with the aim of having the partners come and share the findings of the research and how to sharpen these findings into advocacy recommendations and to enable partners to have some tools to implement the advocacy i.e. policy briefs and national advocacy plans. The meeting was also designed to incorporate a peer-assist method, where key resource persons and all partners are able to share perspectives and strategies to help each other. The concept note (Annex-1) for the meeting explains the workshop design in greater detail.

2. Introduction

a. ICPD+15 Advocacy

by Sivananthi Thanenthiran

Siva started her presentation by vocalizing her pleasure to be filled in a room filled with ARROW partners who are passionate and committed towards one of the most fundamental, and yet, ironically till today, least recognised issues in the world.

She talked about the changes that have occurred in the world since the last meeting one year ago, how everybody's moods were one of optimism and hope - political tsunamis had taken place in Nepal, and in Malaysia and Barack Obama had just thrown his hat in running for the Presidential Nominee of the Democratic Party against Hilary Clinton. Now, one year later Barack Obama has been the President of the United States for more than six weeks!

She also reflected on the fact that we live in a time of great paradox because while some barriers have been broken in everybody's minds, others have been set up, the topmost one being the global economic situation. Most nations, governments, donors, citizens and even NGOs are primarily concerned about financial sustainability issues. She addressed a question that was foremost on everyone's mind: Will there be enough money to do our work.

She said that the advocacies had to be continued to ensure that all the agendas (in all its richness and diversity) will continue to be represented in these turbulent times, because this will be critical to the millions of women in the region and directly affect their lives in the next few years. And also because we are part of the women's movement, WHAT we do is only as important as HOW we do it - this may well be our opportunity to offer our solution of paradigm change to a world looking for answers and solutions. This project partnership gives us an opportunity to come together, to work together as a region. This partnership spans 12 countries and 22 partners across these countries. This project partnership also gives us a common platform to engage with the rest of the world on our agenda.

ARROW focused on project coordination and collecting 80 cross-country indicators which fall into the categories of Reproductive Health, Reproductive Rights and Sexual Health and Sexual Rights.

Country partners focused on the most critical SRHR issues to be advocated in their respective countries.

National SRHR Issues	Partner Organisation & Country
Unsafe Abortion	Shirkat Gah (Pakistan) Women's Health Foundation (Indonesia) Reproductive Rights Advocacy Alliance Malaysia (RRAAM) (Malaysia) Consultation of Investment in Health Promotion (CIHP) (Vietnam) Research Centre for Gender, Family and Development (CGFED) (Vietnam) Institute for Reproductive and Family Health (RaFH) (Vietnam)

Contraception	Women's Health Foundation (Indonesia) Shirkat Gah (Pakistan) ReproCen (Philippines) Reproductive Health Association of Cambodia (Cambodia)
Maternal Health & Maternal Morbidity	Likhaan (Philippines) Beyond Beijing Committee (Nepal) Academy of Nursing Studies (ANS) (India) Centre for Health Education, Training and Nutrition Awareness (CHETNA) (India) Centre for Health and Social Justice (CHSJ) (India) Naripokkho (Bangladesh) National University of Laos (Laos)
Sexual Rights	Shanghai Women's Health Institute (Shanghai, China) Department of Women's Rights, Hei Longjiang Women's Federation (Hei Longjiang, China) Peking University Women's Legal Aid Center (Beijing, China) SEA Consortium on Gender, Sexuality and Health (Thailand)

Just as 2009 is the year for ICPD+15, 2010 is the year for MDG+10

The country reports impact directly on:

Target 5B: Achieve universal access to reproductive health &

Target 5A: Reduce by three-quarters, the maternal mortality ratio

The dissemination of these findings will be relevant, critical and crucial to the setting of the global agenda in this year and the next. She ended her presentation with a quote by Margaret Mead:

"We create the future by being able to visualize it; by being able to imagine it; by being able to dream about it."

b. Introduction of Advocacy: Concepts for Clarity and Discussion; Introduction to Issues Management

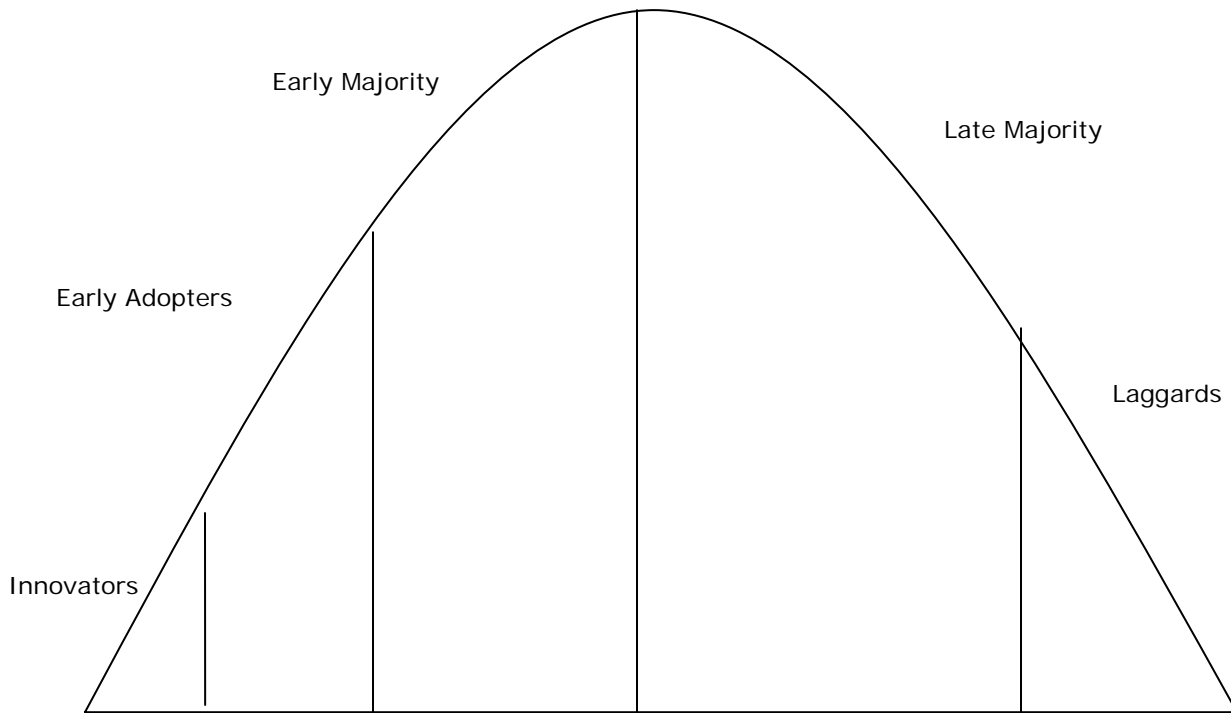
by Malou Tiquia

Objectives

- Day 1:
 - Strengthening research finding and recommendations
 - Prioritizing issues based on country research
- Day 2: Skills building of partners to develop national policy briefs
- Day 3: Skills building of partners to develop national advocacy plan

The Innovation Adoption Curve

The Innovation Adoption Curve helped locate the way in which NGOs often work.



NGOs and activists often fall into the innovators and early adopters categories. Innovators are champions, committed, *ideological*; Early Adopters are open to change, *visionary*, imaginative, looking for a strategic leap forward in their lives. However, lawmakers and policymakers and programme implementers often fall into the early majority and late majority categories. Early Majority are *pragmatists*, comfortable with ideas, but need to see solid proof of benefits; Late Majority are *conservative pragmatists*, follow the mainstream and established standards, hate risk, but don't want to be left behind and then there are Skeptics.

Why Advocate?

Elements of Community Change Program



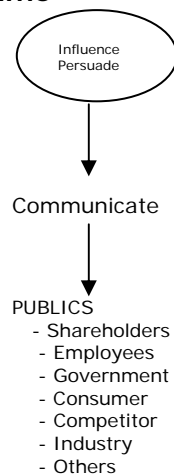
What is Advocacy?

Advocacy is an act or process of pushing, supporting a particular cause (influence outcomes)

Why bother?

- You are a constituent and a voter. Elected legislators pay more attention to communications from their constituents than from any other source. Doors open to those with reputation.
- You are in charge of a brand that has reputation. You have special credibility because of your training and experience.
- Brand is not a controversial issue. Everybody is in favor of the brand. They just don't know exactly what it stands for or what it means beyond the brand. So if you don't explain what your brand stands for, nobody else will.

The "A" Frame



1. **Analysis** – Analysis is the first step to effective advocacy, just as it is the first step to any advocacy action. Activities or advocacy efforts designed to have an impact on public policy start with accurate information and in-depth understanding of the problem, the people involved, the policies, the implementation or non-implementation of those policies, the organizations, and the channels of access to influential people and decision-makers. The stronger the foundation of knowledge on these elements, the more persuasive the advocacy can be.
2. **Strategy** – Every advocacy effort needs a strategy. The strategy phase builds upon the analysis phase to direct, plan, and focus on specific goals and to position the advocacy effort with clear paths to achieve those goals and objectives.
3. **Mobilization** – Coalition-building strengthens advocacy. Events, activities, messages, and materials must be designed with your objectives, audiences, partnerships, and resources clearly in mind. They should have maximum positive impact on the policy-makers and maximum participation by all coalition members, while minimizing responses from the opposition.
4. **Action** – Keeping all partners together and persisting in making the case are both essential in carrying out advocacy. Repeating the message and using the credible materials developed over and over helps to keep attention and concern on the issue.

5. **Evaluation** – Advocacy efforts must be evaluated as carefully as any other communication campaign. Since advocacy often provides partial results, an advocacy team needs to measure regularly and objectively what has been accomplished and what more remains to be done. Process evaluation may be more important and more difficult than impact evaluation.
6. **Continuity** – Advocacy like communication is an ongoing process rather than a single policy or piece of legislation. Planning for continuity means articulating long-term goals, keeping functional coalitions together, and keeping data and arguments in tune with changing situations.

The Role of Issues Management

Issues management is an action-oriented management function which seeks to identify **actual, emerging** or **potential** issues that may impact on the organization and to mobilize and coordinate organizational resources to influence their development. The components of issues management are to identify, analyze and prioritize actual, emerging and potential issues, to mobilize and coordinate the resources to deal with them and to actively and strategically influence their development.

The 10 Steps on Issues Management are:

1. Make issues management someone's responsibility.

It naturally seems to go with public affairs, public relations, or development. If your organization is not doing this, take it upon yourself to do it. When a crisis hits, the value of issues management will be recognized and you could be a hero.

2. Continually scan the environment.

Subscribe to the leading publications about the nonprofit world and to those publications that cover your nonprofit's particular area of expertise. Attend conferences and meetings to learn about issues and how your peers are dealing with them. Be alert to news stories, blogs that cover your area, and other organizations' publications. Train yourself to ask, "Could that affect us?"

3. Find patterns and notice repetition of themes.

When you see an issue crop up over and over again, take note and put together a file for it. Collect and save information on that issue. Set up an issues file on your computer and in your filing system. Keep a file folder ready on your desk to put information into when you come across anything that falls under any of the topics you have identified. Set up Google alerts for the keywords of your issues so you will receive news articles about them.

4. Identify the top issues.

Make a list of all the issues you've taken note of. Then, working with others in your organization, identify the top 5 or 10 issues that you think are likely to be relevant for your organization. Ask for time at a staff meeting to present your list and get feedback. Set up a meeting with your executive director to tell her what you are doing and to ask for his help in identifying the top issues.

5. Prepare position papers on each of those top issues.

The position paper should provide background information about the issue, include examples of the issue being a problem for other organizations, and specify why and how this issue could affect your organization. Document any action that your organization has taken to address the issue. If nothing has been done, suggest that this issue is important and some action should be considered.

6. Prepare a statement setting out your organization's philosophy on each issue.

State how your organization is addressing the issue...be specific as to what you have done and plan to do about it. Include copies of policies already in place to address that issue.

7. Circulate your position papers and statements to your leadership team.

Invite those leaders to a meeting where they can comment on the issues and advise you on how to flesh out the position papers or update them. Do this when you have rough drafts of the position papers. Be prepared to change a lot of this material as your leadership team brings its knowledge to the table.

8. Develop a notebook or file for issues management.

Prepare a notebook, or set up an online folder, that contains all of the position papers and make sure that all members of the leadership have copies. Make sure that board members have copies of the position papers. These make excellent additions to the materials that new board members receive. Get on the agenda of a board meeting to introduce your issues management program and to invite feedback.

9. Revisit all position papers at least once a year.

There is no doubt that setting up an issues management program is time consuming in the beginning. But once set up, it can be maintained fairly easily. At least once a year, update your list of issues, discard those that don't seem relevant any more, and add others that are new.

10 Steps on Issues Management

10. Use the issues file whenever an issue goes "live" for your organization.

When an issue goes "live" for your organization through some event or interest from the media, use the position paper as background to write message statements that you and others can use when talking with the media, supporters, volunteers, clients, and other constituencies. Include "talking points" that support your message.

The policy making process includes an agenda setting as well as the formulation, adoption, implementation and evaluation of the policy.

Implementing an Effective Lobby

There are differences between advocacy, lobbying and influence peddling. Advocacy influences the outcomes, while lobbying influences decisions made by the government and influence peddling is like a 'revolving door' – you are not an expert but you get to open doors (knowledge of access and pressure points in the legislative maze)

Lobbying can be defined into two different categories: direct and indirect (grassroots) lobbying. Direct lobbying is communicating your views to a legislator or staff member of any other government employee who may help develop legislation. Indirect (Grassroots) lobbying is building a constituency on an issue.

When lobbying, it is important to state who you are representing; yourself, an organization or a coalition, the numbers, the mandate, and what influence your 'membership' has.

It is also important to know if there are politics on the issue; what is the Government's stake on the issue; what are the main barriers in getting Government to your side; what is the Government's underlying philosophy/ideology; how does your issue fit with the legislative agenda; how important is the issue to your organization/constituency; what is the view of the opposition?

When lobbying, it is vital to know when to lobby. It's best to lobby before an election, before the issue you are lobbying for (or against) goes public, at publicity peaks, before the issue goes to congress, during the passage of legislation and generally on 'Quiet News Day'

How to Lobby:

- Direct Lobbying:
 - Personal meetings
 - Telephone conversations
 - Individually written mail
 - Individually addressed mass mail
 - Mass Mail-ins
 - Electronic deluge
 - Petitions
- Indirect Lobbying:
 - Media campaigns
 - Targeted political campaigns
 - Media hits
 - Seeking professional help
 - Thru CBOs
 - Thru party organizations/from own political party
 - Mass demonstrations
 - Internet campaign

The issue(s) is identified by the observations of service providers, women contacting service providers or other agencies about the problem and specific research studies. When scoping the issue, it is important to research how widespread the problem is, how severe the problem is, what the age group(s) and characteristics of the group most likely affected are.

In order to bring about the change that is desired, the strategies employed include getting the government to recognize the problem, developing realistic/possible recommendations/options that the government is likely to consider, knowing the legislative process and language as well as the parliamentary rules.

In summary, advocacy is action for policy change to improve Sexual and Reproductive Health and Rights, and action to ensure policy implementation action to gain government support for civil society as a whole. It is not action to raise awareness for behaviour change (eg. Condom change), a resource mobilization or a promotion of the organization to gain visibility.

CRITICAL SRHR ISSUES: COUNTRY PRESENTATIONS - ISSUES FOR NATIONAL ADVOCACY

3. CRITICAL SRHR ISSUE 1: CONTRACEPTION

a. Indonesia: Contraception in the Decentralization Era (Women’s Health Foundation)

Research Questions:

- The FP-health seeking behaviour: are most women using both services, public and private? When will they use private SDPs (Service Delivery Points) and when are they going to a Public Health center?
- Knowing what is lacking on the side of FP health providers when dealing with clients who need abortion services
- For the urban poor women, what type of mechanism is provided for having free inserting Implants and IUDs? (special insurance program for the poor)
- Are women facing failure in implants and IUDs getting “back-up services” from the government or SDPs who did the insertion?
- How many women have undergone abortion(s) when they have faced failure in implants and IUDs?

Key Findings

Research questions / Objectives	Findings												
1. How far the local government has fulfilled Universal Access to the full range of FP methods: the right to access FP methods of choice since the decentralisation policy	<ul style="list-style-type: none"> • The supply of contraception, in particularly the FP methods, was still decided by the health providers • The health providers (mostly midwives) who work in the morning at the government public health centers, while in the afternoon/evening at their own practices, still the most popular health providers regarding family planning. • Why the midwives are the most popular for FP matters? <table border="1" data-bbox="537 1587 984 1835"> <thead> <tr> <th>Assistance during delivery</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>General Physian</td> <td>1.0</td> </tr> <tr> <td>Obgyn</td> <td>8.2</td> </tr> <tr> <td>Midwife</td> <td>51.1</td> </tr> <tr> <td>TBA</td> <td>38.0</td> </tr> <tr> <td>Relatives/others</td> <td>1.7</td> </tr> </tbody> </table> • The above table shows that private midwives are the most popular assistance during delivery. 	Assistance during delivery	Percentage	General Physian	1.0	Obgyn	8.2	Midwife	51.1	TBA	38.0	Relatives/others	1.7
Assistance during delivery	Percentage												
General Physian	1.0												
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	<p>Most women who were assisted by a midwives during delivery will choose midwives for FP matters</p>
<p>2. How far the local government has fulfilled the right to make decisions concerning reproduction free of discrimination, coercion and violence</p>	<ul style="list-style-type: none"> • Discrimination: <ul style="list-style-type: none"> ○ From the several interview with the health providers it is known that morning after pill were not promoted and the reason were: "afraid for misuse by adolescent or not-marriage person". ○ Force marriage of girls 15 years and younger is still practiced in the research area (15%) and so early childbearing still common. • Coercion: <ul style="list-style-type: none"> ○ It seems that the data shows the output of the third and fourth pregnancies ended with a death baby during delivery. Most likely the 3rd and 4th pregnancy are due FP failure. Women drink herbal mixtures to expel the substance in their womb. ○ Violence during sterilization (tubectomy).
<p>3. How far the local government expanded and improved family planning services to lessen the instance of unsafe abortion.</p>	<ul style="list-style-type: none"> • From the survey it is difficult to know the: <ul style="list-style-type: none"> ○ Numbers of FP failure, the FP acceptors become pregnant. According to the Head of NFPCB 60% of abortion's reason are contraception failure. ○ Numbers on the incidence of abortion, since no one would answer about their experience in having an induce abortion. The only data is about spontaneous abortion. • The data from the survey shows that 38% women were assisted during delivery by TBAs; while from previous studies it is known that women whose delivery were assisted by a TBA most likely used TBA to perform abortion. • Since abortion services still considered as illegal no one among the health providers interviewed would talk about abortion.
<p>4. How far has the local government improved the quality of family planning services and the overall reproductive health care.</p>	<ul style="list-style-type: none"> • Only the physical building of the public health centers were improved, beside some health personnel were added since decentralization came into force. While the FP fieldworkers became lesser every year (8 persons retired every year and no new FP fieldworkers can be remitted). One FP fieldworker should supervise 2 villages. • Since most likely women had chosen midwives to assist their delivery as well as their family planning providers, but the place is not the at the public health centers! The midwives who almost all are member of the Indonesian Midwives Association (IBI) promoted their private practice called "Delima Midwife" which are specially trained to give quality services. Although the cost at their private practice are higher the women prefer them. • The opening hours of the Public Health Centers are only until 12.00 and very often the doctors are not there and so the hands of the nurse and the midwives are full to help the sick people and children. • Lack of legal protection for the victims and there is no

	insurance system to cover the cost of reparation. A woman who intended to have a tubectomy was sent back home when the operation was failed. The woman had a big caesarean scar while all the previous three deliveries were normal. The government never has a regulation which deal with the possible consequences of sterilization failure or malpractice.
5. Is there any coercion and or failure felt by woman who joined the sterilization campaign?	<ul style="list-style-type: none"> The sterilization (tubectomy) program held 3 times a year which gathered each time at least 50 women at once still not receiving the highest standard of care. Through the neighbourhood structure, the local community leaders promoting the sterilization program. When the number of women were fulfilled, a van will be rented to being all those women from each neighbourhood to the hospital which provide the sterilization services. Each women were asked to pay for the van Rp. 250.000,-. Is that called participation? Some malpractices were seen, where is the accountability? Stop justifying community-financing arrangements in the name of strengthening accountability to communities.
6. How to eliminate early marriage and early pregnancy?	<ul style="list-style-type: none"> The Amendment of Law no 10 year 1974 on Marriage is a must. Because according to Law no 10 year 1974 on Marriage the legal age of marriage of females is 16, while the males is 19 and this is discriminatory.
7. Why adolescent and unmarried persons are still discriminate d regarding RH information and services?	<ul style="list-style-type: none"> The Amendment of Law no 23/1992 on Health could not be delayed since no chapter accommodated reproductive health and rights, since the ICPD PoA was launched in 1994. The Indonesian government should develop comprehensive policies and plans on adolescent health, taking into account the Committee's general comment No.4 (2003) on adolescent health and development. Beside evidence shows that married adolescent are very often unable to access the services they need with regard to their reproductive health. The government should ensure access to reproductive health information, counseling and services for all adolescents.

Prioritize recommendations for advocacy:

Ranking of Recommendations	Suggested Criteria:
1. Adocacy regarding policies and budget	<ul style="list-style-type: none"> Urgency of the issue: Barrier in law and regulations should be overcome the barriers
2. Rights of public to information on all FP methods	<ul style="list-style-type: none"> The morning after pill should be promoted Adolescents and unmarried person should have access to information &RH services. Peer education will be held to increase their knowledge
3. Raise additional resources for capacity building the health personnel and FP fieldworkers	<ul style="list-style-type: none"> Conduct training for health personnel and FP fieldworkers in order to use the human rights framework in FP programs

4. How far is male participation implemented in the Bogor Regency?	<ul style="list-style-type: none"> The number of men who practicing FP method (condom and vasectomy) was very low: only 1.7% used condom and only 0.4% undergone vasectomy.
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Discussions and Conclusion

- In the study area there were no civil-society actors or NGOs which monitor the quality of reproductive health service and there is also no patient rights charters.
- Rights of public to information on all FP methods with their side effects were not fulfil. Beside *morning after pill* were not promoted since the health providers said that it will be misused. Only to certain patients (who came regularly to their practice) *morning after pill* will given.
- The FP fieldworker had no regularly contact with the Public Health Centres' providers because since the establishment of NFPCB the responsible agency to provide IUD, implant and sterilization are NFPCB and not the Public Health Centres
- Strengthening *Community Participation Vs Accountability* in reproductive Health & Rights
- The religions and community leaders are still considered as the pioneers of the early FP programs in the early years of the 1970s. These leaders are not only at the national level, but also at the local level. The opinion of the chair of a religious organization regarding FP Programs will influence the attitude of their follower. In order to be successful NFPCB asked all the chair of several religious organization to sign a MOU to provide FP programs at their Health Facilities. Beside, the NFPCB asked also to sign MOU from the Air Force, Army, Marine and Police to sign MOU in order to provide FP programs at their facilities.

Comments from Resource Person(s)

Rashidah Abdullah:

I feel that the recommendations are not really recommendations yet. So I think you really need to say what the recommendations are. When I was preparing for this, the core aspects, at least it my view, need to state the:

- Issue/problem
- Action. What needs to be done and how it needs to be done. Need to be a little bit more specific about the how.
- Who is responsible for that action in some detail
- Time. When is it going to be done? When are you going to get the message across. It's all a learning process. What is the advocacy, what is the change you are trying to bring forward?

Indu Capoor:

Agree with Rashidah. When recommendations are given, they have to be very specific. The link between findings and recommendations is a little weak and it really needs to be explored in depth. So each issue, as it comes out, needs to have a clear recommendation, of what you would like to change about that. The findings were very interesting, but the recommendations were too general for anyone to act on. I will look at it again and tell you how to link the findings with the recommendations. Should be clearly linked, and specifically who are you targeting for the recommendations, how it will be done, what the budget is, timing.

Discussions and Suggestions

Atas responded by saying that since 2001, there has been a decentralisation policy and since then, the responsible union for the health sectors is the local government. In West Java, not just the Bogor region, it seems that most of the policy makers are not prioritising Family Planning in the yearly planning, so the budget is also very small. Need to advocate to the local government. Secondly, there is no regulation. For the first time, there was a regulation, it was from the health of the region because they can issue and act for regulation for decreasing maternal mortality. From the three provinces in Java island, West Java is always the highest in MMR, so the health of the regency is now, since decentralisation has the authority to act on regulation and we hope that this will also act as regulation for family planning as it has priority, because then the budget is also there. The health budget will also be higher, how big is the portion for the family planning budget.

Indu pointed out that Atas' explanation has given a very clear advocacy message, that prioritisation of family planning in the local budget, that an increase in budget, an increase of resources in the family planning budget. Those become sharper when you're making that is a clear needs to be put in the recommendations section.

Atas also said that midwives are all in one association, and they are very strong. But, on the other side, They don't share their 'knowledge'.

Neha wanted to know who assists these women giving birth. 50% midwives and 38% traditional, so how does one differentiate between both?

Anjana asked why the midwives and the Traditional Birth Attendants (TBA) more popular?

Atas responded to both by saying that the TBA's are usually fairly old women, who pass on the skills through the women in the family. Most people believe in these women, because after delivery, they have rituals, and most women are sent to these women by their mothers or older family member. Midwives are trained, and after training are supposed to be sent to remote areas. Assistant Midwives later became TBA's. Midwives are allowed their own practices and the association of midwives give them the means to supplies.

Rashidah pointed out that the 2nd recommendation needs to be clearer. How are you thinking/who do you think will take that action. How will it be done? NGO/Government?

Atas responded, saying that this issue was raised by ARROW, and a AFC, about participation and accountability. Using women's movement, the wives of the bureaucracy, and those women (under Suhorto –used to) still mobilise. That is why participation and accountability. There should be an NGO in Bogor to monitor the accountability of all parties.

Tini also added that in their foundation, they have a network working on these issues. We've gone to the Ministry of Health and they need to continue doing so.

b. Cambodia: To understand the barriers to family planning commodities among married couples, (Reproductive Health Association of Cambodia)

Research Questions:

- Why is there a low rate of contraceptive used among married women?
- Are men still a barrier for FP decision?
- Knowledge and fear of side effects, SES , Age, and Access barriers to health services

Key Findings

Research questions/Objectives	Findings
To understand the barriers to family planning commodities	<ul style="list-style-type: none"> • Accessibility: <ul style="list-style-type: none"> ○ Through focus group discussions (FGDs) both men and women, FP commodities are very easily accessible for both short and long-terms methods in their community; • Acceptability and Affordability: <ul style="list-style-type: none"> ○ In that particular community, short-term methods are more trusted than the long-term one. Few women thinking that IUD is almost for those who work less (not doing heavy works); ○ Without consent from their spouses, women can use any kind of short and long-term commodities; For definitive methods it is obligated to get spouse's consent.
To understand the barriers to family planning commodities	<ul style="list-style-type: none"> • Health Concerns <ul style="list-style-type: none"> ○ Through focus group discussions, men expressed that they learnt them (side effects) from their wives and their close relatives who are using FP methods. And the women heard them from the other women and also from their close relatives; ○ The highlighted health concerns getting from the brainstorming questions were "feeling asthenia/weak, hot inside, womb thinning, cancer, irregular bleeding, becoming increasingly thinner and infertility – difficult to get pregnancy after couple years of using FP methods; ○ The costs of side effects' treatments are very high than the FP commodities' fees. These make women and family thinking more about whether using it or not; ○ Even interviewed HC midwife also believes that early using FP methods among young couples could lead to infertility;

To understand the barriers to family planning commodities	<ul style="list-style-type: none"> • Informed Choice <ul style="list-style-type: none"> ○ Through actual and appropriate mass media in the community such as radio, TV, community based promotional activities ... married couples could prior decide before going to get selected methods either at health facilities or at community based organizations; • Cultural Acceptances <ul style="list-style-type: none"> ○ Role of Mass Media & Community Promotional Activities improve the cultural acceptance of the use of FP; ○ Interpersonal Channels which consist of relatives, friends and neighbors play the important role of spreading believes and trusts; ○ Role of religious believes and culture; • Decision Makers <ul style="list-style-type: none"> ○ Husbands and experienced/old ladies influence/enhance the decision making on whether to use the family planning methods;
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Prioritized Recommendations for Advocacy Issue

Ranking of Recommendations	Criteria (why do you think this issue should be critical to address for advocacy now?)
Recommendation 4	For new government health staff that assigned to work at service delivery facilities should receive at least an initial training on family planning subject;
Recommendation 5	For those who are currently providing FP commodities should receive refresher training with appropriate follow up and supervision regularly;
Recommendation 4	Reduce MMR
Recommendation 5	Reduce MMR

Discussion and Conclusion

1. Misconceptions

- Women remain belief that some methods are not applicable for them due to misunderstanding and is not due to physical examination by health care providers before using it;
- They are afraid that while using them they could not do more or heavy works because they have thought that – 1)- their body force is not strong enough to use it; 2)- lack or not enough of daily foods with working hard make them weak;
- Among health care practitioners, few of them have observed that early using FP among young couples (just got married) may cause infertility after couple years of using any FP methods; it seems that lack of initial (for new officials) or refresher (for those who currently provide

services) trainings and lack of follow up/supervisions from higher level will keep this misconception going on;

2. Health Concerns/Fear of Side Effects

- Lessons-learnt from relatives, friends, neighbors ... about health concerns/side effects especially for particular effects such as infertility, bleedings, loosing (for those living with poverty) or gaining (for those living in medium or high classes) weight become strong barriers that affect the decision-making on FP commodity use;
- All of mass media through various channels at community level focuses much more on promotion, availability of FP commodities rather than explaining about foreseen side effects

Comments from Resource Person(s)

Malou said that most of what has been presented is programmatic, which means putting together an info tool/pack would be the best idea.

Rashidah said that there were a lot of findings that have come out, and agreed with Malou, that a lot of the information is programmatic. She thought that it was probably the way the issue was framed at the end. A suggestion was to have one recommendation focus on training as it might help to make it more advocacy oriented, if the ICPD PoA is used. What has the government done? What has been improved? This can make it more advocacy oriented.

Vathiny responded saying that her organisation asked their but he misunderstood about FP. She also said that there is currently no budget allocated for MMR and the plan is to raise that under FP, to say that it is one issue and therefore to put it under one budget.

Indu said that the link between the findings and the recommendations is weak and there is a need to go deeper. She questioned if there was enough money for IEC, and where the money is being used. She said that there should be a break-up of the budget, and suggested that the break-up be studied. She also questioned if the recommendation was solely for service providers. Her suggestion was to get an increase of budget for MMR and to break it down clearly, talk about the gap in the policy and then go to the programme budget. :

Pallavi asked if these recommendations were based on the findings of one Focus Group Discussions of 20 people or more. She also said that if there are no quality care of contraceptives, on advocacy issue could be quality care. She shared that in India, women's groups have fought for this. Another point she made was that the issues are always being presented from a women's perspective, and that it should also include men.

Vathiny responded that they had looked at the group that needed to be studied. The province has been the same since 1999, so the question is why the contraceptives are not contributing to the reduction of MMR. She said that the result of the FDGs can be used represent the study. Budget for Quality care is not there because the FP programme is still a passive issue. Therefore, there is no budget for training, follow-up trainings of providers or contraceptives. Donors who support contraceptives are tired because there is no support. Focus is only HIV/AIDS. Nobody is looking at FP/MMR. She also said that everything is put to midwives although there hasn't been a training in five years in midwifery and there isn't enough money to scale it out. She also said that they have no power to bring the men in and get them involved, although she agrees that there is a need to bring them in.

c. Philippines: Contraceptive Behavior of Filipino Youth in Metro Manila Communities: The Philippine Case (Reprocen, University of Philippines)

Research Questions

- Why is there a low-level of contraceptive use among adolescents?
- What is the policy climate vis-à-vis raising awareness of young people on ASRH? And of others about young people's ASRH?
- Have the rights of young people to have safe, effective and affordable FP methods been protected? Have they been expressed in national health and population policies?

Key Findings

Research questions / Objectives	Findings
To determine the reasons for low level of contraceptive use among sexually active youth in select Metro Manila communities	<ul style="list-style-type: none"> • Lack of information on contraception • Concern about side-effects • Cost of contraceptives • Desire to have children • Partner's disapproval of contraceptive use • Distance from sources of FP information and services • Religious beliefs (85% Catholic; influential Catholic Church)
What is the policy environment in awareness raising: <ul style="list-style-type: none"> - of young people on ASRH; and - about young people's ASRH? 	<ul style="list-style-type: none"> • Hostile environment and stigma placed on ASRH • Difficulties with conflicting social norms on premarital sex • Disapproval and condemnation received from health service providers discourages them from seeking advice.
Has there been sufficient government support for effective and affordable FP methods expressed in national policies?	<ul style="list-style-type: none"> • Young people get little or no information from gov't health clinics and schools • LGUs should provide for training of health center workers on FP knowledge and counseling skills

Prioritize Recommendations for Advocacy Issue

Ranking of Recommendations	Criteria (why do you think this issue should be critical to address for advocacy now?)
Conduct FP and sex education seminars Secure more involvement of the private sector	Suggested criteria: <ul style="list-style-type: none"> • Timeliness / urgency of the issue • Do-ability

Pass law or ordinance mandating government-supported training of health workers & parents	<ul style="list-style-type: none"> • Effectiveness • Efficiency • Community readiness
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Discussion and Conclusion:

1. Lack of effective access to FP information, services and supplies
 - Sex education classes are not uniform and consistent; confined to anatomy and physiology and often founded on moralistic perceptions
 2. Large unmet need for contraception
 - Fee reduction not implemented in government health facilities
 - There is no national government policy to provide contraceptives to sexually active adolescents.
 - Church teachings on confining sex within marriage and only for the purpose of producing children leaves adolescents RSH concerns a non-priority.
 - Submissive role of women extends to decision-making on use of contraceptives- 1/2 of women surveyed had a perceived need for contraceptives vs. 1/3 of men partners
 3. Reasons for non-use contraceptives of married and unmarried young people
 - Policies for family planning given only for the married
 - For urban poor communities there is almost complete dependence on subsidized or free FP services and supplies due to obvious lean economic resources
- Conclusions: Improved contraceptive information, services and supplies are needed to reduce the incidence of unplanned pregnancy among young women.
- Empowerment of women is crucial to the exercise of RSR
- Decision-making capacity of young women should be bolstered

Comments from resource person(s)

Indu wanted to know the difference between adolescents and young people, and said that a clarity on those terms were needed. She also questioned how many FP and sex education seminars can be conducted and said that it would be better to emphasize introducing sex education in the curriculum. 50 or 60 seminars can be conducted, but integrating it into the curriculum would be more effective. She also said that the Link between findings and recommendations need to be stronger, deeper.

Discussions and Suggestions

Beth responded by saying that legally those under 21, and young people are those under 30. She also said that she has very little trust in the public sector, and thinks that it's better to depend on the private sector. She said that the modules to conduct seminars are already available. The teachers in public schools who teach sexuality education are physical education teachers and counsellors. Although it is part of the education model, nothing has happened due to the objection of the church. Although the modules for guidance counsellors and PE teachers have all been developed, they have not been able to train them yet, as it depends on the regional director and if he/she is open-minded.

Indu noted that India faced the same problem: objection from the Hindu

fundamentalisms against sexuality education. She then said that she does not see any advocacy points in the recommendations.

Rashidah suggested to consider advocating to more NGOs and others using the models that have been prepared so it makes it easier. She also said that in coming up with a sharp finding, look at the list and find the main findings that can lead for advocacy. She also noted that this was a really good study but noted that there was no mention on whether this was a new finding. Has it been found before? She said to include that, as it would make the recommendations become more powerful.

Beth said that she had heard about it as stories, but this was the first time it was official.

Malou said that Beth might consider using that area as a common ground for FP. She said that they might want to use it as a modelling for the Catholic church and show the government and the Catholic church that it doesn't impact on their belief. On an aside, she noted that gender is a problematic word.

Pallavi said that they are facing the similar problem in India. She suggested that whenever the topic of sexuality education comes up, to make it age specific or the community might oppose. She also suggested a review of the models and to make them as a life skill framework instead of sexuality education. Giving knowledge is not enough, skill building needs to be improved

Beth said that life skills and values are part of the module. It is also age specific as the module is for high school. Catholic church wants it to be 17 yrs, but that brings them to the demographic –low use of contraception, unplanned pregnancies.

4. CRITICAL SRHR ISSUE 2: CONTRACEPTION /ABORTION

a. Malaysia: Increasing Access to the Reproductive Right to Contraceptive Information and Services (Reproductive Rights Advocacy Alliance Malaysia)

Research Questions:

- Why has the contraceptive prevalence rate not increased? (Has people's unmet need for contraception decreased since ICPD? Have the barriers to contraceptive use been identified and reduced?)
- Have unwanted pregnancies amongst young people been reduced and are there stronger sex education and service efforts to prevent these?
- Has accessibility of legal abortion as part of reproductive health services increased? Has there been a decrease in repeat abortions and improvement in the quality of post abortion counseling and as well as training of providers?

Key Findings

Research questions / Objectives	Findings
<p>Why has the contraceptive prevalence rate not increased and unmet need and unwanted pregnancies not decreased?</p> <p>CPR of 48%, stagnated for 20 years; unmarried people excluded</p> <p>Unmet need of 24 % married women for limiting births [increase from 18% in 1998]</p>	<ul style="list-style-type: none"> • Programme related barriers such as women's+ men's fear of side effects, husbands not allowing contraception etc. have increased. • Minimal qualitative research done to understand +address programme barriers. • Low policy priority for FP+SRH, with morbidity related HIV/AIDS concerns+ RH cancer as well as the MDGs, having higher policy priority. • No national ICPD action plan+ new strategies to over come barriers. • Policy makers+ demographers view that as fertility rate is declining due to later/no marriage, no need to promote FP. • No comprehensive IEC+ media plan to address barriers. • Young/unmarried people's need for sexuality education +FP services not recognized
<p>Have unwanted pregnancies amongst young people been reduced and are there stronger sex education and service efforts to prevent these?</p>	<ul style="list-style-type: none"> • Unwanted pregnancies of young people appear to be increasing, sex education efforts are not stronger and service efforts have improved only minimally. • No national data on unwanted pregnancies of young people • Abandoned babies+ births at school, work etc. increasingly reported in media [all ages] • GO study on unwanted pregnancies in 2007 but not released to public or FPAs. • Increasing trend in premarital sex found by research studies • Revised sex education in school curriculum approved by policy makers since 2006 not yet implemented. • Some progress in increasingly providing contraceptives discretely in MOH clinics for "high risk youths" and in FPA clinics.

<p>Has accessibility of legal abortion as part of reproductive health services increased? Has there been a decrease in repeat abortions and improvement in the quality of post abortion counseling and as well as training of providers?</p>	<ul style="list-style-type: none"> • Accessibility has not yet increased but remains very restricted in public hospitals + outdated abortion methods. • Better access in private sector but not openly done, expensive, not regulated, drs not known, stigmatised. • No national data on repeat abortion rate+ quality of post abortion counseling. From one study appears higher than WHO average of 1 per lifetime. [Fathilah.2008] • Legal status of abortion incorrect in some medical curriculum. • No improvement in training of providers.
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Prioritize Recommendations for Advocacy Issue

Ranking of Recommendations	Criteria (why do you think this issue should be critical to address for advocacy now?)
<p>A National ICPD Action Plan to be urgently developed with diverse NGO input to address low CPR, high unmet need + unwanted pregnancies.</p>	<p>A strategic plan on population + development is now being done so this is urgent. ICPD 15 provides opportunity for input+ the 2004 demographic survey finding is still hot.</p>
<p>Sex education curricula approved to be urgently implemented by MoE with support of MoWFD +encouragement of NGOs.</p>	<p>This is urgent for young people's lives. GO agencies are waiting for NGO advocacy.</p>
<p>Misconceptions on the legal status of abortion to be corrected in policy, code of ethics, services, curricula etc. by MoH, MoWFD +MMA.</p>	<p>Critical for abortion access to improve. ICPD 15 provides a policy level advocacy opportunity+ RRAAM has built awareness of issue.</p>

Discussion and Conclusion:

1. Policy

- The population policy of the Ministry of Women is economic + demographic and not reproductive rights based or women centred. ICPD POA has had no impact + may not be known or understood.
- Population, FP+SRH are sensitive to ethnic based political parties.

- The abortion law is clear but there is confusion on stated legality among policy makers+ minimal discussion until recently.
- The new sex education curriculum has been approved by cabinet but political concerns are said to be behind delayed implementation.
- The population statement was not developed or reviewed with participation of diverse NGOs.

2. Programmes

- The GO RH programme is health based not rights +needs based,+ services focusing on high risk women for Family Planning (FP) are consistent with this approach.
- Training of policy makers, doctors , nurses etc. in SRH, FP, gender + rights has been very minimal so knowledge of SRH +the rights approach is low.
- The low policy priority of FP translates into low curriculum+ service emphasis.

3. NGO advocacy

- FRHAM is represented with 1 place in the Population Board of 20 members. More like minded NGO organisations are needed to strengthen NGO views. Women activist NGOs have only recently been involved in abortion advocacy through RRAAM but not yet active on contraception+ sex education which have only recently been brought out as NGO advocacy issues. Women's groups have been very successful on VAW advocacy+ gender equality laws+ are thus key advocacy allies.

Comments from resource person(s)

Malou liked the idea of positioning it as a rights-based, so there are more people coming together because it is rights based. She also noted that suggesting a good National ICPD plan is good.

Indu said that allying with only like-minded organisations or people only will not work as opposition is still going to be there. She suggested that instead of advocating against them, work together.

Discussions and Suggestions:

Mary said that they had noticed that the NGOs with the 'louder' voice always managed to get a larger budget. They are wanting other SRH orgs to join in to make their voice louder.

Neha wanted to know the date that was used as a baseline when they looked at the increase or decrease of contraceptive use and how reliable the data was.

Ramasamy said that FRHAM carries out a Malaysia population family survey (which is once every ten years). So in the last 30 years the use of the contraceptive use has not increased and pointed out that that was the most reliable source at hand.

b. Vietnam: A Review of Abortion Policy and Practice in Vietnam (Family Health, Research and Development Center, Research Centre for Gender, Family and Development, Institute for Reproductive and Family Health)

Research questions:

- What abortion has taken place in Vietnam in the past years?
 - Which population section has more abortions?
 - What factors affect abortion behaviors?
 - What are the consequences of abortion on women and society?
 - What is the issue of safe abortion and post-abortion care?
 - Why is abortion practice problematic in Vietnam?

Key Findings

Research questions / Objectives	Findings
Why is abortion practice problematic in Vietnam?	<p>Number of unwanted pregnancy keep increasing</p> <ul style="list-style-type: none"> • Unmet need of contraceptive provision <ul style="list-style-type: none"> ○ lack of informed choice ○ quality of contraception ○ availability of accessible, affordable contraceptives (dependent on the donors) • Low involvement of men in family planning • Poor access to information • Poor sex education (reluctance to provide SE to young people) (unsafe sex behaviours among youth. <p><i>(alarming fact of adolescent abortion: the rate of abortions among young females and adolescents is much higher and it is estimated to be 20-30% of the total number of abortions in the country every year. A survey of 190 unmarried women who had abortions shows that 20.53% of them are school children and students (Vy and Hoa, 2007:28)</i></p>

<p>Why is abortion practice problematic in Vietnam?</p>	<p>Unsafe abortion/Post-abortion complications:</p> <ul style="list-style-type: none"> • Stigma to women who get abortion (especially for unmarried/young women) <ul style="list-style-type: none"> ○ leading to delayed abortions ○ going of private health clinics for confidentiality, despite there are no adequate safety facility and practice. • Poor quality of health care service: <ul style="list-style-type: none"> ○ Lack of sensitive and friendly behaviour at public health facilities. ○ Poor counselling provision (only available at project-based facilities) ○ Lack of post-abortion care • Poor management: poor implementation of monitoring systems •
<p>Why is abortion practice problematic in Vietnam?</p>	<p>Abortion against female fetus:</p> <ul style="list-style-type: none"> • Son preference • Economic constrain <p>Overall impacts on abortion</p> <ul style="list-style-type: none"> • Gaps in Policy documents <ul style="list-style-type: none"> ○ Lack of gender sensitiveness ○ Lack of right approach • Poor policy enforcement/implementation: <ul style="list-style-type: none"> ○ No feasible monitoring systems to be developed and enforced ○ (inefficient recording system, unreliable statistics) ○ Lack of trained community health workers ○ Lack of willings to make use of NGOs models

Prioritize Recommendations for Advocacy Issue

Findings/ Discussion	Recommendations
	<p>For Government: Develop and enforce a serious and manageable monitoring systems in health care service, including the abortion care monitoring. Open to learn form NGOs good practices: more collaboration and consultation Keep training/raising awareness for policy makers/decision makers at different levels on SRHR and ICPD commitment.</p>

	<p>For NGOs: Strengthening knowledge for people in communities, particularly in rural areas on reproductive health, sexual health and HIV/AIDS through different forms of communication.</p> <p>Keep assertive/aggressive to insist government to stick with ICPD commitment. Build coalition of NGO communities to advocate for women rights for safe abortion.</p>
	<p>For Donors: Technical assistance on personnel training and reproductive healthcare services are needed so as to have safe abortions. Focus should be given to the improvement of skills to local health providers, particularly those in rural, remote and mountainous areas.</p> <p>Financial assistance to build intervention models and conduct baseline surveys and training to improve community capacity through participation of local NGOs</p>

Comments from resource person(s)

Malou said to look at the methodology, and the linking to data to the issue of advocacy. She also said that finding the percentage would have to be tied up into the advocacy that is wanted. How would you advocate your issue?

Rashidah said that there needs to be more research on the situation of abortion, and the recommendations need to be more specific. Coalition of NGO's is a VERY good recommendation.

Ngoc responded by saying that there are a lot of statistics in the papers. She said that the paper needs to be reworked after being sent to a reviewer. She also noted that of course there should be an analysis because that area needs to be worked on more and needs linked to a monitoring system, like abortion care. She said that it was found that it is very important for Vietnamese staff to be involved with that.

Discussions and Suggestions:

Pallavi wanted to know if the son preference leads to sex selective abortion. Son preference. Does it lead to sex selective abortion?

Ngoc responded by saying that son preference is a major reason for abortion in Vietnam.

Malou said that then that should also be considered an issue.

c. Pakistan: What has been the impact of the recent progressive family planning policies (contraception and abortion), at the community level? (Shirkat Gah)

Research Question

- What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?

Key Findings

Research questions / Objectives	Findings
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	Availability and accessibility of family planning facilities is limited, leading to higher numbers of unwanted pregnancies.
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	Lady Health Workers in many areas are deployed mainly for delivery of primary health care to children; women in the community have access to no facilities for family planning, as alternative Family Welfare Workers are unavailable (from FGDs).
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	Both men and women consider contraceptives to be women's responsibility.
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	General health care facilities, and regular presence of skilled health personnel, are insufficient.
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	Basic Health Units are inadequately staffed and equipped.
What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	There is inadequate public awareness of family planning, and the various methods of contraception.

What has been the impact of the recent progressive family planning policies (contraception and abortion) at the community level?	False beliefs and misconceptions abound; there is much reliance on herbal remedies and diets, including for induced abortion.
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Prioritize Recommendations for Advocacy Issue (Contraception)

Ranking of Recommendations	Criteria
Strengthen and expand the doorstep approach (LHW program) of providing FP services to reduce the unmet need for contraception	Government beginning to focus on LHWs Increasing pressure from civil society
Properly staff and equip health facilities and ensure distribution of full range of contraceptives	Availability and accessibility of family planning facilities is limited, leading to higher numbers of unwanted pregnancies.
Improve knowledge about the efficacy and qualities of various contraceptives.	At least 58% of women in the reproductive age group have cited fertility as a reason for not intending to use contraceptives.
Provide quality Post Abortion Care services including PAC counselling	High levels of unsafe induced abortion and related complications. Inadequate healthcare provider training to address post-abortion complications.
Legitimize abortion for cases of rape and incest	Civil society actively pursuing abortion rights; some positive changes in legislation regarding women's rights
Enact appropriate legislation to ensure safe abortion	

Recommendations for Abortion:

- Provide quality Post Abortion Care services including PAC counselling
- Legitimize abortion for cases of rape and incest
- Enact appropriate legislation to ensure safe abortion

Discussion and Conclusions:

Gaps in the current policy: at policy and/or programme, and/or activity levels:

- A barrier to achieving ICPD goals is the shift in focus of policies and programmes from the ICPD to MDGs. There is a lack of synchronised efforts, sector-wide approaches and intersectoral collaboration to address the unmet

- need for family planning, unsafe abortions, low literacy, and the dearth of women's empowerment initiatives.
- Inadequate attention is paid to strengthening primary health care and emergency obstetric care.
 - Priority is not given to Reproductive Health and Family Planning (RHFP). Despite the dire need for expansion, and the fact that it is integral to health, RHFP does not receive either sufficient funds or due attention.
 - Literacy rates are low and not enough attention is being paid to improving them.
 - There is a lack of political commitment.
 - Resource allocations are inadequate There are many changes of government as well as of people in the ministries.

Conclusions:

- There is a need for greater political commitment.
- Existing progressive policies need to be fully implemented and the implementation needs to be monitored.
- The existing infrastructure (BHUs, RHCs, LHWs, etc.) needs to be made fully functional.

Comments from resource person(s)

Rashidah said that the recommendation for abortion is really strong. She said that to make the case, abortion should include cases of rape and incest. She noted that recommendations should be hopeful and the recommendation for contraception is not so great. She also noted that the advocacy action needs to be more innovative. she noted that the policies are already in place, the problem is in the implementation. So why not put the policies into implementation?

Malou agreed with Rashidah and wanted to know if there was a policy for lady health workers? She also wondered if it would be possible to institutionalise the policies to support further implementation if implementation was a problem.

Discussions and Suggestions:

Rahal agreed that the policies need to be implemented, But she noted that in terms of getting it out there, it might be a problem.

Ninuk wanted to know if abortion was legal in Pakistan.

Rahal said that there is a clause. It is allowed in cases to save the life of the mother, or to provide treatment for the mother.

Indu questioned if there was sex selective abortion in Pakistan

Rahal responded that if such was the case, it was not something that is publicised. If sex selective abortion is done, it's not publicised.

Indu noted that there was a need to find out as in a place like Pakistan, the women workers are unempowered, so a policy that is implemented will be very good.

d. Indonesia: Unsafe Abortion: Policies and Practices and Contraception in the Decentralization Era (Women’s Health Foundation)

Research Questions:

- Why have women chosen to perform an unsafe abortion?
- Do the women know that if complications occur after she under went unsafe abortion practices at a TBA, that she should go to a health facility for the help, otherwise she will die?
- Do women know that to be eligible for Post Abortion Care at the hospital a woman has to have had an incomplete abortion.
- Who do women know that some persons (midwives/TBAs) can perform incomplete abortion practices?
- Who were the persons (their characteristics) who performed the unsafe abortion/incomplete abortion?

Key Findings

Research questions / Objectives	Findings
To document women’s efforts in terminating their unwanted pregnancy	<ul style="list-style-type: none"> • most women came to the clinic after went through an exhausted efforts in terminating their pregnancy (92% married, 79% were between 20-39 years old, 85% high school and higher education graduates, came from other provinces, women from all religious background came to seek help). • 84% tried to abort by drinking herbal toxid traditional medicine; 5% massage their abdomen, 11% tried combination ways
To explore policies and practices in addressing the demand of abortion services	<ul style="list-style-type: none"> • Policy: only PAC is provided in the emergency unit of the teaching hospital, abortion by request will refer to Human Reproduction Clinic. • Abortion can only perform by senior Obgyn • Resident (Obgyn candidate) can only observe the procedure performed by their senior • Method & equipment: • Not fully followed WHO standard, using outdated method & equipment, responsible for higher complication • The curriculum re-safe abortion, is not always in place, depend on the policy set up/decided by person in power in the University

Recommendations:

- With regards to abortion should reflect international human rights standards related to the protection of women’s lives and health and public health needs of women who may have unwanted pregnancies and may die due to the complications of unsafe abortion

- Safe abortion services for all indications guaranteed by the law must become an integral part of comprehensive health care and services in order to minimize the unnecessary death and morbidity caused by unsafe abortion
- The Criminal Code needs to be revised in order to de-criminalized women who seek abortion services. The Criminal Code also needs to be revised in order to decriminalized medically qualified who provide safe abortion services when the law allows.

The key recommendation is that **a health law is crucial to be issued.**

Discussions and Conclusions:

- Women have to face a big continuum of suffering/variety of dangerous situation in their efforts to terminate their unwanted pregnancy. From the perspective of women, she is seeking safe abortion services, unfortunately so many barriers prevented her efforts. 3 barriers: structural, institutional, individual.
- In view of the legally restrictive nature of abortion, health care providers are un-aware of the grounds on which abortion can be provided within the current law. Also there is a lack of training of providers in methods of safe abortion.
- women wants to space or limit the number of children, unfortunately they still lacking in knowledge & information about contraceptive methods. Many of them still heavily influenced by mislead norms and beliefs.
- In the absence of the law, every stakeholders have their own interpretation regarding abortion, consequently there is no standard to guarantee the safety of women in accessing abortion care.
- There are some different "*mazhab*" (school) in Islam, each has different discourse regarding abortion. Some of these discourse are actually more tolerant.
- The government has signed a number of international agreement: ICPD, Beijing Platform of Action, MDGs.

Comments from resource person(s)

Malou said that this group used statistics to portray the drastic positioning, which graphically stated the situation in the country. It was very good.

Discussions and Suggestions:

Alongkone wanted to know why performing abortion was disallowed.

Ninuk responded, saying that the head of OBGYN in the hospital is against abortion, and wants to prevent the young generation from having an abortion. The problem with that is, if the women are refused help, they will try everything to abort themselves. They become relieved after abortion. She noted that it is important to sensitize them to the importance of the situation.

5. CRITICAL SRHR ISSUE 3: MATERNAL HEALTH

a. Philippines: Removing Barriers to Critical Reproductive Health Services that Avert Maternal Death and Disability in the Philippines (Likhaan)

Research Questions:

- Why are pregnancies unplanned?
- How do women deal with unplanned pregnancy?
- How do they deal with a continuing unplanned pregnancy?
- Why are women not delivering with trained/professional attendants?
- Why and how do women get the emergency treatment that saved their lives?
- What factors facilitate and what hamper women's access to lifesaving health services

Key Findings

Findings
<ul style="list-style-type: none">• 6 of 9 women knew how many children they would have preferred. Their preference is based on appraisal of economic limitations and the desire for their children's welfare.
<ul style="list-style-type: none">• 5 of 9 women never used FP because of poor knowledge or because of concerns about reputed side-effects); 2 initiated but discontinued due to ill effects; 2 used FP regularly but not perfectly.
<ul style="list-style-type: none">• More Muslim women used or tried to use FP compared to in Manila. While Manila women did not cite external prohibition as reason for non-use, government FP supplies are unavailable in Manila but available in Basilan
<ul style="list-style-type: none">• There exist significant access problems, specifically availability, affordability and acceptability. In ARMM, government health centers offered pills and injectable although supplies were short and erratic. Government supplies, though not completely free, were more affordable than supplies sold by private pharmacies. Both government and pharmacy did not dispense supplies to minors and unmarried women and men.<ul style="list-style-type: none">○ The range of FP methods in ARMM is limited to pills and IUD. This narrow range is attributed to women's general reluctance to expose their intimate bodies to health providers during consultations.

Recommendations:

- Practical steps
 1. Inform women about fertility, effective contraception, obstetric emergencies

1. Encourage organization of mutual help groups in communities, esp. poor and remote communities, to assist women wanting contraception or giving birth e.g through transport and funds
 2. Train primary health care personnel in integrated safe motherhood, including –FP, normal delivery, basic emergency obstetric care
 3. Refurbish health centers to assist women delivering, women who had abortion or women who want to use contraception
 4. Encourage all women to deliver in health facility or with skilled attendant.
- Longterm steps
 1. Rationalize, strengthen and integrate public hospitals at district and provincial levels; ensure cadre of trained and well motivated health professionals at these levels.
 2. Review laws affecting health care delivery including Safe Motherhood serves eg decentralization, social insurance law, midwifery law, abortion law
 3. Institutionalize citizen’s action groups around safe motherhood, equity and rights
 4. Push for passage of RH bill which mandates critical safe motherhood services and funds

Discussions:

- The fact that all 9 women survived means that the system –despite its shortcomings -worked for them. Some factors:
 - Quick decision by women, spouses & TBAs to refer
 - Funds for expeditious travel to the facility and down payment – whether from relatives, politicians, loans, social insurance
 - Capable EmOC personnel and facility
- Prevention of unintended pregnancy through effective contraception is critical. Yet there are formidable problems, eg
 - weak national program
 - strong opposition by Catholic Church
 - donor moves towards privatization of FP
- Analysis of DOH’s Administrative Order (AO) on Safe Motherhood (from poor and marginalized women’s perspectives)
 - (for completion)

Comments from resource person(s)

Malou warned that there was a danger of generalising. The women are from different places, so there shouldn’t be a generalisation.

Indu was not sure if there’s enough evidence for policy making, but noted that it was a great opportunity for advocacy. She said that although it might not be able to be converted into a policy brief, it was a great opportunity to advocate. This is a photographic evidence.

Rashidah said that the recommendations need to be more specific. Citizen’s action group is a good idea, but it doesn’t say how or where it will be linked. Qualitative data is great, but you need more. In terms of validity, it’s great. She noted that in-depth women’s stories, their experiences, might be something to think about when advocating.

Discussions and Suggestions:

Djalía noted that this is the methodology adopted by Likhaan, but there is also secondary data, that may have been used to 'generalise'

Atas wanted to know how they went about with their methodology with two different places like Manila and Mindanao.

Djalía responded, saying that Likhaan and PinK have their own contacts, they know people, so they initially asked questions to see if the people fit into the criteria.

Ava noted that talking about safe motherhood issues is complex. She wanted to know if there were differences in the decision-making by the women themselves and if there were any support packages for the poor and marginalised.

Pallavi noted that within these ten, there is a variance in culture, and background.

Sunita commented on the methodology of the research. She said that it was too small a number to make a policy brief and wanted to know where the comparison was. She noted that although various health care providers and policy makers have been spoken to, that, and secondary data is not shown. It needs to be shown in order to reach out and bring the facilities to the people. She suggested Mobile Vans?

Djalía said that she was not sure if she was the right person to address some of the questions, but she did note that they were looking into developing some of the life stories, although there is a need for infrastructure. She also agreed that in terms of methodology, it was too small a number to make an advocacy policy brief, so that might need to be redone. As for the rest, she will discuss it with her partners.

b. Laos PDR: Cultural beliefs and traditional rituals about child birth practices in Lao PDR (National University of Laos)

Research Questions:

- Why do Lao women still give birth at home?
- What are the socio-cultural contexts about child birth practice in Laos?
- What are the gender aspects of child birth practices in Laos?
- What are the traditional rituals of child birth practices in Lao ethnic women?

Key Findings:

Research questions / Objectives	Findings
To get better understanding about socio-cultural and gender perspectives of Lao ethnic women regarding with child birth practices	<ul style="list-style-type: none"> • Child bearing <ul style="list-style-type: none"> ○ Meaning of child bearing ○ Antenatal care ○ Food taboo ○ Care and support : physical , psychological ○ Sexual intercourse during pregnancy ○ Health risk during pregnancy • Child birth <ul style="list-style-type: none"> ○ Birth preparedness ○ Birth assisting ○ Health risk during child birth • Post-partum period <ul style="list-style-type: none"> ○ Umbilical cord cutting ○ Mother roasting (Yu kam or Yu fai) ○ Food taboo ○ Placenta disposal
To explore the influence of Lao ethnic women's family members regarding with child birth practices.	<ul style="list-style-type: none"> • Family influence <ul style="list-style-type: none"> ○ The decision for place of delivery is influenced by husband, mother, grand mother and mother in law
To explain the reason behind the traditional child birth practices among Lao rural women	<ul style="list-style-type: none"> • Financial constraint • Position of delivery • Quick labor • Willing to stay closer with the family • Fear of medical procedure • Lack of privacy and confidentiality

Prioritize recommendations for advocacy

Ranking of recommendations	Criteria
Motivation of women and theirs family	<ul style="list-style-type: none"> • Motivation of family especially husband as well as advocating overall reproductive and sexual health and rights. • Effective programs on information, education and communication on safe motherhood programs should reach women and their relatives • This should be enabling women to make an informed decision about their choice of delivery.

<p>Advocacy of Policy maker to make the safe mother hood program more accessible</p>	<ul style="list-style-type: none"> • The provision of mobile maternity services might be an alternative solution for unplanned home delivery • Mothers who plan deliver at home need information about how to access a trained TBA or preferably, a skilled birth attendants (Community midwife) available for domiciliary.
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Discussions:

- Childbearing is the most significant ritual passage of new status of parents.
- The ritual expression by elderly *"pregnancy means waiting for death- Luk Khao Thong, Lo tha meui tai"*. A pregnant woman is seen as different from other women.
- For pregnant women, their behavior and diet are different from other women in order to protect themselves from danger and be able to carry pregnancy to term.
- The majority of mothers attended ANC, only few of them delivered at the hospitals.
- If the pregnancy is fine, the mothers decided to delivery at home.
- The study also found that the main reason for home delivery was
 - lack of money to pay for delivery, transportation and food.
 - Quick labor or precipitate labor
 - lack of accessibility to health services
 - Fear of medical procedure in hospital
 - Birth position , need privacy and confidentiality
 - Traditional and cultural beliefs and decision making within the households.

Comments from Resource Person(s)

Indu suggested making MMR a political agenda. She said that the infrastructure should be in place before advocating and educate women. She also wanted to know how they would promote the strategy for emergency obstetric care. she suggested that they don't go the way the way of typical institutional birth, but instead strengthen the TBA's

Rashidah said that as this is an ICPD15 research project, recommendations and strategies should be related to that. Safemotherhood programme 2002. Recommendations need to relate it back to the programme, ICPD and your policies. FDG: what women are saying are a barrier. Put it together.

Alongkone said that the national survey was held in 2005. He also added that they were new in the field of advocacy and were not sure how to do advocacy. He also added that the Prime Minister is head of the National Committee for Mother and Child. So there is a need to figure out how to position the research and advocacy.

Malou noted that knowing that the PM is the Head is great. It is a steering committee. That's great!

Discussions and Suggestions:

Atas noted that MMR is very high in Laos. Safe motherhood started in 1999, but she thinks it is very slow because the population is very high, like Cambodia. That should

be addressed, why the safe motherhood programme is going so slow. MMR is so high, and the advocacy issue should be very strong, and quick.

c. Nepal: Prevalence of Utero-Vaginal Prolapse in Tribhuvan University Teaching Hospital and its Socio-cultural Determinants (Beyond Beijing Committee).

Research Questions:

- To identify the magnitude of uterine prolapse in specific geography, caste/ethnicity, age, economic status, education, age at first pregnancy, birth spacing, occupation, gender status at family etc.
- To find out the most common risk factors of uterine factors (social, economic, medical and others)
- To find out the relation between uterine prolapse and accessibility of essential and emergency maternal health care at community level
- To find out the relation between uterine prolapse and maternal health care seeking practices in the community.
- To find out the impact of uterine prolapse in quality of life
- To identify the relationship on uterine prolapse and gender based violence.

Key Findings:

Age group	%
23-30 yrs	6.06
31-40 yrs	12.12
41-50	34.85
51-60	21.21
61-70	19.7
71-80	6.06
Total	100

Marital status	%
living with husband	86.36
Widowed	12.12
Separated	1.52
Total	100

Cost of service taken(Nepali Rupees)	%
30-50	27.27
200-300	7.58
350-500	30.30
501-1000	10.61
1100-2000	7.58
2001-6000	9.09
10000-16000	7.58
Total	100

Contraceptive use	%
No	59.09
Yes	33.33
	6.06
Total	98.48
Missing	1.52
Total	100

Conception history:

Age at 1st pregnancy	%
Teenage	65.16
20- 32	34.86
Total	100

History of Abortion	%
No	56.06
Yes	37.88
Total	93.94
no response	6.06
Total	100

History of prenatal death	%
No	80.30
Yes	12.12
no response	7.58
Total	100

Maternal care

Delivery Assistant	%
mother-in law/neighbor	68.18
ANM/Staff nurse	7.58
Self	22.73
relatives and nurse	1.52
Total	100

Place of Delivery	%
Home	89.39
Hospital	10.61
Total	100

Women's workload

Duration of carrying load after delivery	%
1 week	78.79
3week	1.52
4week	1.52
2-3 month	1.52
Total	84.85
no need	16.67
Total	100

Practice of carrying load	%
1 time in week	9.09
2-3 times in a week	18.18
4-5 times in week	1.52
Daily	71.21
Total	100

Gender based violence:

History of Domestic Violence	%
No	39.4
yes (physical)	6.1
Total	47.0
no response	54.5
Total	100

Health seeking behaviour

Treatment practice for UP	%
No	50
herbs/special food	12.12
visited Jhankri	4.55
Pessary	25.76
pessary and herbs	6.06
DJ/herbs	1.52
Total	100

Use of ring pessary before	%
No	65.23.64
Yes	34.85
Total	100

Degree of cervical descent

Degree of cervical descent	%
1st degree	28.8
2nd degree	24.2
3rd degree	47.0
Total	100

The physical experiences of Uterine Prolapse includes pain, reduced intake of food, have difficulty working, a sexual dysfunction, a bigger amount of discharge, infections and tissue decay.

The psycho-social effects of prolapse are stress, emotional isolation, abandonment by husband or divorce, ridicule and shame, inability to work, lack of economic support, risk of violence and abuse, discrimination.

Conclusions

- Uterus prolapse is a major public health issue with little attention
- High prevalence; high demand for services
- Surgical services limited to cities
- Poor and the excluded women not able to access services
- Need for a multi-pronged, multi-sectoral concentrated effort

Discussions and Suggestions:

Du Li wanted to know why women delivered at home when the service at the hospital is free. She also suggested a regression analysis for the data collected.

Ava said that free delivery service was just introduced in February 2009. She is hopeful that maybe one year down the road, this service will be utilised. She said that they only received the data a week before they got here and will be doing a regression analysis once they go back.

Pallavi noted that since there are different techniques to the operation, patients don't need to stay longer than necessary. She suggested that gynaecologists be trained for that. Also she said that contraceptives should really be introduced and if gender discrimination is an issue, then it needs to be addressed.

Sunita noted that 38% of the women fall under the 30 – 40 age group. She wanted to know what the advocacy issue for these women are.

Ava said that it will be a blanket kind of advocacy for what ALL women can do. Issues on Gender empowerment are issues that they haven't thought of in that much detail.

Pallavi noted that there is a need to work on the rural technology, so the women can get some help.

d. India: Nutritional Anaemia: A Neglected Agenda (Academy of Nursing Studies and Women's Empowerment, Centre for Health Education, Training and Nutrition Awareness, Centre for Health and Social Justice)

Research questions:

- To learn about the knowledge, attitudes and practices of adolescents, pregnant women to and lactating mother and parents of young children about anemia and Iron Folic Acid tablets
- To learn about the knowledge, attitude and practice of service providers, Auxiliary Nurse Midwives, crèche pre school and Medical officer
- To learn about the awareness level of the community leaders about their role in prevention of anaemia
- To learn the efforts made by the government to prevent nutritional anaemia
- To learn the change at the policy / program in the domain of nutrition and food security affecting women and adolescent girls
- Understand the level / degree of integration between policy / program in domain to address the issues of malnutrition among women.

Key Finding

The primary data collection is on going. It will be completed by end of March 2009.

6. CRITICAL SRHR ISSUE 4: SEXUAL HEALTH AND RIGHTS

a. Thailand: Sexual Harassment in Workplaces and Educational Institutes (The Southeast Asian Consortium on Gender, Sexuality, and Health)

Research Questions:

- What are the problems, magnitude, forms and contexts of sexual harassment in Thailand
- What are the existing policy responses and laws regarding sexual harassment?
- Do the existing policies, institutional regulations and laws regarding sexual harassment effectively respond to women's human rights?

Key Findings

Research questions / Objectives	Findings
<p>What are the problems, magnitude, forms and contexts of sexual harassment in Thailand?</p>	<ul style="list-style-type: none"> • Magnitude <ul style="list-style-type: none"> ○ during the past 5 years sexual harassments were reported in the news more frequently, but there is no official statistic informing its magnitude that available ○ A report on Children Surveillance in 2005 revealed that 6.42 % of children aged under 18 experienced sexual harassment while in 2006, is 31.32%, which shows a sharp increase ○ ABAC Survey in 2005 reported 23.8 % and 22.9 % of women in the workplace and educational institutes respectively experienced sexual harassment ○ ABAC Survey in 2006 reported adolescent girls are more likely than adolescent boys to experience sexual harassment (60%:26%) • Forms and contexts <ul style="list-style-type: none"> ○ women, girls are asked/forced to have sex in exchange of promotion or to up the scores for their exams ○ new technologies are used as a means to harass women, for example distributions of women's sexual life VDO tape through the internet, use a mobile phone camera to record women's bodies and disseminates it via the internet ○ women, transgender, and young girls are the most vulnerable groups and they are in a subordinate position of the offenders ○ women in particular professions such as domestic workers, laborers in factories, in beauty salon, waitress, air hostess, etc. were often reported as victims ○ take place in schools, universities, workplaces, public spaces, public bus, shopping centers, entertainment places, beauty salons ○ the offenders usually are men who are teachers, superiors • Problems <ul style="list-style-type: none"> ○ there are problems in the way Thai society and popular media define and understand "sexual harassment" due to patriarchy culture ○ there is no specific local/Thai term to name "sexual harassment" practiced in Thai society. It is a practice that have no term

	<p>which means it is not seen as a problem or as one form of violence against women</p> <ul style="list-style-type: none"> ○ lack of awareness and understanding among key stakeholders ○ sexual harassments either happened to women or male transgender are not received serious public attentions and responses ○ unequal power relations between the victims and the offenders are prominent ○ women who filled the compliant about unwelcome sexual advances/harassment or risk of rape often encountered intimidations ○ there is a tendency to judge sexual harassment that occurred as women's wrongness or as women behave and dress improperly
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Prioritize issue for advocacy

Ranking of recommendations	Suggested Criteria:
For government, NGOs, parliament members	<ul style="list-style-type: none"> • urge the government to form a multi-sectoral committee to review relevant laws on sexual harassment and come up with a draft implementing rules and guidelines that will include clear definitions of sexual harassment and measures to judge it. • encourage a strong commitment from the part of policy and law makers to deal with the problem effectively
For government, workplaces and organizations	<ul style="list-style-type: none"> • encourage the government, workplaces both public and private, formal and informal sectors and educational institutions to set up a sexual harassment focal point in their organizations and to make the procedures for handling complaints gender-sensitive and friendly to the victims
For NGOs, labor union, government organization such as Ministry of Education, Ministry of Human security and social welfare, judiciary, scho	<ul style="list-style-type: none"> • focus on public communication by encouraging campaigns that address people's attitudes toward the issue of sexual harassment. • Use target-specific messages that are empowering for the victims • Connect sexual harassment with women's human rights as well as the issue of healthy society

Discussions and Conclusions:

The gaps:

- no clear and strong laws, policies and regulations to prevent sexual harassment and to restore women's rights and dignity
- lack of clear and strong commitments to tackle the problem at a all policy levels

- need to improve society's understanding and attitudes towards sexual harassments and their understanding about the negative impacts of the victims

Comments from resource person(s)

Rashidah said that the recommendations are very clear and well presented in terms of criteria for the recommendations. She also noted that there is a long list of who will do it, which is good, but wondered who will take the lead? It's important that someone does that. She also noted that the 1998 law is recent, so why is it weak? Need to reflect on that in the discussion.

Suchada said that she will remember that and thanked Rashidah for the comment.

Discussions and Suggestions:

Suchada said that when women bring cases to the court, they are taken negatively. They have to fight the negative attitude both in the media and those who were not involved in the situation. She gave as an example a story about a student who brought the media in, where she was forced to have sexual intercourse with her lecturer in order to get a good grade. The backlash was bad on the girl. The bias is internalised already, it's rooted in their culture.

Pallavi noted that Suchada had recommended a committee for SH to be set up in the work place, which they did in India, although it is weak.

Indu questioned what instigates male behaviour. She said saying patriarchy is not enough, instead she suggested shaming the men using media. It's worked in India.

Atas noted that Thailand has a national commission of Women's Rights. She wanted to know if there was a special committee.

Suchada said that many places have got the attention of the human rights commission committee. But the process and procedure of the law, to make judgements is the problem.

Atas asked about the criminal court.

Suchada responded that there is a criminal law that raises the issue, but as she had mentioned, the process and procedure of the law, to make judgements is the problem.

Atas shared that in Indonesia, both the successful and unsuccessful cases are being taken up.

Mary said that in her organisation, there is a programme that reaches out to juvenile delinquents who have been arrested for multiple cases, including sexual harassment. Research showed that the boys weren't aware of the sexuality or the importance of it. She said that she would share that research with Suchada.

Sunita noted that when talking about SH and Violence, it's women vs men, or men vs women. In India there are a group of women who are working to stop violence against women, and they involve men in this. So a recommendation should be how to involve men in this?

Suchada responded, saying that it's been done, but because of the long roots in

their culture, it cannot be done so easily. The program that promotes healthy sexuality tries to overcome that cultural bias.

b. Thailand: Sexuality Education for Adolescents (The Southeast Asian Consortium on Gender, Sexuality, and Health)

Research Questions

- What are the status and situation of sexuality education in Thailand?
- What are the contents, approaches and coverage of existing sexuality education curriculums?
- Do the existing sexuality educations recognizes sexual rights of adolescents?

Key Findings

Research questions / Objectives	Findings
What is the status and situation of sexuality education in Thailand?	<ul style="list-style-type: none"> •Barriers <ul style="list-style-type: none"> ○ there is no policy that mandates compulsory sexuality education in public and private schools ○ varieties of curricula, concepts and approaches ○ school principles do not give priority to sexuality education ○ lacks of teachers/instructors who have comprehensive knowledge, are skillful and aware of the need to teach the youngsters about sex education ○ students do not pay attention due to inappropriate teaching methods that do not draw their interests, and lack of skillful instructors ○ being offered as a snap short (one time training/seminar) ○ they are against by parents and teachers if they integrate contents such as a condom use skill, FP, safe sex methods, sexual diversity etc. ○ nationwide only a small number of adolescents received a comprehensive sexuality education due to the problem of its coverage •Opportunity <ul style="list-style-type: none"> ○ there were many attempts and many agencies (Gov. and NGOs) which are offering sexuality education to out school and in school adolescents

	<ul style="list-style-type: none"> o NGOs for example PATH had introduced new sex education curriculum which is o Ministry of Education announced an integration of sex education for all Thai students and the Office of the Basic Education Commission developed "the national sexuality education guideline" for all students from first grade to twelfth grade
<p>What are the contents and approaches of existing sexuality education curriculums?</p>	<ul style="list-style-type: none"> •Conservative Approach <ul style="list-style-type: none"> o Instructor-centered o classroom and lecture-based o biological development-oriented o sexuality is not the major subject o emphasize more on to control adolescent sexual behaviors, to deter them from what are considered inappropriate sexual behavior, such as premarital sex o not recognize sexual rights and sexual diversity of adolescents o not recognize gender bias and gender differences o not recognize adolescent needs of information for safe sex (adolescent's rights to know is not the focus) •Liberal Approach <ul style="list-style-type: none"> o student-centered learning process, organize youth camps, participatory and interactive learning process enhancing the critical thinking process o attitudinal adjustment, and raising sexual consciousness in the form of games, group activities, and case study analysis o give importance to capacity building, the training of trainers (teachers) and adjusting their attitudes to sexuality education and talking about sexuality issues which was an important new dimension of sexuality education o contents delivered to students are more comprehensive and more focus on sexuality, positive youth development and experience learning o continuous learning process at least 8 hours per a semester, not a one-off training or seminar o contents include human development, body mapping, relationship, personal skill, sexual behavior, safe sex and condom, SRH, AIDS/STDs prevention, social and cultural issues such as gender differences and gender bias, sexual violence, abortion

<p>What is the coverage of the existing sexuality education curriculums?</p>	<ul style="list-style-type: none"> •Conservative Approach <ul style="list-style-type: none"> o offered only in public schools by regular teachers who teach health education subject o snap short teaching and not cover all levels of students, focus more on the secondary level o not nationwide •Liberal Approach <ul style="list-style-type: none"> o offered to both in school and out school youth by trained teachers who partner with NGOs workers (PATH) and NGOs who work to prevent AIDS and to promote healthy sexuality o for regular schools, covers only 759 schools in 71 provinces o for non-formal education schools, covers only in 21 provinces
<p>Do the existing sexuality educations recognizes sexual rights of adolescents or use the rights-based approach?</p>	<ul style="list-style-type: none"> •No existing sexuality education curriculums fully focus on sexual rights of adolescent, and many teachers have not yet applied rights based-approach in their teaching

Prioritize issue for advocacy

Ranking of recommendations	Suggested Criteria:
<p>For government and ministry of education</p>	<p>support a policy that mandates a standard comprehensive sexuality education for students in all schools through a process of multi-sectoral consultation.</p>
<p>For people and organizations who are involved in curriculum development and teaching</p>	<p>Ensure integrating sexual rights sensitivity, critical thinking skill towards social and cultural values towards sexual relations and gender practices in the contents of comprehensive curriculums thus youth will adopt more progressive values to protect themselves from unintended consequences of relationships</p>
<p>For ministry of education, NGOs</p>	<p>Develop strong teacher training programs that will change the teacher's conservative attitudes to be more sensitive and respectful to adolescents' sexual rights including right to learn, rights to know about sexuality and FP methods.</p>
<p>For policy makers, parents, teachers, NGOs, communities and students</p>	<p>Ensure participations from all stakeholders, especially policy makers, parents, teachers, communities and students in supporting a standard comprehensive sexuality education</p>
<p>For government, NGOs, teachers, and parties involved in curriculums development</p>	<p>Support teaching sexuality education that addresses acceptance of gender and sexual diversity thus transgender's human rights will be respected</p>

for government, policy makers, educational administrators teachers	Ensure teaching sexuality education is a continuous learning process, and the subject should be taught separately from other subjects, and should have different levels of curriculums that are suitable to youth in different age groups
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Discussions and Conclusions:

- Despite the effort and collaboration from many parties in recent years, many barriers remain
 - parents’ and teachers’ attitudes towards youth sexuality and towards providing the young about sex education remain conservative
 - Conservative adults still believe that teaching FP methods such as condom use skill to the youngsters will lead to early sex or premarital sex rather than to prevent it.
 - there is no clear policy initiative for a mandatory sexuality education in schools
 - no clear policy commitment at a provincial and school level
 - lack of rights-focused
 - no special focus on adolescents who are transgender
 - coverage remains the big issues
 - lack of qualified teachers and teachers need continuous capacity building as well as coaching

Comments from resource person(s)

Indu said that she thoroughly enjoyed the presentation. Her only concern is that in recommendation 1, the recommendation says a standard, comprehensive curriculum. In her view, adolescents are a not homogenous group but a heterogeneous group. A 12 year old in a city is very different from a 12 year old in a rural area. It’s not the variety that is the problem. Indu noted that in India, it is not possible to have a ‘one size fits all’ curriculum. Broad, comprehensive guidelines at the local and provincial level need to be included. How will you monitor it? School setting, if it’s not included in a monitoring system, teachers will not teach it, and students will not learn it.

Suchada said that these 2 issues are very important and has gone through many debates in Thailand. proposing a standard sexuality education is to ensure that all necessary contents have to be included in the curriculum, but she agreed that there is a need to recognise the diversity of the adolescents. It depends on the context on the adolescents, but the main principle must be included and the monitoring must be done, although the system is very weak.

Malou said that in 2 of the recommendations, it states ‘support’ instead of ‘initiate’. Considering the findings are so detailed, will someone else be allowed to take the lead? In terms of advocacy, when you say you are going to support, she didn’t see how such detailed recommendations can fit into a framework for another organisations that might have a different way of looking at things. She would assume that is a coalition, although there would be a negotiation of which findings would be advocated.

Suchada responded, saying she will probably decide in the advocacy meeting.

Discussions and Suggestions:

Ninuk said that she enjoyed the presentation and thought that the recommendations were very good. Her question was who will lead the movement and wondered if there already is an NGO that will lead the movement.

Suchada said that cooperation/collaboration is very important. As mentioned in the sexual harassment presentation, there is a need to identify the organisation that will take the lead.

Tini said that would like to know more about that as Suchada had mentioned that they already had the guidelines in place. She wanted to know what the result was because in Indonesia it is too difficult to go into the schools to teach sex education. The teachers don't know how to teach it.

Suchada said that they need to set up the curriculum as well. Teachers only have the guideline, they don't have training.

c. Thematic Issue - State Vs Sexuality: Impact of Law on Transgendered People in Asian-Pacific Countries (Neha Sood)

Research Questions:

- Our over-arching research/ monitoring question is:
- How do laws and policies related to sexuality impact human rights/
- How is access to SRH services restricted due to factors related to sexuality?
- Other smaller questions within this issue are:
 - Within laws and policies related to sexuality, whose rights are affirmed? Whose rights are excluded and how?
 - How can laws and policies be modified to affirm sexual rights?
 - What are attitudes of health care providers towards sexuality?
 - Do people who do not conform to social norms of sexuality face harassment/ discrimination/ violence by health care providers? What is the nature of harassment/ discrimination/ violence?

Key Findings

Research questions / Objectives	Findings
To examine how laws in 12 Asian-Pacific countries violate or affirm sexual and reproductive rights of transgendered people	<ul style="list-style-type: none">• Social Attitudes<ul style="list-style-type: none">○ Prejudice, discrimination and violence○ Homophobia, Transphobia○ Barrier to accessing health, formal education and employment

<p>To examine how laws in 12 Asian-Pacific countries violate or affirm sexual and reproductive rights of transgendered people</p>	<ul style="list-style-type: none"> • Legal situation in Nepal <ul style="list-style-type: none"> ○ Supreme Court has ordered government to ensure that Lesbian, Gay, Bi-sexual, Transgender and Intersex (LGBTI) people have equal rights as others and to end discrimination. ○ This has empowered LGBTI people. ○ Citizenship cards with 'third gender' identity. ○ Committee formed to look into issue of same sex marriage ○ Transgendered people often do sex work and get arrested for that as sex work is illegal in Nepal.
<p>To examine how laws in 12 Asian-Pacific countries violate or affirm sexual and reproductive rights of transgendered people</p>	<ul style="list-style-type: none"> • Legal situation in Thailand <ul style="list-style-type: none"> ○ No specific laws that criminalize. ○ Thai Red Cross policy to not accept blood from LGBTI people. ○ Military sued for listing transgendered people as mentally ill.
<p>To examine how laws in 12 Asian-Pacific countries violate or affirm sexual and reproductive rights of transgendered people</p>	<ul style="list-style-type: none"> • Legal situation in India, Policy situation in Tamil Nadu <ul style="list-style-type: none"> ○ Hijras criminalized in post-colonial India; since de-criminalized. ○ Homosexual acts criminalized; applied to transgendered people. ○ Transgender Welfare Board. ○ Ration cards with 'third gender' identity. ○ Government order to schools and universities to ensure transgendered students not denied admission. ○ Sex-change operations reimbursed.

Prioritize issue for advocacy

<p>1. Change laws that criminalize or discriminate against LGBTI people</p>	<ul style="list-style-type: none"> • Rights violations need to be stopped urgently. Additionally, tide of change starting in the region (Fiji, Hong Kong, Nepal). • Health and education are basic needs • LGBTI communities are mobilizing and ready for programs that will strengthen them. • Opportunities need to be created for transgendered people to progress.
<p>2. Sensitize and make aware health personnel and teachers</p>	
<p>3. Implement programs to empower LGBTI people</p>	
<p>4. Establish affirmative action for transgendered people</p>	

5. Build public awareness and opinion about gender and sexuality diversities	<ul style="list-style-type: none"> Necessary long term objective
6. Need for gender plural and non-heterosexist education curriculum	<ul style="list-style-type: none"> Necessary long term objective
7. Anti-discrimination laws	<ul style="list-style-type: none"> Effective only in the long run after sensitization efforts.

Discussions and Conclusions:

Discussions:

- Heterosexist laws exist pertaining to marriage, divorce, inheritance
- Heterosexist policies exist in public and private sectors (partner benefits, insurance, etc)
- Prejudiced judiciary and police harasses LGBTI populations
- Health Sector
 - Lack of knowledge of LGBTI health issues including anal STIs, hormone therapy etc
 - Lack of sensitization and awareness of personnel
 - No infrastructure for transgender – separate wards (only M/F), lines, toilets
- Education
 - Lack of sensitization and awareness of teachers
 - Lack of focus on LGBTI issues and personalities in curriculum
- Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people lacking self-esteem and life skills.

Conclusions:

- Human rights framework useful in changing law
- Need to change laws that criminalize or discriminate against LGBTI people
- Need anti-discrimination laws
- Establish affirmative action for transgendered people: need to make policies that encourage progress in education and employment
- Need to create political will to bring about policy change. Ex. of Tamil Nadu – reached out to an MP who took on the cause at the state level
- Need to build public awareness and opinion about gender and sexuality diversities
- Need to sensitize and make aware health personnel and teachers
- Need for gender plural and non-heterosexist education curriculum at multiple levels – school, universities, professional education etc
- Need for programs to empower LGBTI people

Discussions and Suggestions:

Rebecca wanted to know what LGBTI was and said that there was a need to know about the statistics of LGBTI in these countries.

Ninuk said that in Indonesia, the lesbian groups are beginning to come up and have formed an NGO. She said that she will try to get them into contact with Neha. She was also curious to know, to direct that kind of movement, which ministry would she

go to?

Anjana noted that there needs to be a lot of qualitative research needs to be done. Why 20 in Nepal, 3 in India, and 10 in Thailand? In Nepal, sex work is not illegal, it's silent. Citizenship card is not necessary to access health services.

Suchada suggested that Neha look at how these issues are covered under the civil law.

Lin Lixia wanted to know how Neha analyses the implementation in the countries.

Djalja suggested exploring the possibility of engaging people who have the potential to be on our side to be elected.

Sham said that in her experience, there is discrimination by gay groups against LGBTI

Atas wanted to know if Indonesia could also contribute to Neha's 12 country study. She asked Neha to send the interview guidelines, and she'll connect them

Neha thanked everyone for their questions and suggestions and responded:

Rebecca - LGBTI stands for Lesbian, Gay, bisexual, Transgender and Intersex. Transgender and intersex is gender identity. LGB is sexual orientation. Statistics of population, this information is not available. That grouping does not find itself in the government consensus. Parents, when and how do they throw their children out of the home. Simplified answer: the norms of society. When a child is born male, then there are certain expectations from the parents. They will throw the child out simply because they worry about what people expect.

Ninuk - the relevant ministries would be the Ministry of Law, Current Affairs. But they are not allies. Now our ally is the Minister of Health, and we try to capitalise on that. It depends on the country context.

Suchada – look at other laws.

Lixia – how the supreme court order is implemented in Nepal? So far, identity card is being given out with a 3rd gender. It only came out in Dec 2008, so we need to study it further. I am analysing the Supreme court order. The human rights framework has been useful and very helpful. As well as using the human rights committee.

Atas - thank you for your comment.

Sham – within the movement of sexual orientation and gender identity, yes, the gay men hog the spaces, and the LGBTI are marginalised by the G. Yes, this grouping is problematic, but it is also strategic.

d. China, Shanghai: Health Care Utilization of Migrant Women in Shanghai (Shanghai Women's Health Care Institute)

Research Question:

- What influences the service-utilization of low-cost service for pregnant migrant women?(from both sides of provider and recipient)

Key findings:

Research questions / Objectives	Findings
Hospitals (service provider)	<ul style="list-style-type: none"> • Finance support influence hospital's positivity <ul style="list-style-type: none"> ○ Pay ¥800 for vaginal delivery ○ the policy attracts pregnant women from other areas out of Shanghai • Community-based health education and policy-publicizing, convenient services will promote policy-implementing (e.g. free shuttle between community and hospital) • Lack of obstetric human resources in some districts.
Migrants (service recipients)	<ul style="list-style-type: none"> • Know little about the policy <ul style="list-style-type: none"> ○ Lower education level ○ Limited channels to know the policy • The reason of choosing the hospital <ul style="list-style-type: none"> ○ Cheaper ○ Safer ○ More accessible

Discussions:

The influencing factors include:

- Health care service system
 - Profit decrease
 - lack of obstetric human resources
- Migrant women
 - Limited information about low-cost policy
 - Lower expense
 - Convenient transportation

Conclusions:

What should we do next?

- Policy Advocacy (to government)
 - Community-based surveillance to cover the 90% migrant pregnant women
 - Finance reimbursement to hospitals
- Technical support and guidance (SWHI)
 - To increase the number of obstetric workers
 - To strengthen the capacity in service providing
- Health education (SWHI & community & hospital)

Comments from resource person(s)

Rashidah noted that there was not much discussion, but more of a repeat of findings. She was wondering about the policy itself. Does the policy itself provide who should publicise the policy? She noted that the recommendation said policy advocacy, which is good. She wanted to know if the policy says anything about discrimination and/or migrant women.

Discussions and Suggestions:

Ava noted that she knew a lot more about China after Tan Jing's presentation. She wanted to know what the figures for home delivery and how that works.

Tan Jing said that from the 1960's in China all delivery services can be done in hospitals, although some women have home delivery. Now, the rate of delivery in hospitals has reached 98%. The rate of MMR is very low, maybe 12 000 per 100 000. The main reason for MMR is lack of information, and they only go to the hospital when the condition is serious.

Atas wanted to know if abortion and/or contraception is an important issue to prevent pregnancy, especially in regards to the 'one child policy' in China.

Tan Jing said that there is a family planning committee at the provincial and district level, so all the FP services are available, also at the maternity hospital abortion is available and legal.

Atas suggested that the numbers of migrant women be brought to the meeting one year so the rest of the partners could see as well.

Indu wondered how many Yuen to a Dollar

Mei responded, saying 800 Yuen is about 110 USD and this cost will be borne by the individual.

Indu wanted to know how accessible a 2nd child norm is in Shanghai, in regards to the one child policy. She wanted to know how the government reacts to that.

Du li, Tan Jing, Mei and Cici all responded saying that under certain conditions 2 children are allowed. These conditions include those who are ethnic minorities, if the first child has any genetic disorders, or if the parents are only children, then they can have 2 children.

Neha asked for clarification on the term reproductive insurance.

Tan Jing explained that this meant that all the expenses will be covered by the government, from pre natal to post partum. But the money needs to be paid first, then reimbursed by the government later. The migrant women haven't been covered, which is why the government has been pushing the hospitals to decrease the cost.

Suchada wanted to know if they could get a reimbursement if they go to a private hospital.

Tan Jing responded in the negative, noting that there are only 4 private hospitals in Shanghai, while there are 81 government hospitals.

e. China - Beijing: Primary Analysis and Policy Recommendations on Beijing Migrant Women's SRHR (Beijing Women's Law Studies and Legal Aid Centre)

Research Questions:

- To learn the basic status on Beijing migrant women's SRHR.
- From the right's perspective, to analyze Beijing migrant women's reproductive rights and related rights, and to make recommendations to national policy makers.
- To advocate government to prioritize the issues, publish new policies and laws to protect their rights, eliminate the inequity and disparities between migrant women and residential women, and establish and further enhance the public service system on migrant women's SRHR.

Key Findings:

Findings
<ul style="list-style-type: none"> • On migrant women's problem <ul style="list-style-type: none"> ○ Lower paid (average income: 1000RMB per month) ○ Low awareness and lack of money to seek health care service (44.9% did gynecologic examination in recent 3 years when suffered serious reproductive diseases.) ○ Bad living condition and sanitation(87% live in a small simple room with no toilet and no wash shower equipment, and the average living space per person is 7 m².)
<ul style="list-style-type: none"> • Problems on community service providing <ul style="list-style-type: none"> ○ Large number of migrant women do not know the community services, such as free condoms, health care training, gynecologic examinations, etc (66.5%). ○ Few migrant women obtained the training on health care and vocational skills in their community (informed by a community service provider).
<ul style="list-style-type: none"> • Problems on medical service <ul style="list-style-type: none"> ○ There are only 3 lower charge hospitals in Beijing and the equality of the medical equipments is not good (informed by interviews). ○ No good doctors. ○ Doctors are lack of patience. ○ Patients have to wait a long time for their examining results.
<ul style="list-style-type: none"> • Discriminations between migrant women and residential women <ul style="list-style-type: none"> ○ Very few have reproductive insurance because they have no Beijing residential card (informed by quantitative analysis and interviews). ○ No access to the free annual screen on breast cancer and cervical cancer organized by Beijing government (informed by interviews). ○ No subsidies for poor delivering families provided by Beijing government (informed by interviews). ○ Not benefit from their local governments (informed by focus group discussions).

- **Problems on the administration for migrant population**
 - Lack of transparency and monitoring system for budget used in migrants' vocational training program and reproductive health check-up (informed from interviews).
 - Non-accessible data base system for NGOs and lack of gender- and group-disaggregated data (informed from interviews).
 - Lack of a good public health care system (informed from interviews).
 - Lack of an equal social security system(18% has medical insurance and the insurance for personal injury at work; 3.6% has reproductive insurance).

Recommendations:

For government

1. Provide more opportunities for vocational trainings to migrant women and implement the current policy.
2. Provide equal reproductive insurance to migrant women.
3. Provide an accessible and affordable public health care system.
4. Provide an equity educational system for migrant's children.
5. Provide an accessible data system, a transparency and monitored budget system for public.

Discussions and conclusions:

- The most important things migrant women prioritized are:
 - Survival for their family
 - Education for their children (have to pay much more money than the children in Beijing, and have to go back to their hometown to take the entry examination for university.)
- Most migrant women do not care about their health because lack of knowledge and money (8% has regular health check-up organized by their work units, but from the interviews and focus group discussions, almost no one has that).
- Government did not provide enough policies and services to benefit this group, and did not completely implement some policies.
- Recommendations for community service providers
- Need more passion to promote and expand their services in order to get more migrant women involved in their services.
- Need do more advocacy for migrant women's rights, such as communicating with labor department to implement its policy to help migrant women get more vocational training opportunities and job positions.

Comments from resource person(s)

Rashidah said that the recommendations are good and specific, actions are very clear. She suggested a recommendation that is going to help government to take this action as that was not clear, and there might be a need to think of a mechanism. She wanted to know if there is a policy for migrant women, and if so, would it be recommended to be reviewed.

Lin Lixia said that there are policies on protecting migrant workers' rights, but the implementation is not satisfying. Now they want to push the government improve the policy implementation and allocate more budget on these issues.

Rashidah said that that was a very good recommendation that Lin had just said.

Discussions and Suggestions:

Rebecca wanted to know why there was discrimination between the migrants and Beijing women although they are still citizen's of China.

Lin Lixia noted that the women migrants are more vulnerable, and they have different identity/insurance cards, marking them as different. The government pays more attention to men and not women.

Atas wanted to know who issues the insurance cards and what would happen if an unmarried migrant woman gets pregnant.

Lin Lixia responded, saying that it was insurance companies that issued them, and if the woman is unemployed at the time, she gets nothing. Unmarried women cannot get this service. The cost is born by themselves.

Indu noted that advocacy is as useful as how specific it is. The more specific you are, who do you want to give this recommendation to, the more likely it will work. She also suggested that there be a planning commission, so the broader recommendations can be given there.

Lin Lixia agreed that that was a very good recommendation – local municipal government, the ministry and national planning commission.

Pallavi wanted to know how many child and maternal deaths there were and how the one child policy affects these women's mental health.

Lin Lixia said that she hasn't done this kind of research, but thinks that in the hometown they are in the same situation. In her research, more than 80% of women come from the country side, and it's very rough. She has talked to some migrant women and about 40% women want to continue to live in Beijing because otherwise they cannot get more income, and they care about children's education. She notes that most of these women don't think that it is a bad living condition. It is their survivor instinct.

Tini queried Lin's 3rd recommendation. How long will it take for this to be in place? And who?

Lin Lixia said that the 3rd recommendation was targeted to both municipal and national government. She said that if the government pay a lot of attention to this, then it won't take long. She said the 1st step is to get the government to take notice of the problem. In Beijing, like Shanghai, there is low-cost delivery, although there are only 3 hospitals. But she notes that these 3 hospitals are a success and this success can be built upon.

f. China - Heilongjiang: A Quantitative Study on Migrant Women Workers' Reproductive Health Care Needs and Services (Heilongjiang Women's Federation)

Research Questions:

- What influencing factors are for sexual/reproductive health among the migrant women workers?
- What about the utilization of sexual/reproductive health service, such as accessing, available and acquisition etc?
- How do the migrant women workers to maintain, protect and promote their sexual/reproductive health?
- What about understanding and awareness on gender? and how to impact on sexual/reproductive health?

Key Findings

Major Research Problems	Findings
Migrant women workers' understanding and awareness on sexuality and reproductive health is still low. Their strong demanding on the knowledge of contraceptives, sexual and reproductive health are still unmet.	<ul style="list-style-type: none"> • 46% of females and 45% unmarried migrant women didn't know any emergent contraceptive method.
Reproductive health technology and corresponded health care skills had not popularized among migrant women. They didn't even know any new contraceptive techniques.	<ul style="list-style-type: none"> • 44.9% women (including married and unmarried) knew little about STD. Most women were aware of the serious results of HIV infection. They mostly thought that HIV could cause death. 73.3% migrant women looked down upon HIV infectious women, they were reluctant to live together with HIV patients.
In some communities and working places, the demand of migrant women's sexual/reproductive health care had not been met entirely.	<ul style="list-style-type: none"> • 26.3% migrant women preferred to receive contraceptive knowledge through mass media, and family planning institute was the second way. The investigation showed that 70.7% had never received free contraceptive knowledge from communities and working places. 75.3% had never received free contraceptive tools from communities or working places.

Recommendations (prioritized by advocacy issue):

1. In order to increase migrant women's sexual/reproductive health care awareness and knowledge, to meet corresponded health demands, the government should build up reproductive health service networks on

- community level, such as health promotion and capacity building, therefore it can promote their accessibility of health knowledge and they can receive reproductive health care equitably.
2. As for the feature of “floating”, women’s health care consulting departments should be established in migrant women’s working places, together with reproductive health care institutions, other health care organizations and labor rights protected departments, to conduct health education, consultation and other services.
 3. We should build up partnership with reproductive health organizations to conduct women’s health services routinely and monitor migrant women’s sexual/reproductive health condition, to strengthen the connection between government agencies (such as Family Planning Committee) and local communities, to make efforts on getting migrant women involved in various activities in communities.

Discussions and Suggestions:

Suchada wanted to know what he meant when he mentioned emergency contraceptive methods?

Tan Jing responded on Ren’s behalf, saying that women don’t take any contraceptive measures before sexual intercourse, so they take it after.

Ninuk added that women can take pills 3 pills after unprotected sex over 24 hrs. But it is not recommended as a contraceptive measure.

7. From Research Findings to Advocacy Plan

by Phan Thi Uyen

Context / Root Causes

- Gender inequality: gender based violence, discrimination, patriarchal system
- Religious fundamentalism
- Economic context: urbanization, globalization, privatisation
- Sustainable achievement for a policy?
- Evidence-based Research for Advocacy
- Methodology:
 - small qualitative vs. large quantitative survey (small FGD of women, IDI/ the crucial point to show the women’s lived experience, stories to use for the media/ attraction of policy makers)
- Critical issue:
 - Urgency of the issue
 - Opportunistic contexts

Turning Recommendations into Advocacy

- What are the gaps in the current policy: at policy and/or program, and/or activity level ? (Findings and Discussion)
- Perspective matters:
 - ICPD 15 POA framework
 - Gender, women’s lived experience perspective

- o Right-based perspective

Which Level of Advocacy to be Targeted?

- To lobby a formation for a law
- To re-examine the law/ policies: good policies but poor understanding and interpretations (with influences from the religious and moralistic interpretation of seeking abortion and performing abortion)
- To monitor the implementation of the law/policies or improvement of the programs (FP budget, training for health providers, IEC, Nutrition, Safe motherhood program)

Advocacy Strategy

- What needs to be done?
- By whom? Who are allies and opponents ?
- How?
- When? (short-term and long-term plans)

8. Action Oriented Recommendations

by Rashidah Abdullah

To include:

1. The issue or finding which the action is aimed at addressing.
2. What concrete action is needed to be taken to lead to the changes required.
 - This is the hardest part to plan, as the action needs to be one which will indeed lead to the changes needed. It involves strategic thinking, and understanding the contexts, capacities and motivations of actors.
3. How the action is to be done. Some details on key activities or aspects which will make the action effective.
4. Who is recommended to take the action which implies responsibility or leadership. Who else needs to be involved. Needs to be accurate and realistic for credibility.
5. When the action needs to be taken in time, referring also to the importance and urgency of the action.

Feasibility and effectiveness of the action recommended:

1. Recommendation needs to be practical+ possible so that it wont be rejected quickly
2. At the same time it needs to be bold +innovative if possible when this is relevant, as this provides more hope +encouragement that the action may succeed.
3. Time for action needs to be clear +feasible. If urgent, state what this means-- in the next 6mth etc.

Examples of recommendation:

1. Misconceptions on the legal status of abortion which are affecting women's access to safe, legal abortion, (THE ISSUE/FINDING) need to be urgently (WHEN) corrected at policy, codes of ethics, services, curricula and training levels [THE ACTION] by the MoH, MoWFD and MMA (BY WHOM) through dissemination of correct information, education of providers [public and private], lecturers and media and clear service guidelines. (HOW)

2. The sex education in school curriculum which is critical to assist the prevention of unwanted pregnancies and which has been delayed for two years, (THE ISSUE/FINDING) needs to be urgently implemented (ACTION, HOW and TIME) by MoE + MoFD (WHO) and implementation barriers identified + addressed. (HOW)
3. A National ICPD Action Plan needs to be urgently (WHEN) developed (ACTION) by all ICPD stakeholders including diverse NGOS (WHO and HOW) with the goal of increasing CPR and reducing unmet need and unwanted pregnancies (ISSUE). It would include:
 - A conceptual framework of reproductive rights including youth
 - Higher priority for FP information and IEC services within RH services
 - Qualitative research on FP programme barriers, dissemination of discussion of demographic surveys
 - Service delivery operational guidelines on RR.
 - Medical and nurses curriculum and training review plus expansion
 - Participation of diverse NGOs with shared vision in planning, implementation, monitoring and evaluation
 - Mechanisms for input into policies and programmes, research + evaluation planning, monitoring and evaluation (ACTION DETAIL)

9. Developing a Policy/Issue Brief

by Malou Tiquia

What is an Issue Brief?

- The issue brief is a short, *neutral* summary of what is known about a particular issue or problem. It is widely used in government and industry.
- A *policy* issue brief is about a public problem, one that may or already does affect, or is affected by, government.
- Analysts prepare such briefs for educated generalists (e.g., legislators, managers), who may know little or nothing about the topic, but need to have a general background, quickly.
- The issue brief distills or synthesizes a large amount of complex detail, so the reader can easily understand the heart of the issue, its background, the players (stakeholders) and any recommendations, or even educated guesses about the future of the issue.

Why an Issue Brief?

- Learning how to research and write issue briefs will familiarize you with several issues, in-depth, and build skills such as information search, teamwork, and communication (reading, writing, listening, speaking).
- It will also train you to think strategic and determine what are negotiable and nonnegotiable points of your issue.

Parts of an Issue Brief?

- Identify stakeholders
- Describe issue's history
 - Emergence, Chronology, Trends
- Define the issue
 - Problem, extent, public policy
- Monitor issue's development

Workshop Guide

- Limit to one page
- Make sure the following are reflected in the brief:
 1. Something about your organization, V-M, track record and membership.
 2. Stakeholders in the issue.
 3. Describe issue's history (data/findings)
 4. Define the issue (Problem, extent, public policy)
 5. Monitor issue's development
 6. Restate your main objective.

The sample policy briefs (with comments) can be found in Annexe

10. National Advocacy

a. The National Advocacy Plan

by Malou Tiquia

Common Weaknesses:

1. Lack of focus - trying to tackle more issues, adopt more objectives or target more audiences than resources allow.
2. Unclear aims and objectives - *"if you don't know where you are going, any road will take you there"*.
3. Activity planning happening before (or without) developing an influencing strategy, leading to untargeted actions and reduced impact.
4. Lack of creativity and innovation in developing actions, relying on whatever was done last time.
5. Vague or bland messages.
6. Poor monitoring & evaluation, leading to lack of flexibility, no real accountability and limited learning.

Developing Objectives:

- Situation/environment analysis
- Identify policy gaps (change needed)
- Draw your objectives in achieving that change
- Make you objectives SMART:
 - Specific
 - Measurable
 - Achievable (or Appropriate)
 - Relevant (or Realistic)
 - Time-bound

Agree on Position:

- Produce and agree a short position paper that sets out your understanding of the problem and your recommendations for its solution
- Use internally to ensure understanding and coherence of messages
- Use with potential alliance partners to get agreement around a common position
- Use with targets as a back up document to summarize your position

Choice of Audience:

Your choice of audiences depends on many factors, including:

- How much do they agree with you?
- How important do they see the issue?
- How much influence do they have over the decision maker?
- How accessible are they to you?
- How much influence can you have over them?

Understand Change Process:

- Who makes the decision?
- How is the decision made?
- When is the decision made?
- What influences the decision?

Communicate your Message:

- Messages should be consistent and coherent
- Communications are clear and focused
- To achieve both, you would need to build your core message

Contents:

- Aims (*how will beneficiaries be affected*)
- Objectives (*specific changes to be made*)
- Target audiences & key influencing strategies
- Proposition (*core message*)
- Action plans & timetable for each audience/strategy
- Resources & budgets
- Risks & Assumptions
- Monitoring & Evaluation plan

Discussions and Suggestions:

Sunita asked Malou to elaborate on the take away message.

Malou explained that the take away message is important. She also said that the access point is the staff, they are the access person.

Beth wanted to know Malou's opinion about forming alliances with people/organisations you don't agree with at all?

Malou responded, saying that for activists, it is a case to case issue. Activists are purists, while lobbyists just get the work done.

Indu commented that the most important thing is to know the reputation of the person you are going to ally with. If the reputation is a problem, then it might be difficult. Forming alliances with credibility is of great importance.

b. National Level Advocacy

by Sivananthi Thanenthiran

Overall Strategy:

Recommended overall strategy:

1. National advocacy
 - The ICPD+15 project partners advocate their issues through National Policy Dialogues (NPD). The national partners' will know the most effective way and means to conduct their national policy dialogues within their political context. The strengthening and sharpening of national findings and recommendations and the creation of issue policy briefs constitute an important step in achieving the goals of the national policy dialogues. At the national levels, it may be important to present the regional overview and to situate national achievements within regional scenarios precisely with the aim of comparing and pressurizing national governments.
2. Women's Health and Rights Advocacy Partnership (WHRAP) Asia-Pacific
 - The long-term objective of the ICPD+15 work is to form an advocacy body that will function at the regional and international levels which is comprised, initially, of the ICPD+15 project country partners which include Malaysia, Indonesia, Philippines, Thailand, Cambodia, Vietnam, Laos, Nepal, India, Pakistan and China. The WHRAP Asia-Pacific vision is to include as many countries and organisations from the region as possible who will function as a regional advocacy network.
3. Global NGO alliances
 - The second long-term objective is for WHRAP-AP to aim to build international global alliances on sexual and reproductive health and rights (on the whole) and on the specific issues of contraception, abortion, maternal health and morbidity, privatization of the health sector and its impact on srhr, sexuality and sexual rights, and srhr issues in disaster management. WHRAP-AP work closely with other network allies such as LACHWN, Amanitare, ASTRA, CSBR, WGNRR, in order to promote the SRHR agenda at the global platform.

Siva said that the aim of WHRAP Asia Pacific is: "to ensure that OUR (the Asian-Pacific region) issues, OUR perspectives, OUR experiences continually inform the global community and help shape the global SRHR agenda". She went on to say the seed members will be this group because they are at a critical juncture: from the few meetings that ARROW has attended, it seems that this project may be one of the few in the world which is doing any form of monitoring of ICPD, in the world.

Siva also pointed out that the ICPD ends in 2015 and if no real ICPD review process has been done by UNFPA at this juncture then what would the global SRHR movement head in 2015? She said that this group has the critical information and strategic information necessary to input and intervene in the global SRHR movement:

- 80 cross-country indicators, divided clearly into RH, RR, SH & SR across 12 countries in the region.
- 12 country case studies which can be divided into 4 main, critical issues: contraception, abortion, maternal mortality & morbidity, sexual rights.

- 3 thematic studies: sexuality, impact of disaster on srhr, privatisation of the health sector and its impact on srhr.

This group has a combination of perennial issues: very old - maternal mortality; old - contraception; new - sexuality, privatisation/ health sector reforms and questioned why there has been no progress on some issues.

She reminded the group that in the April 2008 meeting this group had been bold enough to question if the ICPD PoA was still relevant, and in the course of one year, it has been understood that without documents such as the ICPD PoA and the Beijing PfA, the world will be driven primarily by the MDGs framework and perhaps international conventions (because they are legally enforce-able).

She said that everyone is already aware of what the problems of the MDGs are and everyone would be reduced to (easily, although the ICPD PoA actually impacts other MDG goals) to Target 5. Target 5 comprises of:

- Target 5A: Reduce by three-quarters, between 1990 - 2015, the MMR (MMR, proportion of births attended by skilled health personnel)
- Target 5B: Achieve by 2015, universal access to reproductive health (CPR, adolescent birth rate, antenatal care coverage - 1 visit, 4 visits, unmet need for family planning).

She pointed out that everyone has asked where all the rights in the MDG framework are, because are not sexual and reproductive rights the lynchpin upon which the manifestation of sexual and reproductive health outcomes such as Goal 5 hinge upon?

- the indicators used to mark the goal of 'universal access to reproductive health' – are not 'universal' in the groups they cover (usually heterosexual, married women figure in the data) where are the young, the unmarried, the non-heterosexual? Plus where is the sexual health and sexual rights agenda? Let alone the agendas of the disabled, the elderly, the vulnerable, the tribal, the migrants, the trafficked, the sexually harrassed, the victims of violence, the marginalized etc. etc.? All these groups (and many more not mentioned) are covered by the ICPD PoA but not by the MDGs framework?
- The next question we must ask ourselves is - and it is a very frank one - despite the comprehensiveness of the ICPD PoA, why then has the SRHR agenda not moved forward as we would have wished it to?
- In the little research we have done these are some of the findings:
- There are no universal standards/ best practices in SRHR set; still is seen as a 'Western' agenda. In many countries, the same debate keeps emerging taime after time. For example, Bolivia, emergency contraception. There must be some mechanism by which gains can be concretised so that we cannot regress back. Or else we will have to keep fighting for the same issues.

A suggestion: One of the amazing things this group should and could do is to set some, agreeable, critical universal standards. These standards will be by Asians, for Asians. And in this group itself, we have these standards already set: abortion laws in Cambodia, Nepal, Vietnam, China; sexuality laws in Nepal.

In the little research ARROW has done, these are some of the findings:

1. The notion of the universality of rights. In many of our societies we continue to operate under the framework of some groups have reproductive rights and sexual rights but not all. Sometimes this can be a sliding scale, when we deny some people rights, we can be creating a situation that no one can have these rights. E.g. privatisation - rich people should not be accessing 'free services.'
2. Divided/ fragmented SRHR movement. People and groups always working separated from other people and groups.

Under the umbrella of WHRAP-AP, because it operates a loose advocacy coalition, bring together diverse organisations to give the strength of numbers and representation. But we need to do a ToR by which the group would work by and adhere to.

She asked everyone to give some time to work through the logistics of bringing this to fruition. And she also urged everyone to keep connected, citing the ICPD15 blog (www.monitoringicpd15.wordpress.com) or other mechanisms.

She noted that Ibu Ninuk had given an excellent idea, that respective national governments are urged to look at the continuation of the ICPD agenda, in absence of another internationally agreed upon document.

11. Country Presentations: The National Advocacy Plan

a. Vietnam: Youth-Sensitive Standardized and comprehensive Abortion Counselling Targeting Unmarried Female Youth

The advocacy **goal** is that unmarried female youth enjoy proper abortion counseling to avoid health consequences caused by unwanted-pregnancy and unsafe abortion practice

The advocacy **objectives** are:

- To attract attention of MoH decision making board to the issue of abortion counseling for unmarried female youth.
- To have health policies revised with regard to efficient and effective implementation of abortion counseling for unmarried female youth

The core message of this advocacy plan is: ***“proper performance of youth-sensitive, standardized and comprehensive abortion counseling results in effectively protecting unmarried female youth from the continuity of unwanted-pregnancies, unsafe abortion and negative effects on their RH”***

Action plan:

Objective	Action
To attract attention of MoH decision making board to the issue of abortion counseling for unmarried female youth	<ul style="list-style-type: none"> • Preparing press release of research results, focusing the advocacy issue and offering the report document to mass media. • Sharing the report with NGO networks and mass organizations • Organizing a planning advocacy workshop with allies to prepare for dialogue meeting with MoH.

	<ul style="list-style-type: none"> • Developing policy paper for MoH • Contacting with influencing persons at MoH to deliver policy paper and proposal for a dialogue meeting.
<p>To have health policies revised with regard to efficient and effective implementation of abortion counseling for unmarried female youth.</p>	<ul style="list-style-type: none"> • Organizing a dialogue meeting with decision makers of MoH, local health managers • Follow-up activities: 1) Continue collecting stories, typical cases; 2) Keep communication with contact persons of MoH and update MoH officials with further document and information • Timeline: from May to September 2009

Comments from resource person(s)

Indu asked if there were religious groups who oppose the agenda? She also pointed out that parents might also be opponents, or even teachers, and said that finding out who the opponents are is a must. Indu also said that a policy is not enough, the implementation needs to be good. There is no awareness at the grassroots level and didn't see other NGOs as allies in the presentation.

Malou said that in terms of the objectives, it would be better to identify who in the MoH has been targeted. Deputy Minister, Secretary? There is a need to be specific. She asked which policies they want revised, pointing out that when made an objective implementation should be supported by data, which should be included. She said that the aim is too general, so it can be real for any country. It has to be contextualised in terms of the country and the aim and objectives should be linked. What is the aim and what are the objectives in order to reach the aim needs to be specific.

Ngoc responded saying that they thought that it was very important to identify the religious group as an opponent. In the context of Vietnam, there is a very broad overview on abortion, so there are a lot of different things. The target is more on the policy makers and the health practitioners, the process and procedure of the law, to make judgements is the problem. Parents and teachers are now seen as allies.

b. Laos PDR: Reaching the Unreached : Providing Quality and Free Safe Motherhood Services for All Poor Women in Laos

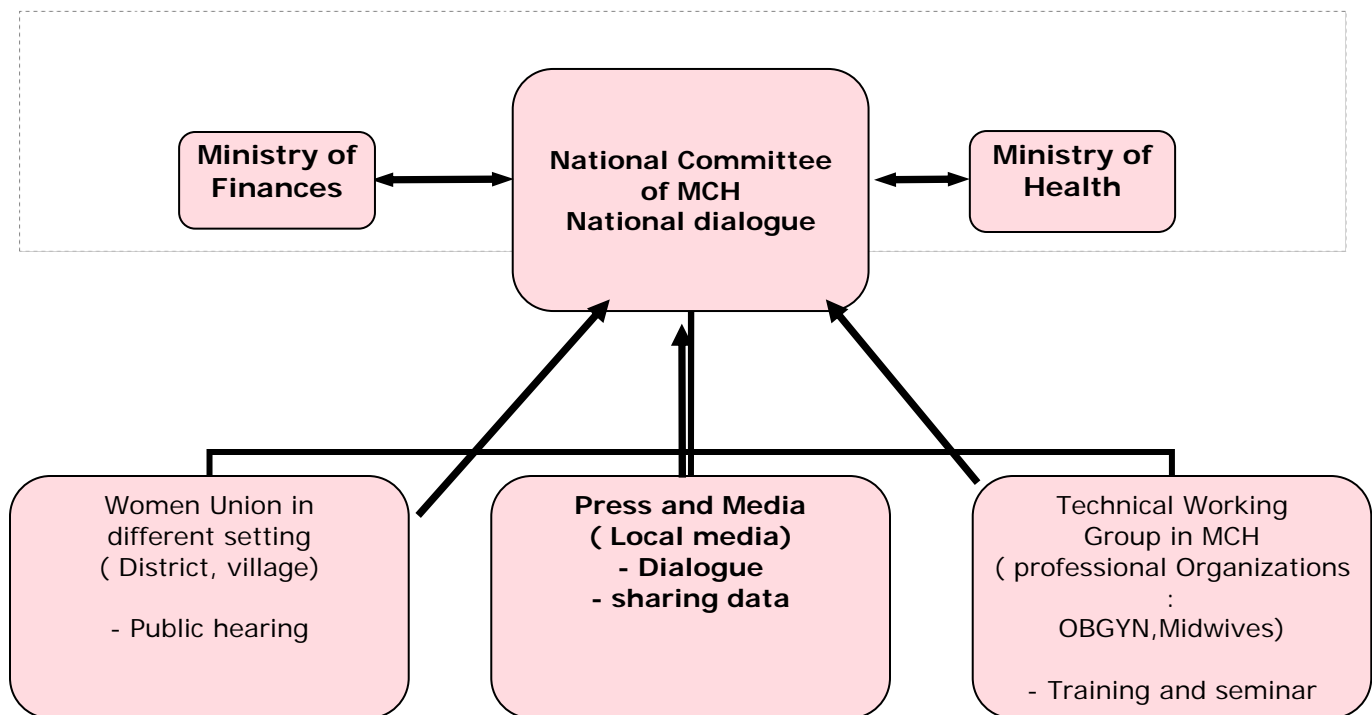
The **goal** of this advocacy plan is to make quality safe motherhood services including Emergency Medial Obstetric Care (EMOC) free for all poor women in marginalized communities in Laos by 2015.

The advocacy **objectives** are:

- To establish mobile services of safe mother hood
- To improve infrastructure and primary health care system at grass root level

The core message of this advocacy plan is: ***“Quality and free safe motherhood services must be accessible by all poor women”.***

Action plan:



Discussions and Suggestions:

Ngoc wanted to know the timeline of this advocacy plan.

Indu asked if Ministry of Finance was their ally or opponent.

Alongkone said that they we will go back, discuss with the team and finalise the timeline. He also added that maybe the MoF could be opponents.

Sai noted that it would be good if the advocacy goal was grounded within the ICPD PoA.

Sham concurred and said that ARROW can send a certain paragraph that resonates.

c. Indonesia: Passing the Health Law to Respect, Protect and Fulfill women's SRHR needs

The **goal** of this advocacy plan are to pass the new Health Law which is pending for past years five in the parliament (the draft is already in the hand of a small working group consist of parliament member/health commission and MOH officials which get the mandate to finish it)

The advocacy **objectives** are:

- To pass the Health Law in 6 months (before September 2009→presidential election). Strategies (March – September 2009) are:
 1. Monitor the progress of the bill (audiences with MOH and Parliamentarian, April 2009)
 2. Identify new strategic partners to push the progress (medical professional, persons in power, religious leaders, media→ April – May 2009)
 3. Develop new strategic policy brief as an advocacy tools (by elaborating the draft policy brief together with the existing partners→ March –April 2009)
- Note: there will be continuous monitoring the progress of the bill together with the allies. The risk is the noisy fundamentalist/narrow minded parliamentarian*
- Create and plan better strategy to continue the effort to pass the health law. Strategies (Nov 2009-January 2011) are:
 1. Identify the new parliament members including their political background and platform (meeting: formal and non formal)
 2. Identify strong figure of: medical professional, human rights activist, religious leaders, legal professional to be able framing the SRHR/abortion issues in a Right Based approach
 3. Strengthening the parliamentarian and MOH especially the new female parliamentarian and female parliamentarian caucus to be able voicing and defending SRHR issues including abortion (meeting: formal and non formal)
 4. Identify and train the new media partners to groom public awareness and opinion

Strategic Advocacy Tools:

- Renew policy brief,
- SRHR fact sheets
- Facilitate public dialog
- Documenting each advocacy action and process
- Monitoring and evaluation action and process in order to create the new strategy

Comments from resource person(s)

Rashidah said that it was a very good presentation.

Indu wanted to know which law they were referring to.

Tini responded, saying that it was actually an amendment, where they will put a new chapter on RH in the existing law.

d. Nepal: Prevalence of Utero-Vaginal Prolapse in Tribhuvan University Teaching Hospital and its Socio-cultural Determinants

The **goal** of this plan is to reduce UP prevalence.

The advocacy **objectives** are:

- To campaign and assert for women's rights for gender-justice, equity and equality

The core message of this advocacy plan is: ***“UP prevention and management is a women's health rights which requires holistic measures”.***

Action plan:

The plan is to start lobbying with stakeholders once they return to Nepal. They will also be lobbying with CA members and Secretary of the Ministry of Health. The estimated date of the finalized report is by the **31 March 2009**, and the policy briefs by the **2nd week of April**.

Comments from resource person(s)

Malou said that the plan was very good and detailed.

Indu said that some data needs to be found.

Anjana responded, saying that the research data already speaks a lot.

Discussions and Suggestions:

Indu said that UP the tip of the iceberg. Imagine how many are facing this problem if only a certain percentage is coming to the hospital. She liked the way they have framed it, as also a woman's rights issue.

Binjwala said that there is data. But the exact number is not known. When she was doing the Focus Group Discussion, there were 15 women were there, but only 2 would speak.

e. India: Nutritional Anaemia: A Neglected Agenda

The **goal** of this advocacy plan is for a reduction of anemia to decrease maternal mortality.

The advocacy **objectives** are:

- Sensitize parliamentarians, policy makers and programme planners to recognize anemia, as one of the key issues contributing to maternal mortality among women.

The core message of this advocacy plan is: ***“Comprehensive national and state level Nutrition policy with special emphasis on prevention of anaemia***

particularly among girls and women; there should be a state and national action plan to prevent anaemia and the; implementation of national and state action plan for prevention of anaemia enabling dietary diversity and fortification. (distribution, availability and compliance of IFA, IEC in right framework)”.

Action plan:

The **state** advocacy action plan and timeline are as below:

- Contacting political parties March-April 2009
- State level report of the primary and secondary data: April 2009
- State level dialogue and sharing of the data with Media -April 2009
- State level dialogue and sharing of data with primary stakeholders
- State level dissemination of data with state government officials, NGOs, CBOs and women’s group: May-June 2009
- State level dialogue with concerned officials for initiation of the process of state policy: June-July 2009

The **national** advocacy action plan and timeline are as below:

- Contacting political parties March-April 2009
- National level report of the primary and secondary data: April 2009
- Dialogue and sharing of the data with Media at National level April 2009
- Dialogue and sharing of data with primary stakeholders at national level (AGC, The Coalition for Sustainable Nutrition Security, ICPD +15 Steering committee)
- Dissemination of data with Government of India officials : May-June 2009

Comments from resource person(s)

Malou said that it was a very good plan.

Discussions and Suggestions:

Phan wondered why only 20% of women taking the pills. What happened to the other 80%?

Pallavi responded that there were various observations that the pills caused stomach pain, nausea, black stool, etc. The women are not sensitised enough to know that this is good for them.

Tini noted that there are many Ministries for the approach and wondered if they had worked out which ministries they are going to approach.

Pallavi said that that hadn’t been quite worked it out yet.

f. Philippines – Mindanao : Removing Barriers to Critical Reproductive Health Services that Avert Maternal Death and Disability in the Philippines

The **goal** of this advocacy plan is to improve RH policies and programs around the three pillars of maternal death aversion: Family Planning, Birth Attendance by trained providers, and Access to Emergency Obstetric Care through:

- RH policies and programs that are made responsive by the perspectives and participation of poorest and most marginalized women
- Increased resources and funds for above RH programs
- Improved, integrated, well-staffed and well-funded local health systems)

The core message of this advocacy plan is: *“11 Filipino women continue to die everyday from complications of pregnancy and delivery. We have the means to avert these deaths: through FP, skilled delivery and EmOC. But these services need to be upscaled and improved in order to reach the women who need them badly –the poorest and most marginalized. Making the services responsive entails resources and funding and organizational strengthening of the health system, especially at the district and provincial levels. Helping women survive maternal complications and promoting their health is a matter of human rights. It also redounds to the greater health of families and their stronger contributions to society. Investing in RH also generates savings that can be channeled to further strengthening of the health system, for women and their families”.*

Advocacy Activities

ARROW	<ul style="list-style-type: none"> • Research report • Advocacy forum at the national level and in ARMM
Parallel efforts around ICPD+15	<ul style="list-style-type: none"> • Government report process • Independent NGO report process
Related Likhaan efforts	<ul style="list-style-type: none"> • Court case against the city of Manila for FP ban (ongoing) • Technical support for enactment of RH Law in HOR & senate (ongoing) • Investigative report on Human Rights Violations around Abortion (ongoing)

Comments from resource person(s)

Malou noted that the weakness of the plan is that you’re trying to advocate three tracks: the national, which is the RH Bill which is somehow related to the women’s charter. She said to look at the strategy done by the women’s NGO, if they cannot get it they go to the women’s right charter. It is a two-pronged attack which is

actually pending in plenary. Again, there is the national, the sub-national which is ARMM, and the local. There was a mention of the positive and the negative. It was positive when it was sub-national, and negative when it came to national. The advocacy needs to be reworked to take into consideration the three tracks. Are you advocating at the national or sub-national level? There are 51 legislators in Mindanao. Mindanao only controls 16% of the budget of the whole of Philippines. This is because they don't agree on a common agenda. It would be better to do a separate advocacy plan for the national, the sub-national and local level.

Djalía said that that is exactly what the research is all about, as the study has two components, the Metro Manila study and the Basilan study. For Metro Manila, the advocacy is on a national level, and for Basilan is on a sub-national level.

Discussions and Suggestions:

Neha commented on the public hearing that Djalía added on as well as the life experiences of the women. She said that they are both great ideas, but there is a need to be conscious and measure the possibility of them facing some kind of backlash for getting their identities known.

Djalía responded, thanking Neha. She also said that they are very conscious of this fact. She shared that 2 weeks after their interview with these women, 2 NGO workers were kidnapped in Basilan.

Mei Li noted that most of the presentations didn't mention the budget, and wondered if there was a need to mention the budget, especially with regards to the economic situation now.

Malou said that yes, there must be an advocacy budget. When putting together an advocacy plan, there must be an advocacy budget.

g. Philippines: Access to Contraceptives for Adolescents

The **goal** of this advocacy plan is to make contraceptive information, services and supplies more accessible to adolescents.

The advocacy **objectives** are:

- To pass national legislation or a city ordinance or policy that mandates sex education classes/seminars and FP counseling to be given by city funded health clinics and schools

“There is an urgent need for a clear public policy allowing adolescents access to contraceptive information and services in the light of the survey results that the low level of contraceptive use among sexually active youth in selected urban poor communities in Metro Manila is primarily due to the lack of information about contraception in public clinics and schools.”

Advocacy Action Plan, Timeline & Resources for Each Advocacy

Audience/Strategy

- Legislators, City mayor, City local legislative body- national policy dialogues, public hearings, strikes and demonstrations, lobbying and media events
- Department of Education, Department of Health- independent studies of experiences in other countries similar to the Philippines, accountability sessions with officials , conferences
- General public-policy reports, action research

Comments from resource person(s)

Malou suggested considering voting for congressmen who are advocates of RH.

h. Thailand : Amendment of the Existing Laws on Sexual Harassment to Mandate the Institutional Support Mechanism in all Organizations (Schools, Universities, Workplaces)

The **goal** of this study is to ensure the law implementations.

The advocacy **objective** is:

- to amend the laws related to sexual harassment to mandate all schools /institutions/workplaces to establish institutional mechanism (a committee) to prevent sexual harassment and to protect, handle, monitor and report the cases in a gender sensitive and friendly manner to the harassed

The core advocacy message is: ***“Make Schools, Universities and Workplaces Free from All Forms of Sexual Harassment”***.

Advocacy Action Plan, Timeline & Resources for Each Advocacy

Actions for primary audiences

1. To form the muti-sectoral committee who will be responsible for amending the relevant laws
 - meeting with them and provide knowledge, data and situation for technical staff from stakeholder organizations
2. To form the steering committee to collect data, monitor and publicize the situation of sexual harassment in organizations/ institutions/workplaces

3. To launch the public campaigns with media, using celebrity to raise strong awareness among civil servants, laborers, students in all levels and general public
4. To hold the meeting with them
5. To organize the training about sexual harassment for them
6. To hold press conference

Comments from resource person(s)

Malou said that there is some data lacking, it is better to be complete, but it was a good presentation good.

Rashidah asked what would be said about Sexual Harassment and ICPD +15.

Suchada answered that it is in the sexual rights section of the ICPD.

Indu suggested including school counsellors and doctors because these are the places and people who can be allies.

Discussions and Suggestions:

Neha said that the core message is sort of also the goal. If the core message could also include what the situation is now, to make these cases more impactful.

Pallavi said that in India, especially in Gujarat, more and more cases where teachers are sexually abusing the students are emerging.

i. Bangladesh: Prevent Convulsion and Save Maternal Lives

The **goal** of this advocacy plan is to reduce the prevalence of Eclampsia for reduction of maternal mortality in Bangladesh

The advocacy **objectives** are:

- Increase allocation of resources for skill development EMOC health professionals
- Ensure supply and availability of Magnesium Sulfate at all health facilities from Upozila to district and tertiary level

The core advocacy message is: ***“Increase allocation of resources for skill development EMOC health professionals; regular supply and availability of Magnesium Sulfate at all health facilities from Upozila to district and tertiary level”.***

Action Plan:

Time line

- Documentation of primary study-April-May 2009
- Public hearings-May
- Media brief and sensitizing meetings-May-June 2009
- Sensitizing meeting with government officials about the issue-June-July 2009

Comments from resource person(s)

Indu said that the major opponents could be a OBGYN

Malou congratulated Rebecca on the change. It's clear, the title is good and dramatised the issue.

j. Pakistan: Provision of Post-abortion Care (PAC) and Safe Abortion Services

The **goal** of this advocacy plan is to advocate for provision of Post-abortion Care (PAC) and safe abortion services

The advocacy **objectives** are:

- Short term
 - To create awareness amongst policymakers about the incidence of induced and unsafe abortions
 - To create awareness amongst policy makers that death and disability results from unsafe abortion and post abortion complications
 - To inform healthcare providers about the existing legal framework regarding abortion
 - To increase accessibility and quality of PAC services including PAC counseling
- Long term
 - To get appropriate legislation enacted providing safe abortion esp. in cases of rape and incest

Note: To advocate for increased access to contraception (second strategy)

The core advocacy messages are:

- **“Reduce maternal mortality and morbidity by preventing unsafe abortions and post abortion complications”.**
- **“Provide quality PAC services including PAC counseling”**
- **“ Legitimize abortion for cases of rape and incest. Enact appropriate legislation to ensure safe abortion”.**

Advocacy Action Plan, Timeline & Resources for Each Advocacy

Planned Activities	Time	Resources
Action oriented research to highlight the linkages of unsafe abortion and PAC complications to inadequate FP/RH services	March – Dec 2009	Shirkat Gah, advisory group of experts, researchers, consultants
Development of Advocacy products (Fact sheets, posters, etc.)	January – December 2009	Shirkat Gah, Pakistan Reproductive Health Network (PRHN) members
Media advocacy meetings	Jan to Dec 2009	Shirkat Gah, PRHN, policy briefs, media packs, relevant IEC material
Awareness raising sessions on Family Planning unsafe abortion and post abortion care, with women and men at Shirkat Gah field sites	On going until 2011	Shirkat Gah staff, CBO partners, community women and men, relevant IEC material
Discussions on Family Planning and abortion with progress religious scholars	On going until 2010	Shirkat Gah and PRHN members
Meetings with local government representatives (EDO, DCO)	On going	Shirkat Gah, CBO partners, PRHN members, advocacy products
Consultations with national, provincial and district level policy makers and stakeholders to devise joint strategies to improve access to quality FP services and to advocate for the provision of safe abortion services and Post-abortion Care	On going	Shirkat Gah, PRHN members, research reports, policy briefs, relevant IEC material, media packs. Financial resources by PRHN member organizations
Sensitization and orientation events for relevant duty bearers for provision of quality FP/RH services	2008-2011	Shirkat Gah, PRHN members, religious scholars, relevant IEC material.

Sensitization sessions with communities, service providers, government officials, and other area influentials to discuss the religious and socio-cultural barriers regarding abortion	On going	Shirkat Gah, PRHN members, religious scholars, relevant IEC material. Resources by organizations hosting the sessions.
Meetings with donors investing in health and population issues	On going	Shirkat Gah, PRHN members
Meetings with representatives of private sector manufacturers of drugs used for medical abortions and medical instruments used to perform abortions	On going	PRHN member organizations providing abortion services

Comments from resource person(s)

Indu said that the title could be changed. Assumptions are it will be political, but she thought that it was good.

Rashidah noted that anti-abortion groups are put under the opposition and wondered if they were organised groups. She also said that it was important to sensitise policy makers. Advocacy and...

Rahal responded, saying that that might have been an oversight, but she thanked Rashidah for pointing it out.

Malou said that the core message sounded a lot like objectives...

k. Cambodia: To understand the barriers to family planning commodities among married couples

The **goal** of this advocacy plan is to have an increased budget allocation for the family planning programme of Cambodia.

The advocacy **objectives** are:

- To gain support from donors
- To increase the donor's commitment and national government commitment in terms of financial allocation for the family planning programme

The core advocacy message is: **"To prevent the high maternal deaths in Cambodia by increased effective utilization of Family Planning"**

Advocacy Action Plan, Timeline & Resources for Each Advocacy

- Media sensitisation workshop(May 2009)
- National Policy Dialogue plus donor agencies (July-September 2009)
- Provincial forum on Stakeholder (October 2009)
- Bicycle Distribution Event (TBD)

Comments from resource person(s)

Indu wanted to know why if there is donor money for HIV AIDS and RH can't the money be used for FP. For instance, HIV AIDS can do condoms and other things, and FP can be easily included in RH. So instead of taking it as an opposition, why don't you use that money which is already available instead of saying reduce *that* money and give us more money?

Vathiny responded, saying that the money of HIV AIDS talking about condom, even that is very difficult. Because there are more than 100 organisations working on HIV AIDS and the national centre for HIV AIDS has a lot of money. So they can do whatever they feel is important.

Indu suggested that they try to influence those rich organisations to include the condom use as a dual protection instead of doing it as parallels and doing another program. If RH has money, why can't that money be used for FP? FP is a RH issue.

Indu noted that that is the problem, and said that the situation is very similar in India, where HIV AIDS is everywhere. She said that this has to be utilised. She also questioned when it was said that they wanted to increase the money, but the technical committee in the audience will not increase the budget and suggested that speaking to someone who is doing the allocation of resources for HIV AIDS might be better, seeing as so much is available for HIV AIDS, so why not for MH or RH? A technical committee is only if there is no solution or if a solution needs to be changed, like magnesium sulphate. But if there are no resources... She added that in India, if there are no resources they will go to the Planning Commission and the Ministry of Planning and Investment. So the audience changes. These are not the officials that they are going to be talking to.

Vathiny responded saying that yes, they can approach the Minister of Health, but by technical person, she meant the secretary who do everything for the policy maker. If the secretary include in the mandate for meeting, this issue will come for the meeting.

Indu said that maybe it is different in Cambodia, but in India, they have a secretary, and he is not a technical person. He has a technical director, or deputy director, or all other things. But the secretary who will decide what will happen is a bureaucrat, he is an administrative officer. He is not a technical person. He makes the decisions. She suggested that maybe they want to say the secretary of Ministry of Finance, or The Minister of Finance could also be added. That's where the resources will come from. All the HIV AIDS donors, if they are giving money for RH, try to influence them to expand their donor money through the secretary demanding for their resources.

Vathiny said that sometimes the donors are very strict, where they only want to stick to what they want to support. Now to approach them, to can use some of the money to integrate FP, but the problem is, there is no money because the money is only used for HIV AIDS and they only want to see the number of indicator they want

to produce to them.

Indu said that she can understand because you cannot imagine how much money there is for AIDS, and it is the same problem in India, and she said that she will be talking to GTZ and others who were at the meeting to increase allocation for RH and not merely HIV AIDS. She wanted to know if there was some Planning Commission and Resource. Another suggestion is to get celebrities to speak to the press about RH issues.

Rashidah said that the big risk is whether the government officials will come. She remembered that in ICPD+ UNFPA gave something to ARROW. And part of the agreement was that UNFPA had to be there as a stakeholder, so sometimes having the clout of the UNFPA representative there, or maybe even if in collaboration, you may have to insure that the Minister or Director General there in some country context.

Discussions and Suggestions:

Binjwala said that UNFPA and WHO have worked together.

Sham shared her experience when she sat with 65 donors in Stockholm, who were talking about how MDG5 was not going to be achieved and how the donors themselves were congratulating each other and saying that they achieved the other diseases. Because those were simple. It was simple to solve those areas because the solution was straight forward. When she asked what was not straight forward about MH, the answer was the gender inequality of the locals and the problem is the donors will reflect and agree with the countries that say that it is too difficult. The only people who will stand and say that it is not difficult is us. And the money is not coming to us. Again, the role and position and contribution made to this group is just going to be an extraordinary responsibility that we bear.

Pallavi said that in India....last 3 months of the financial year, more than 50% of the budget was left over. She said that it is also important to reduce the budget and utilisation of the budget.

I. China: Poor, Reproductive Health of Migrant Women

The **goal** of this advocacy plan is to improve the situation of migrant women's reproductive health and rights.

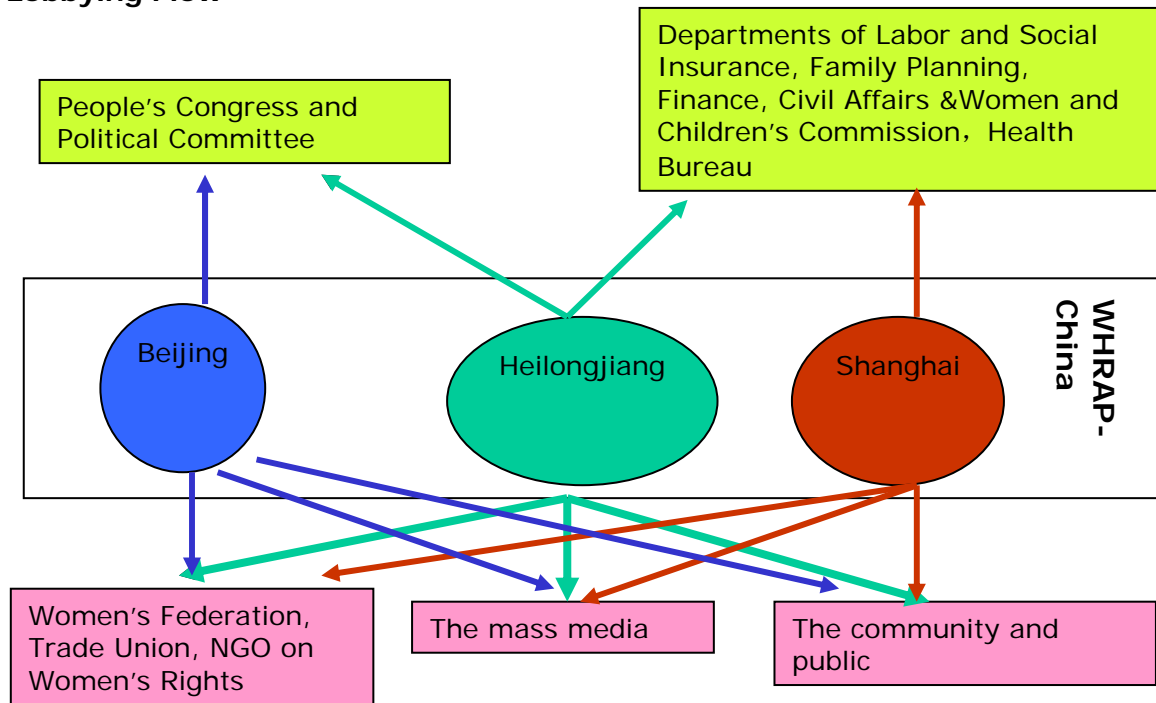
The advocacy **objectives** are spaced out for two years and five years. They are:

- 2-Year Objective: To provide affordable and accessible reproductive health service for migrant women in WHRAP China region.
- 5-Year Objective: To establish the Reproductive Health Insurance for the migrant women in WHRAP China region.

The core advocacy message is: ***“Establish a Reproductive Health Insurance system for migrant women in order protect migrant women’s rights and improve their health to achieve the goal of WHRAP China”.***
Advocacy Action Plan, Timeline & Resources for Each Advocacy

Develop the service package and make the budget line with the finance and social insurance departments	Mar-Jun 2009
Continually and consistently improve the model of low-cost maternal health service and provide high quality of reproductive healthcare for MP. (2009.3-12)	Ongoing
Organize workshops and public hearing to the mass media with experts and professional institutes	Jul-Dec 2009
Arise the public awareness with hot cases	Ongoing
To advocate migrant women’s rights on reproductive health allying GOs and NGOs, media and community (2009.4-6)	Apr-Jun 2009
Community mobilization along with community, family planning and civil affairs to increase migrant women’s awareness (2009.4-6)	Apr-Jun 2009
Submit the Advocacy Plan in the specific occasions, such as taking the opportunity of APCRSR in Beijing in Sep. 2009	Oct- 2009
Work with technical departments and experts to formulate the monitoring indicators for policy implementation (2009.5-6)	May-Jun 2009
Cover the migrant women into reproductive health insurance (2009-2010)	2009-2010

Lobbying Flow



Comments from resource person(s)

Malou noted that the lobbying flow played on their basic strengths

Indu said that RH insurance for women is a great idea, but wondered how they were going to get it to reach the poor women who might not be able to access it easily. A suggestion was to work out a cashless system so these women get their money.

Discussions and Suggestions:

Neha wanted to know what the specific objectives of the WHRAP China National Advocacy are.

Du Li said that the 2-yr objective of the national plan is to duplicate the Shanghai model of providing low cost maternal healthcare to migrant women within WHRAP China areas, then expand it at the national level based on its implementation in the 1st phase

m. Malaysia : Sex Education Curriculum

The **goal** of this advocacy plan is to implement the sex education curriculum as part of the Malaysian education system.

The **objectives** of this advocacy plan are:

- To convince the Ministry of Education, policy makers, schools principals, teachers, counsellors, parents and Women and Children NGOs for the implementation of the sex education curriculum, prioritising RH and RR issues into the Malaysian education system.
- To develop a Policy Brief with the collaboration of the stakeholders to address the issues in sex education implementation.
- Ensure the action plan begins for implementation by 2010 and indicators of progress development are monitored well.

The core advocacy message is: ***“Sex Education Curriculum needs to be urgently implemented otherwise unwanted pregnancies; abandoned babies; STD/STI HIV/AIDs will continue to increase and limit young people future and impact on the family + drain on human capital and financial resources”.***

Advocacy Action Plan, Timeline & Resources for Each Advocacy

An advocacy action plan for formation of and NGO coalition needs to be drawn up with clear objectives and each objective will have the messages, strategies, roles of partners, information and policy briefs, advocacy activities, capacity assessment of partners, risks and opportunities and evaluation of success criteria which all own and are committed to.

Planned Activities	Time	Resources
ICPD 15 Policy Dialogue with top policy makers of 3 Ministries by FRHAM, RRAAM, MNCCRH to present findings and recommendations	June 2009	
Info or policy advocacy briefs developed + disseminated on the issue	By June 2009	

Comments from resource person(s)

Indu said that it was an excellent presentation, and was glad that they had included teachers and PTA.

Discussions and Suggestions:

Neha added a comment, saying that apart from educating young people about sex, sexuality should also be included. She noted that it would be better to use sexuality education instead of sex education.

Rahal added that it can also be called Life skills education

12. Monitoring and Evaluation

by Malou Tiquia

Monitoring

The purpose of monitoring is to:

- Follow the progress in implementing activities
- Define obstacles in project implementation
- Assess progress in achieving project outputs
- Analyze effectiveness of project strategies

Monitoring should be done routinely. Examples of a monitoring plan include:

- Development of MPs website
- Roundtable with journalists
- Establishment of study group
- Organize awareness events for policy-makers (e.g. a hearing)

Evaluation

The purpose of evaluation is to:

- Assess the achievement of the anticipated project results or outcome --extent to which objectives have been met
- To assess the changes in the target group To determine the effectiveness of a program or a project.
- Provide organizational learning

Monitoring should be done periodically:

- Midterm evaluation: formative
- End of project evaluation: summative

Evaluation Framework

- **Relevance:** The extent to which the issue addressed by the project was a priority need among primary stakeholders
- **Appropriateness:** The extent to which the strategies and actions adopted to implement the project were sound and suitable
- **Effectiveness:** The extent to which actual performance compares with targeted performance.
- **Efficiency:** The degree to which the project was able to achieve the targeted results without wasting resources and time
- **Progress:** The extent to which the planned project activities were implemented
- **Sustainability:** The extent to which the systems, processes and services established under the project are likely to continue beyond the project life
- **Management Organizing:** and managing resources in such a way that these resources deliver all the work required to complete a project within defined scope, quality, time and cost constraints

Evaluation Methods

- Quantitative
 - Statistics
 - Survey of clients and service providers
- Qualitative
 - Focus group discussion

- In depth interview
- Observation

Malou ended her presentation by reminding everyone not to do it alone. *“Working together, we can complement each other and achieve improvements with a collective strength, reaching wider audiences with a greater voice.”*

13. ANNEXE 1

ANNEX I: Samples of Policy Briefs

a. Nepal

ISSUE: UP NEEDS TO BE PERCEIVED FROM A RIGHT BASED APPROACH OF A WOMAN'S HEALTH AND ADDRESSED HOLISTICALLY.

Stakeholders: GOs (Ministry of Health, Women, Children and Social welfare, Finance, National Planning Commission, National Women's Commission), donors, I/NGOs, and private sector

History and Extent:

1. UP was a hidden problem but recently acknowledged as a crucial morbidity problem for women that affects not only her life but also the entire livelihood of a family.
2. No national data on the issue.
3. Findings based on small researches

Issue: Uterus prolapse is a major public health issue with little attention but UP specific policy is yet to be formulated.

Monitoring:

1. Work closely with Ministry of Health, Women, Children and Social welfare, Finance, National Planning Commission, National Women's Commission in their planning, programming, budgeting, activities, and implementation.
2. The government committed for 12000 UP surgery but the need is much higher.
3. UP needs to be perceived from a right based approach of a woman's health

(Equity on access to RH service, Geography, Caste/ethnicity, Economic condition, Education, Gender discrimination, Decision making, child bearing, Work load, VAW)

Organisations: BBC/Safe Motherhood Network Federation

Both organizations work on advocacy on women's rights in Nepal, particularly in reproductive health rights of women.

Track Record and Membership: Both organizations are nationally recognized and have successfully lobbied, campaigned, and advocated for major legal and policy formulation and amendments in the country. The organizations have partners and work throughout the country since 1996.

Vision and Mission: To campaign and assert for women's rights for gender-justice, equity and equality

Comments from resource person(s)

Indu said that the issue must be right from the top, organisation must come right at the end. The issue should grip the audience first, then you say WE are the ones to do it.

ISSUE: AMENDMENT OF THE LAWS TO CREATE THE INSTITUTIONAL SUPPORT MECHANISM

Organizations

Institute for Population and Social Research & SEA Consortium on Gender, Sexuality and Health

Identify stakeholders:

1. Ministries: MOE, MOL, MOHS,
2. Civil Society: Labor Union, NGOs working on women and child
3. Representative from universities, Students and Youth Networks
4. Media
5. Lawyers' Council
6. National Human Rights Commission
7. Parliament Member (Women and Children Committee)
8. Private sectors

Issue's History:

- the 1998 Labor Protection Law
- Civil Service Law and Code of Conducts
- Criminal Laws
- regulations, policies in some organizations

Define the problems of the issue

- the laws lack of effective measurements to prevent, handle, monitor and report the cases in all sectors
- the labor law does not protect women/victims who work in informal sectors, such as domestic workers
- the laws and code of conducts often are not enforced by organizations/institutions

Monitor the Issue Development

Thailand issued and implemented several laws related to sexual harassment: labor laws, Civil Service Law and Code of Conducts for gov' workers. However, after implementation there are weaknesses as follow:

- no provision on institutional mechanism in workplace and educational institutes to prevent sexual harassment
- lack of clear and strong commitments from organizations in all sectors because all existing laws do not mandate the organizations to set up the mechanism or the committee body to tackle the problems
- organizations often do not respond to protecting the victims'rights and dignity

In responding to the problems, thus it is essential to propose the law amendment by recommending the government to form a multi-sectoral committee to amend relevant laws on sexual harassment. In particular, to create institutional support mechanism and guidelines to prevent, monitor, handle and report sexual harassment cases in their organizations/institutions in a gender-sensitive and friendly procedures.

Comments from recourse person(s)

Malou said there was not enough data, you are asking for institutional mechanisms set up, but you were effective because you were presenting solutions, so that is good.

Indu noted issue must be right from the top, org must come right at the end. The issue should grip the audience first, then you say WE are the ones to do it.

c. Philippines (Manila)

ISSUE: ACCESS TO CONTRACEPTION BY METRO MANILA ADOLESCENTS

1. The Reproductive Health, Rights, and Ethics Center for Studies and Training (ReproCen) was established in 1993 as a project of the Colleges of Law and of Medicine of the University of the Philippines. It was created to encourage the multidisciplinary discourse and research on reproductive health and rights by involving the disciplines of law, medicine, and the social sciences. ReproCen's work has been geared towards integrating the perspectives of ethics, gender and human rights in curricular development, training, research, and advocacy in the fields of medicine/health care, law and the social sciences
2. Stakeholders in the Issue –Adolescents, health care providers , local government unit officials and constituents
3. The Philippines is the 12th most populous country in the world with a population growth rate of 2.36 % and a fertility rate of 3.5 children per woman. Population is growing rapidly at 3 births per minute. Half of the Philippine population is below the age of 21 and there are 4.9 million sexually active Filipino youth. Almost half of all pregnancies in the country or almost 800,000 births annually are unplanned and 36% of young Filipino women aged 15-24 conceive before marriage. Thus, there is an urgent need for a clear public policy allowing adolescents access to contraceptive information, services and supplies.
4. This study attempts to look into the reasons for the low level of contraceptive use among sexually active youth in selected urban poor communities in Metro Manila. 73% of the respondents do not use contraceptives, 48% of which are males and 51% of which are females. Lack of information about contraception was indicated by 32% of 319 respondents as the reason for their non-use of contraceptives, while concern about side effects was a primary reason for 19% of the respondents. Considering that the study was conducted in urban poor communities, 13% of the respondents said that they did not have money to buy contraceptives, while distance to health centers or clinics was a main reason for 6% of the respondents. Responses from 3 male Focus group discussion participants on how to avoid unplanned pregnancies included undergoing vasectomy and having "quickie sex" only.
5. Given that the EO banning contraception in Manila was not repealed by the new mayor, this problem of non-accessibility of contraceptives and unplanned births will continue.
6. Local government should provide improved and consistent contraceptive information, services and supplies to reduce the incidence of unplanned pregnancy among adolescents. It should address the knowledge gap and misconceptions about contraceptive side effects and other health concerns through 1)sex education classes and 2) counseling in order to develop skills to enable adolescents to practice healthy behaviours knowledge

Comments from recourse person(s)

Indu said that the language must be clear. Eg FGD? Say Focus Group Discussions

Rashidah said that the policy brief didn't really excite me on what needs to be done.

Indu noted that the issue must be right from the top, organisation must come right at the end. The issue should grip the audience first, then you say WE are the ones to do it.

d. China (Shanghai, Beijing, Hei Longjiang)

ISSUE: POOR REPRODUCTIVE HEALTH OF MIGRANT WOMEN

1. Organizations: We are from Women's Legal aid center in Beijing, Shanghai Women's Healthcare Institute and Hei Longjiang Women's Federation.
2. Stakeholders:
 - Local government, population development and Family planning committee. And Women's Legal aid organizations
 - Migrant women/community; (beneficiary)
 - Local health system (service provider).
 -
3. History of the issue:
 - In big cities, there are large amount of migrant women, such as Beijing has 5.1 million migrants that accounts for 1/3 of the total population (2007). Shanghai has the number of 5 million.
 - China is trying to build the Harmony Society.
 - Migrant women are most in lower economic status (average income: 1000RMB per month), bad living condition and sanitation (87% live in a small simple room with no toilet and no wash shower equipment.), low education level and low awareness of health care. 44.9% women knew little about STD. 44.9% did gynecologic examination in recent 3 years when suffered serious reproductive diseases.
4. Issues
 - Reproductive health and rights among migrant women were crucial that needs attention
 - Poor reproductive health condition
 - Higher MMR than general women, above 70% maternal death were from migrant women in recent years.
 - Public policy: reproductive insurance only cover general residents. The migrant women have great demands for the reproductive health.
5. Development of the issue

In big cities, the issue has become more and more serious. It has negative effect to MMR, which is one of integrated indicators of the government. Maternal death has large burden on counties economy.

6. Restate the problem:

So our conclusion is that migrant women's reproductive health has become a problem in Whrap China, our government should enact some more effective policies to protect their reproductive health and rights, such as setting up low-cost maternal hospitals for pregnant migrant women, providing some consultation and training women leader from communities for women's rights and health.

Comments from recourse person(s)

Malou noted that it cannot be too mechanical, too many statistics might be too much

Indu said that it was powerful

e. Indonesia

ISSUE: ABORTION: POLICIES & PRACTICES

Background: WHF established in 2001 by nine female and male activists in SRHR issues with the main aim to have the law no 23/92 on health amended, in particularly to insert a chapter on RH which respect, protect and fulfill women's SRHR Needs, including safe and affordable abortion services. Our latest study (2008) showed:

1. From Women experiences: (502 women respondents)
 - Almost 80% are sexually active adults of prime reproductive age.
 - 92% are married
 - 85% were high school and higher education graduate
 - Although more than half were house wives but 35% are working and have their own career
 - Only 5% of these women partner (husband) have quite good income, so they have the ability to support the women in accessing abortion services.
 - Despite the fact that religious dogma teaches their follower that abortion is a sin/immoral women from all religious background seek help to abort their unwanted pregnancy.
 - Reason for abortion : 60% said their already have too many children or their youngest still too young; 22% stated economic and social reason; others because their suffer from chronic illness or already bleeding.
 - Ways to end pregnancy: 85% drinks traditional or toxic herbal/medicines to abort the pregnancy themselves; 5% went to TBA to massage the abdomen, the rest tried more than one way.

Even though the women in this study are adults, educated and financially capable to access abortion services and they want to limit their number of children, but they seem not capable in controlling their fertility, but the majority of them are not using contraceptive (66%). The study on contraception in 5 villages, shows that the CPR is just 50% (below the National Statistic) and unmet need : 9%.

2. From service providers' side:
 - In the absence of the law:
 - there is no standard policy of abortion care in the Medical School (curricula, practice)/Hospital (service)

- Each Medical School/Public Hospital has their own interpretation and policy whether they will provide abortion services or not, whether they allowed the medical student or obgyn candidates (residents) to learn and practicing variety methods of safe abortion, they can only observe the procedures; only senior obgyn were allowed to perform abortion to married women, with not more than 10 weeks gestation.
- no monitoring in the use of method in order to guarantee the safety of the women who need abortion care. The study showed that D&C (metal curettage that responsible for higher complication/perforation) are still used.

In every stage of their efforts to terminate their unwanted pregnancy, women are exposed to a wide spectrum of hazard/dangerous condition which may caused death, morbidity and impairment: starting by trying to terminate their unwanted pregnancy by drinking traditional/toxic herbs/medicine → went to unskilled providers who massage their abdomen → went to 'back street doctor' → when they finally went to the hospital/obgyn, these skilled providers used outdated method and equipment in performing the abortion.

The above findings, also raised a big question and concern, what will happen to those women (unmarried, single and those who came with late gestation/more than 10 weeks) whose turned down by the clinic.

Recommendation:

A HEALTH LAW drafted by WHF and pending for the past 5 years in the Parliament SHOULD BE Passed. Our new partners (individual persons from the medical society) will be considered as third parties advocate to joint the effort in pushing such legislation.

Concrete Action:

- WHF already taken the lead including drafting the new law, assisting MOH and Parliament in the process of the amendment.
- Based on the study findings, WHF is able to identify new partners (individual persons in the medical society) and Head of National FP Coordinating Board, as new allies to strengthen the advocacy activities → to voicing the concern

Comments from recourse person(s)

Indu said that it would be good to have put the issue first, grab the attention-and arm! Where is the evidence coming from? We assume that the policy makers know everything. They don't. Use simple language, but topical. For example 10 women are dying every 10 minutes.

Discussions and Suggestions:

Siva noted that how you introduce your topic will be useful. The issue and audience.

f. India

ISSUE: ANAEMIA A NEGLECTED AGENDA

Issue: High prevalence of anemia leading to maternal mortality -

Whom to advocate: 1. Ministry of Health and Family Welfare; 2. Ministry of Human Resource and Development

Updating national nutritional and health policy, recognizing maternal anemia, and integrating strategy for prevention of maternal anemia.

The maternal mortality ratio (number of deaths per 100,000 live births) has been declining globally at a rate of less than 1 per cent. The total number of women dying in pregnancy or childbirth has also shown a modest decrease between 1990 and 2005. The current MMR ratio according to SRS, 1998 is India 407 per 100,000 live births; Rajasthan 607 per 100,000 live births and Orissa 367. Whereas estimated figures for FOGSI for Rajasthan is 634 per 100,000 live births and 1292 per 100,000 live births in Orissa during 1992-94. The direct cause of maternal deaths are Hemorrhage, infection, obstructed labour, hypertension disorders in pregnancy and complications of unsafe abortion.

More women are dying than men until the fifth decade of life, which indicates discrimination of women and young girls in their reproductive age. The suffering from illness and inability in women however is of much greater magnitude than deaths. It is ironical that many south Asian countries have not been able to control anaemia among women, which is largely due to poor nutrition, overwork, low preference given to the problem of anaemia by the family members, women and service providers. Anaemia is also a major leading cause of death of women during pregnancy, child birth and post pregnancy period. The direct cause of maternal death due to hemorrhage and infection has the correlation with high prevalence of anemia.

The recent studies conducted by NFHS – 3 shows that 58% of pregnant women between the age group of 15-49 are anemic showing that there is no improvement in the anemia levels in the last few years.

Table 1. Prevalence of anemia

Age group	Percentage of women with any anaemia			Percentage of women with								
	India	Rajasthan	Orissa	Mild			Moderate			Severe		
	India	Rajasthan	Orissa	India	Rajasthan	Orissa	India	Rajasthan	Orissa	India	Rajasthan	Orissa
15-19	56.0	53.9	67.1	36.2	35.5	42.3	17.9	16	22.5	1.9	2.4	2.3
20-24	53.8	52.8	63.3	34.8	33.6	43	17	17.1	19.3	2	2.1	1
25-29	51.4	50	60.6	34.8	33	42.8	14.7	15	16.4	1.9	2	1.4
30-34	50.5	45.7	61.8	34.8	31.3	45.4	13.7	12	15.4	1.9	2.4	0.9
35-49	50.5	45.3	64.2	35.1	31	47.9	13.6	12.4	14.1	1.9	2	2.2

Large number of girls between the age group of 15-19 are anemic. Fourth five percentage of girls get married before the age of 18 years, 20% conceive before the age of 20 years. Higher maternal deaths also takes place in this age group. Which also indicate need to look into the problem of anemia.

The national anemia prevalence exists from 1973. The above mention data clearly indicates that it has failed to prevent anemia. District Level Health Survey 2005 indicates that eventhough IFA tablets stock was available from district to village levels health facilities (>60%), very few women consumed the tablets (20%).

Eventhough National Nutritional policy existing in India from 1993. The policy is not reviewed since it came into existence i.e., 25 years. The 1993 policy data revealed that 50% of expected mothers were anemic which has increased to 58% (NFHS-3).

It is important to note that the existing national nutritional policy does not specific strategy towards anemia in maternal and newborn health care.

**Academy of Nursing Studies and Womens Empowerment (ANS) -
India
Centre for Health and Social Justice (CHSJ) – India
Centre for Health Education and Training and Education (CHETNA) –
India**

Comments from recourse person(s)

Malou pointed out that it took longer than 3 minutes, but handing out the data, using a true story and having a good title were all plus points.

g. Laos PDR

ISSUE: CULTURAL BELIEFS AND TRADITIONAL RITUALS ABOUT CHILD BIRTH PRACTICES IN LAO PDR

1. Background on the organization

The University of Health Sciences (UHS) is the only institution in country to provide education in health sciences. One main task of UHS is to conduct evidence based research and provide to the Ministry of Health for policy making.

2. Stakeholders in the issue

Government part: Ministry of Health including Center of Mother and Child Health

Department of Hygiene and Prevention , Lao Women Union , Ministry of Justice, Ministry of Education, Ministry of Labour and Social Welfare , Ministry of Public Security, Lao Youth Union, Lao Labour Union, Ministry of Information and Culture,

Ministry of Planning and Investment.

International Organization : WHO, UNFPA, JICA, UNICEF, ADB, World Bank

Civil Society: Media (TV program), Press, NGO, Lao Association of OBGYN (LAOG), Nurse and Midwife Association, Skilled Birth Attendants Committee

3. Describe issue

The policy of safe motherhood program in Laos was drafted on 1997, endorsed in 1998 , implemented on 1999 and revised on 2002. It consists of:

- The right of women in receiving health services , in different period of life, for instance childhood, adolescence, marriage , childbearing, childbirth , post partum, breast feeding mother , pre and post menopause.
- The right of new born including receiving health services.
- Main components for services of safe mother hood program
 - Antenatal care services, including of management of complications during pregnancy. Safe delivery, including of management of complications during delivery and essential new born care. post partum services, family planning services
- Service of safe motherhood program in different setting levels such as central, provincial , district and health center
- Some service charge are subsidized by government and others organization such as International organization, Non government organization, Community poverty reduction fund.

4. Define the issue

- MMR is 405 / 100.000 live birth, more than 74% of pregnant women do not receive ante natal care, 85 % deliver their infants at home with untrained traditional birth attendants, relatives, friend.
- **The poor women in rural community are not able to access or afford to safe motherhood services.**

5. Monitor issue's development

The working group in the national committee for Mother and child Health should include the expert member from civil society, they should convene to discuss the national agenda to include MMR situation in the country, so that PM can put together a national action plan.

6. Restate the main objective

Ministry of Health should make quality safe motherhood services including EmOC free, from home to institution for all poor women in marginalized community in Laos.
in cases of woman is unable to avail institutional delivery, government should provide mobile services at home by 2015.

Comments from recourse person(s)

Malou noted that the presenters' hands were shaking and said that that's the reason why lobbyists shouldn't hold papers, shaking means that the person is not confident.

Indu said *"shake hands, be proud, you are giving the data."*

Discussions and Suggestions:

Siva pointed out that sometimes when you hold the hand firmly, they cannot get away!

h. Pakistan

ISSUE: POST ABORTION CARE AND COUNSELLING (SHIRKAT GAH, PAKISTAN)

Organisation:

Shirkat Gah Women's Resource Centre is a national organisation. It was established in the late 1970s and is one of the pioneer women's rights organisations in the country. Its vision is to work for a just, progressive and democratic society where women are fully empowered; and where resources are shared on a sustainable and equitable basis. Its mission is to build women's capacity; and advocate and mobilise for positive changes in policies and practices. It has a Collective, comprised of senior people in the women's rights arena, whose functions are similar to a board of directors'.

Stakeholders:

Women in the reproductive age group and their families; healthcare providers (doctors, nurses, midwives, traditional birth attendants); policymakers.

Issue's History:

Approximately 890,000 induced abortions take place annually in Pakistan. About 11% of these are unsafe and contribute to Pakistan's high maternal morbidity and mortality rates since they result in infection and injury to organs. Doctors perform 14% of abortions; the majority of unsafe abortions (65-70%) are done by nurses, Lady Health Volunteers and *dais* (local traditional birth attendants). Many women go to untrained providers for abortions since the general belief is that abortion is illegal. The law states that abortion is permitted to save the life of the mother or to provide necessary treatment, but since healthcare providers

are often ignorant of the law and also have their own cultural and religious biases, they may refuse to perform an abortion when requested, even if it falls within the parameters of the law.

Defining the Issue:

Though healthcare providers will provide post-abortion care to women who present with post-abortion complications, PAC is not currently listed as a priority issue in the Health and Population Welfare policies. In addition, there is no provision for PAC counselling in the training given to healthcare providers.

Typically, women in Pakistan use abortion as a method of birth control and opt for one after completing their desired family size (4-6 children). The preferred method of providing Post Abortion Care in Pakistan is Dilation & Curettage (D & C), although medication abortion and Manual Vacuum Aspiration (MVA) are both now available in the country and are the WHO-recommended methods for post-abortion care. These procedures are far safer and simpler to perform than a D & C. MVA can be done on an out-patient basis and medication abortion can be self-administered by the patient at home. However, aside from a few programmes administered by NGOs, there are no training programmes for healthcare providers in MVA (manual vacuum aspiration) or medication abortion, or for PAC counselling.

Issue's Development:

Several NGOs have recently been advocating for Post-abortion Care. Funding for PAC programmes has increased and there is a growing recognition that if safe PAC services are provided, they will contribute significantly to reducing the high rates of maternal morbidity and mortality.

It is essential that healthcare providers be trained in providing PAC counselling and services, especially through the use of manual vacuum aspiration and medication abortion. This will ensure the provision of safe PAC abortion services and will reduce the chances of women developing further complications or dying due to abortions that have not been performed properly or by qualified providers.

Comments from recourse person(s)

Indu noted that she appealed to everyone. Good, it makes the person feel powerful when you appeal -YOU can make the difference. Only comment is you could have added 'I'll send you the details or I'll be here to help you'. Otherwise it was superb

Malou said that if the person turns the comment around, continue the conversation: where can we meet in common ground? Don't make the person an enemy. There is a colloquial meaning of gestures. Remember lobbying and advocacy is communication, meeting on the same ground as your enemy is a good point.

Discussions and Suggestions

Pallavi wondered if the budgetary part which will go into the training of these people could be compared to war.

Neha wondered if the mindset of the person hward been taken into account. What if the person turns around and says: "So? The women deserved to die, abortion is a sin."

Indu agreed and said that it's extremely important to know the background and the

stand of the person you are advocating to. Research not only the topic, but the person.

Siva added that picking one statement/data is a good idea

i. Bangladesh

ISSUE: PREVENT CONVULSIONS, PREVENT MATERNAL DEATHS

A simple low cost treatment with MgSo4 can prevent 16% of maternal deaths in BGD that is caused as a result of eclampsia.

Eclampsia is the third major cause of maternal mortality in BGD and is characterized by high blood pressure during pregnancy which, when untreated leads to eclampsia & consequently women die.

Women in age group 25-34 are mostly affected. This is very sad tragedy & a gross violation of human rights to life, since eclampsia can be treated with an effective low cost & easy solution.

Bangladesh government is excellent has done National Maternal Health Strategy - which covers antenatal care, safe delivery including EmOC , post natal care & Family Planning , prevention of unsafe abortion , how ever the implementation of the strategy is limited.

What needs to be done:

We highly recommend that government addresses the issue of eclampsia by:

- Ensuring availability & regular supply of MgSo4 at all health facilities from upozila to districts & tertiary.
- Secondly train the health service providers to identify cases of pre eclampsia & eclampsia in antenatal check up, during delivery & post delivery care.

As policy makers are responsible for citizen health & wellbeing – we are from Naripokkho a renowned women activist organization works for advancement of women health rights - we request you to ensure the full implementation of National Maternal Health Strategy including in services the availability of MgSo4 which is the only proven effective & low cost treatment of eclampsia.

More supply of MgSo4 save more women lives in BGD.

Comments from recourse person(s)

Indu said that it was very good, though she suggested not to use the words magnesium sulphate too much. She suggested to start with the positive thing that Bangladesh has done. She said not to go too much on the magnesium sulphate and to find out from his constituency-suppose Pakistan/India has done it and you're in good relations to them-then bring it in and say they have done it and got good feedback.

Malou-same as Indu

j. Cambodia:

ISSUE: TO UNDERSTAND THE BARRIERS TO FAMILY PLANNING COMMODITIES AMONG MARRIED COUPLES

The Reproductive Association of Cambodia (RHAC), a national NGO and a pioneer in SRHR active in 12 out of 24 provinces of Cambodia. RHAC provides a comprehensive SRH through 17 private non profit clinics, and raise awareness and BCC through its peer educators and village health volunteers about 20,000 to normal population, adolescent and various vulnerable adolescent groups, support the gov. health centers 217 to provide accessibility of the people, especially rural poor. All program design with gender sensitive and rights based-approaches.

Stakeholders: The Cambodian Government are taking active in combating with HIV epidemic successfully in the last decade, so the donor agencies and the national programs put all effort and resources to HIV, which had taken away all the intention to the Population and RH issues. Member of Parliament, Ministry of Health, donors seem to forget and put MMR at less priority in the National program which contributed to budget allocation this program. Women die every year around their birth related issues are still concerned as among the highest in the region.

Issues history: Cambodia is one of the countries that could not achieve the ICPD on Maternal Mortality to reduce to below 125 per 100,000 live births in 2005. From the CDHS 2005 found still high at 472.

Despite all the effort and budget flow to HIV, the country are compromised in other activities and FP is one of the program which reduced the 1/3 of MMR are shrink down less attract from Govern, donors to response to the large unmet need for contraceptive and the unwanted pregnancies caused to unsafe abortion and the deliveries by the skills train providers also still very low, CPR is 40% still lower that ICPD framework. The services that provides FP is about (60% of primary health care can provide FP ICPD 2005 framework) reported can provide FP, however, there were no services utilization on this particular services because of the quality of services

Define issue: Te young married couple still fear to use contraceptive due to misperception on side effect and fear of infertility when they haven't got child yet. Lack of update knowledge of FP for the providers and number of providers are still haven't increased in terms of quality and quantity to deliver FP services and counseling in the public sector. The health staff create rumor related contraceptive side effect, and fear of not having money to their health care. There are no monitoring and supportive supervision on FP planning due to lack of resources and staff allocation.

Our organization is the only sole org. who implement in FP, the budget for FP is stay the same for the last 7 years so we can not expand the services to meet the country need and there are more than hundred org work in HIV because the mandate of donors are willing to support more and only few support in FP. Since the CPR is not ncreased the few donors are tired to continue to support and the Government of Cambodia is not prepared and not ready to take over in contraceptive commodity.

Despite of this issues of high MMR and low CPR, the national RH program should be strengthen it program implementation, and budget to provide training and refresher training to current providers and new coming staff on contraceptive

The community providers also need to expand to entire country and also target to the rural poor and underserved women. Media campaign on FP need to extend to further sides effect and actively in radio and TV. The Life Skills Curriculum for in school also integrates the FP methods and choices.

Without donors commitment and the National program design expand to improve the capacity and expand to the need using on and remove all the barriers to FP to help our vulnerable women as wives and mothers die every day due to unplanned and unsafe abortion and their maternity on the way by haemorrhage or complicate delivery.

Comments from recourse person(s)

Indu said that it was a good presentation. Pausing was good, she looked everywhere and started from the positive. Her comment was that something could have been handed out.

Discussions and Suggestions:

Atas said that the starting was very good, but climax was too early, it should have been at the end.

k. Philippines (Mindanao)

ISSUE: IMPLEMENTATION OF LOCAL GOVERNMENT UNITS OF THE GENDER AND DEVELOPMENT PROGRAM MANDATED BY LAW FOR THE PROVISION OF FAMILY PLANNING SERVICES AS A MEASURE TO REDUCE MATERNAL MORTALITY AND MORBIDITY

ORGANIZATIONAL PROFILE: Pinay... Kilos! is a non-government organization composed of young women and women advocates, mostly young professionals and students, based in Zamboanga City, working on the issues of Peace and Women Rights in conflict areas in Mindanao, specifically Zamboanga City, Zamboanga Sibugay, Basilan and Sulu.

STAKEHOLDERS IN THE ISSUE: Local Government units, specifically Local Chief executives, Health personnel/providers, community-based women organizations

THE ISSUE: The Philippines is one of the 68 countries contributing to 97% of maternal deaths. In 2000, maternal mortality was estimated to be at 200/100,000 live births. The 2006 survey showed an uncorrected rate of 162/100,000 births, a glaring manifestation that in a span of 5 years, there is barely any reduction in maternal mortality. This is way below the ICPD benchmark of reducing maternal mortality ratio by $\frac{3}{4}$ of the 1990 level by 2015.

The risk of maternal deaths is magnified with the risk of having mistimed, unplanned, unwanted and unsupported pregnancy. In fact, studies showed that of the 400,000 maternal morbidities in the Philippines, up to half can be prevented

through effective family planning.

The situation is even more critical for the marginalized women of the Autonomous Region of Muslim Mindanao, to which 7 of the 10 poorest countries in the country belong. According to a Save the Children Report, ARMM is the worst place to be a mother in the Philippines. Taking into account the contribution of unplanned/unwanted pregnancies to maternal mortality and morbidity, the latter may therefore be significantly reduced through the availability and accessibility of Family Planning services and supplies in the community. There is a very huge gap in this area in ARMM as evidenced by an extremely low contraception prevalence ratio in the Region.

The Case study conducted by PINK and LIKHAAN of 4 women who suffered maternal complications as a result of unplanned pregnancies in Basilan, a province in ARMM, served to confirm (?) and visually describe the issue that needs to be addressed – that is, that these women, and all other women like them, could have been saved from death or near death experiences if only Family Planning services were made available and accessible to them.

The enactment of the Reproductive Health Bill is called for. But while this is pending in Congress, there are existing mechanisms available to address the issue, one of which is the mandate given by law to Local Government Units to provide funds and resources for Gender and Development or GAD. Majority of local executives and policymakers are not aware or are delinquent in performing this mandate. There is therefore a need to engage local government towards the full and effective implementation of GAD and a corresponding women's movement to ensure and monitor this implementation.

Comments from recourse person(s)

Indu agreed with Neha about the conversational language: 'You must be aware that we have done this, that you have signed this'. Some people hate confrontation, so appeal in a personal way. Always start with something good about that person. Never tell lies, but find out one good quality of the person so it appeals better

Discussions and Suggestions:

Neha said that it was a great speech, but more suited to the floor. When you meet someone in the hallway, the language you use is very different, it should be a little more conversational when you're lobbying

Djalía agreed that it was prepared for a more formal environment

I. Vietnam

ISSUE: PROPER ABORTION COUNSELING FOR UNMARRIED FEMALE YOUTH

- We are CGFED and RaFH – we both are NGOs working in the field of Reproductive Health and gender for 15 years. We have much experience on working close with the community people and collaboration with other civil society organizations and Government agency in promoting women health and rights. We are memberships of several NGO networks
- Joining the ICPD + 15 monitoring project coordinated by ARROW, an reputable regional NGO, we look at the issue of abortion in Vietnam. In our research findings, we have found a very urgent issue to be raised and called for action of policy maker at MoH, local governments, civil society that can benefit women especially unmarried female youth.
- The legal abortion has been addressed in various state policies targeting population development and health care such as Law on Protection of People's Health (1989) and reproductive health issues has been added and emphasized in National strategy on reproductive health care from 2001-2010, population Ordinance and various decisions under law. In last 10 year the government has made great effort to reduce abortion rate. The National Health Survey (2001) shows that complications due to abortions account for 35.36%. Among several contributing factors to this situation, the lack of proper counseling services before and after abortion appears a key factor that need to be prioritized.
- According to National standard for reproductive health care issued by the Ministry, the counseling service should be given to all clients, including abortion cases. However, it is hardly practice or just performs in properly in health care Unit at different levels. The available counseling is mainly provided to married women while unmarried female youth can not receive it due to social discrimination against their sexual activeness.
- No youth friendly counseling provision leads these unmarried youth to the continuity of their unwanted-pregnancy and forces them to seek for unsafe abortion. There are more negative effects on their health such as post abortion complications, infertility, RTIs, mental illness, that make uncountable cost for individual, family and community.
- We are urging you to play the leading role to ensure the proper performance of youth sensitive, standardized and comprehensive counseling. Proper budgeting for and strictly running of a monitoring mechanism throughout the health care system are prerequisite you would take.
- Our two NGOs and others in national and international NGO networks will complement to your effort by provision of training on SRHR for youth as we have done for a decade, for shake of our healthy young women generation.

Comments from recourse person(s)

Indu commented that it was good, though in this kind of case you could have taken a young person with you to connect the case with the face, it would have had more impact. It started so well, but time is an issue. You can appeal – *'one more minute, this will make a difference'*.

m. Malaysia

ISSUE: SEX EDUCATION CURRICULUM

Malaysia's budget is mainly concentrating on education and health.

We are today advocating for the implementation of the Sex Education Curriculum for the public and private primary and secondary schools in Malaysia which today is still not being implemented today despite all the publicity we have today regarding the behavior of our youth of today. Malaysia is a nation of 27.3 million where more than 1/3 or abt 10million is the young with 19% are those between the age of 15-24 years.

The stakeholders of this issue are the shool going children between the ages of 7 to 19 years, the teachers, counselors, parents and Ministry of Education and Health. Not forgetting the women and youth's group

The Federation of Reproductive Health Associations Malaysia formerly known as the Federation of Family Planning Associations Malaysia of which I am representing today, is one of the oldest NGO in SRH and FP in Malaysia with 13 States Member Associations thoroughout the nation of Malaysia.

The Ministry in 2006 had allocated 20M for the implementation of this curriculum in all schools but till today, nothing has been done. All we had had been meeting and discussing why there is no implementation till today.

The sex curriculum was a compilation of efforts by the MWFCDC (thank you Datuk Dr Ng Yen Yen), MOE, MOH (of which we thank all your efforts and cooperation) and a group of NGO esp from the women and children sectors

Our experience in the youth education is that we are the pioneer in the development of the family life education module more than 25 years ago. We have in all our State MA youth committees /clubs and have the experience of running a few youth projects the most recent ones being funded by UNFPA ie. increasing the awareness of youth in Schools and also those in the juvenile homes.

Why all of you present today here can make a big difference to the youth of today and tomorrow by having the sex education curriculum implemented as soon as possible are :

1. the sex education in school curriculum is critical in assisting the prevention of unwanted pregnancies amongst the young. A survey in 2001 – 2004 showed 315 cases of abandoned babies and a media reported 1 baby being abandoned every other 10 days.
2. In 2004, 1765 rapes were reported to police as compared to 1,217 in 2000 and recently there were a lot of cases reported on abandoned babies.
3. The young people are now sexually active – a study in 1995 show 9% having sex are between the age 15-21 yrs. Another survey in 1997 showed 18% of those having sexual encountered to be between 15-18 yrs.
4. Malaysia is now eligible for Global Fund as it has not yet achieve Mill ileum Development Goal 6 – HIV/AIDs and the no of PLHIV in Malaysia is more than 80000.
5. To educate/update and arm the SRH knowledge and information of our children to protect our children from internet pedophiles so that they are aware of the risks of strangers posing as parents

For monitoring the issue development we recommend the

1. formation of a Steering Committee comprising of Ministries (MOE, MOY, MOH) NGOs (diverse and like minded) as well as the academia.
2. the provision of immediate workshop/seminars to sensitize all service providers in the public hospitals to provide information to access SRH services to the young without any stigmatisation and discrimination

If we do not implement this curriculum urgently, we may end up with a society of leaders with inadequate knowledge of SRH/HIV and FP. We are very concern and committed to this issue and request for the implementation of this curriculum by early 2010

Comments from recourse person(s)

Indu said that she would have started with Mr Rama, he started right. Body language speaks much more than your words. There were too many We's and not enough You's, I would have said that there are many other people who will assist you, and put an emphasis on how YOU will benefit

Malou said to always prepare a takeaway message, what you will remember. Don't forget to always tell a story; it's a powerful way of communicating and contextualising, and builds an image to an issue. Spinning the message: there is ONE factual message, positioning your message is important. Spin it: headlines headlines in the newspaper screams and grabs attention. That is good, but don't spin too much.

Indu also added saying it would be good to topicalise it. At this point of time you should know what the opinion of the person is before saying something. For instance, some of Gandhi's items were supposed to be sold, the person selling it told India that he would sell it if India increased the health budget by 4%. These kinds of message makes people realise that you can't say either/or, but timing is crucial. Fear does sometimes help, but do research first.

ANNEXURES II: ICPD+15 Strategic Advocacy Planning Meeting

A. Concept Note

1. Introduction and Background

The ICPD PoA is the one international conference document that sets forth the agenda of sexual and reproductive health and rights. In order to monitor progress towards the ICPD goals, ARROW has always created and implemented a regional ICPD monitoring project. Hence, every ARROW Work Programme and Budget cycle has had regional monitoring project as evidenced by the +5 and +10 processes. Monitoring ICPD has been the key mechanism of ensuring that the SRHR agenda stays on the agenda of national and regional governments. The +15 project secured 2-year funding from Ford Foundation, with additional funding from SIDA for the monitoring of sexual rights indicators. A research planning meeting was held in April 2008 and country studies were initiated in 11 countries. A set of 80 indicators were chosen to be monitored across all countries and comprise of the following crucial categories:

1. Reproductive health
2. Reproductive rights
3. Sexual health
4. Sexual rights

Partners were empowered to freely choose the most critical SRHR issue in their country and focus on close monitoring and advocacy on that specific issue. The issues chosen by the partners comprise of the following crucial categories:

1. Contraception
2. Abortion
3. Maternal health and morbidity
4. Sexual rights

Issue wise the country groupings are:

<i>Abortion</i>	<i>Contraception</i>	<i>MH & MM</i>	<i>Sexual rights</i>
Vietnam	Cambodia	Laos	Thailand
Malaysia	Malaysia	Philippines	China
Indonesia	Philippines	India	Sexuality
Pakistan	Indonesia	Nepal	
	Pakistan		

In addition to this, three regional thematic studies were also commissioned:

1. Privatisation of health services and its impact on SRHR
2. Disaster situations and their impact on SRHR
3. Sexuality agenda in SRHR

2. Project progress to date

Project progress, unfortunately, has not been even across all partners for various reasons. The table below attempts to capture the data that has been collected from all the partners according to the Southeast Asian region, the South Asian region and China.

Country partner	Progress as of 1 March 2009	Expected progress as of 12 March 2009
Malaysia (1 partner x1 issue)	First draft, reviewed	Has findings, reviewed, has incorporated reviewer's suggestions
Indonesia (2 partners x 2 issues)	One case study in (50%)	First draft, has findings, not reviewed
Philippines (2 partners x 2 issues)		First draft, has findings, not reviewed
Thailand (1 partner x2 issues)	First draft, reviewed	Has findings, reviewed, incorporated reviewer's suggestions
Vietnam (3 partners x1 issue)	First draft, reviewed	Has findings, reviewed, incorporated reviewer's suggestions
Laos (1 partner x1 issue)	First draft	First draft, has findings, not reviewed
Cambodia (1 partner x1 issue)		First draft, has findings, not reviewed
India (3 partners x 1 issue)	In only in April	Has findings, but not a first draft
Bangladesh (1 partner x 1 issue)	Late signing, in only in May-June	
Nepal (1 partner x1issue)		Has findings, but not a first draft
Pakistan (1 partner x 2 issues)	First draft in	Has findings, reviewed but not incorporated reviewer's suggestions
China (3 partners x 3 issue)		Has findings, but not a first draft

This meeting has been crafted around the progress and accomplishments of the project thus far, taking into account the variances between partners.

3. ICPD+15 in Asia-Pacific: Strategic Advocacy Planning Meeting

3.1 Objectives

The objectives of the ICPD+15 Strategic Advocacy Planning Meeting are:

- Share, discuss and strengthen the key findings and recommendations of the 11 ICPD+15 monitoring country studies.
- Develop strategic policy recommendations for clearly identified target groups (i.e. government, UN agencies, donors and NGOs) at the national, regional and international levels based on the findings of the monitoring studies of ARROW and her partners.
- Identify and achieve clarity on the components of national advocacy plans.
- Write-up the first drafts of the national advocacy plans.
- Achieve clarity and write the first drafts of the national policy briefs.

3.2 Recommended overall strategy

2.2.1 National advocacy

The short-term objective is for the national partners to advocate their issues through National Policy Dialogues (NPD) as per the project requirements. The national partners' will know the most effective way and means to conduct their national policy dialogues within their political context. The strengthening and sharpening of national findings and recommendations and the creation of issue policy briefs constitute an important step in achieving the goals of the national policy dialogues. However, there also needs to be a regional/ international leverage present to support and to step up the pressure for the national level advocacy. At the national levels, it may be important to present the regional overview and to situate national achievements within regional scenarios precisely with the aim of comparing and pressurizing national governments.

3.2.2 Women's Health and Rights Advocacy Partnership (WHRAP) Asia-Pacific

The long-term objective of the ICPD+15 work is to form an advocacy body that will function at the regional and international levels which is comprised, initially, of the ICPD+15 project country partners which include Malaysia, Indonesia, Philippines, Thailand, Cambodia, Vietnam, Laos, Nepal, India, Pakistan and China. The WHRAP Asia-Pacific vision is to include as many countries and organisations from the region as possible who will function as a regional advocacy network.

3.2.3 Global NGO alliances

The second long-term objective is for WHRAP-AP to aim to build international global alliances on sexual and reproductive health and rights (on the whole) and on the specific issues of contraception, abortion, maternal health and morbidity, privatization of the health sector and its impact on srhr, sexuality and sexual rights, and srhr issues in disaster management. WHRAP-AP work closely with other network allies such as LACHWN, Amanitare, ASTRA, CSBR, WGNRR, in order to promote the SRHR agenda at the global platform.

This Strategic Advocacy Planning Meeting aims to fulfill the first, short-term objective of the recommended overall strategy.

3. Participants

The meeting will involve 1 or 2 participants from each national partner. The participant will be the officer/ ED who will be primarily responsible for the advocacy that the organization will do around the country report.

4. Programme Methodology

The programme has been divided into 3 critical areas of achievement:

- 1) Issues management session which enables partners to prioritise their by strengthening their findings and recommendations and prioritizing the recommendation issue for advocacy.
- 2) National advocacy planning session which enables partners to present their policy analysis, stakeholder analysis, and identify their advocacy goals and strategies.
- 3) Policy/ Issue brief session which enables partners to do the first draft of their policy/ issue brief.

On the first day, each partner will make a 10-minute presentation on their national findings and there will be a 10 minute peer-assist discussion on strengthening the findings and the recommendations at the national level. The presentations will be grouped according to the issues to enable the thinking in the room to be focused on issues.

On the second day, each country will spend some time to re-package their research findings and their recommendations into policy/ issue briefs which consist of 4 main categories:

- 1) Executive Summary
- 2) Context and importance of the problem
- 3) Critique of the policy option
- 4) Policy recommendation
- 5) Desired outcome: First draft of 12 national policy briefs.

On the third day, each country will also make a 20-minute presentation on

The country presentations will be focused on the following questions:

- 1) Advocacy plan: crucial questions: Aims (How beneficiaries will be affected) and objectives (specific changes to be made)
- 2) Target audiences & key influencing strategies
- 3) Stakeholder analysis
- 4) Proposition (core message)
- 5) Action plan and timetable for each audience/ strategy
- 6) Resources and budgets
- 7) Risks and assumptions
- 8) Desired outcome: First draft of the 12 national advocacy plans with common understanding of critical elements and common framework for further review and refinement.

B. AGENDA

	Thursday, 12th March	Friday, 13th March	Saturday, 14th March
Objectives	* Strengthening research findings and recommendations * Prioritising issues based on country research	* Skills building of partners to develop national policy briefs	Skills building of partners to develop national advocacy plan
Deliverables	1) Strong, critical and action-oriented research findings	1) Develop a policy brief and re-package research	1) Share a stakeholder analysis 2) Identify advocacy

	and recommendations 2) Prioritisation of issues for advocacy 3) Share policy analysis	findings into the 4 components: executive summary; context and importance of problem; critique of policy; policy recommendations	goal 3) Identify strategies to achieve the advocacy goal
Time Schedule			
9.00 a.m.	Opening and welcome remarks; introductions	Presentation: Putting together policy brief What is a Policy brief?	Presentation: What constitutes a national advocacy plan?
10.00 a.m.	Presentation: Introduction of Advocacy: Concepts for clarity and Discussion Introduction to issues management	Workshop [Participants will develop respective country policy briefs]	Presentation: Components of the national advocacy plan
10.30 a.m.	TEA BREAK	TEA BREAK	TEA BREAK
11.00 a.m.	CONTRACEPTION Country presentations <ul style="list-style-type: none"> • Indonesia • Cambodia • Pakistan • Philippines [Presentation by Partners]	Workshop [Participants will develop respective country policy briefs]	Country presentations
12.00 noon	CONTRACEPTION/ABORTION Country presentations <ul style="list-style-type: none"> • Malaysia • Vietnam • Pakistan • Indonesia [Presentation by Partners]	Workshop [Participants will develop respective country policy briefs]	Country presentations
1.00 p.m.	LUNCH	LUNCH	LUNCH
2.00 p.m.	Maternal Mortality and Morbidity Country presentations <ul style="list-style-type: none"> • Philippines • Laos [Presentation by Partners]	Country presentations	Country presentations
3.00 p.m.	Maternal Mortality and Morbidity Country presentations <ul style="list-style-type: none"> • Nepal • India [Presentation by	Country presentations	Country presentations

	Partners]		
3.30 p.m.	TEA BREAK	TEA BREAK	TEA BREAK
4.00 p.m.	Sexual health and Rights Country presentations <ul style="list-style-type: none"> • Thailand • Thematic paper on Sexuality (Neha Sood) [Presentation by Partners]	Country presentations	Country presentations
5.00 p.m.	Sexual health and Rights Country presentations <ul style="list-style-type: none"> • China (3) [Presentation by Partners]	Country presentations	Presentation: Monitoring and evaluation
6.00 p.m.	Presentation: From Issues to Advocacy (wrap up)	Country presentations	Evaluation of meeting

C. LIST OF PARTICIPANTS

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D. PARTICIPANTS' EVALUATION (summary)

1. Participants evaluated the meeting each day and ARROW received three evaluation forms, from each participant. We received 26 filled evaluation forms on day one, 25 filled evaluation forms on day two and 26 filled evaluation forms on day three. The participant response rate was 87 per cent on day one and 83% on day two and 87% on day three. The summary of the findings from the filled-in evaluation forms are presented below.

2. **Lead Resource Person**

The introductory presentation by resource person on advocacy concepts and issues management, was received very well, all 26 (100%) of the participants noted that the presentation was clear, and 21(81%) gave a ranking of 4&5, and noted the presentation was relevant in the understanding of, how to prioritise the issues for advocacy. Additional responses included, *it was very clear, structured and easily understandable, guidance on advocacy and lobby is very good, advocacy session should have more time for participants to digest and ask questions*, other comments included *Malou should have given more input on the presentations*. With regards the session on skills building of partners to develop policy briefs, on day two, 20 (80%) of the participants gave a ranking of 4&5, additional comments included, *clear, helped to prioritise the issue, very important, relevant, good*, other comments included, *there was some confusion in following the guidelines, and an example of a policy brief should be distributed to participants before practising, and there was miscommunication in giving instructions about the policy briefs*. With regards the session on skills building of partners to develop national advocacy plans on day three, 19(76%) of the participants gave a ranking of 4&5, additional comments included, *it would have been more effective to have only one presentation,, it helped us make our national advocacy plan, very clear and understandable, excellent, to the point, good, very nice and so exciting*, other comments included, *may be an advocate from South Asia would be more relevant as lobbying is not the preferred form of advocacy in the region, more comments from the resource person would have been good, too west focussed lobbying style, did not take into account many issues we deal with , therefore not very realistic or applicable, confusing*.

3. **Other Resource Persons inputs on partner presentations**

With regards the inputs by the other two resource persons on country findings and recommendations, 21 (81%) of the participants gave a ranking of 4&5, additional comments included, *despite the short time, the objectives of the meeting were met and satisfied, good and friendly comments by resource persons and participants, the resource persons were active, friendly, and sincere, focussing on all participants, excellent input by Rashidah, good input by Indu, but she needs to bring more south Asian perspective, not just India perspective*. With regards the inputs by the resource persons on the policy briefs, 7 (27%) gave a ranking of 4&5, and 18 (69%) did not respond to the question. Additional comments included, *the inputs were useful, good learning session by seeing the role play and real life feedback, it shows the potential advocacy, and its very important to enhance the skills for national policy briefs, thank you ARROW, and resource persons, small details were looked into, everything matters in advocacy, very good, Rashidah has been very helpful and encouraging with passion, sincerity in her efforts to build up our advocacy skills, thanks Rashidah, Indu Capoor was very supportive*. other comments included, *....comments are sometimes based on personal opinions and experiences which may not be*

applicable to local realities. A total of 19(73%), found the inputs by resource persons on the national advocacy plans helpful, additional comments included needed more detailed comments and more time for more input, glad to have received positive comments and feedback, for some they were great , should have been better regional linkages/knowledge, especially for South-Asia.

4. Working processes and methodology and major learning's from country presentations

All (100%) the participants gave a ranking of 4&5 for the workshop methodology used to develop the policy briefs. Additional comments included, *excellent methodology for learning process, excellent for learning process, the practical lobbying and comments after were useful, resource persons gave instructions at once so people can remember it easily, other comments included, could have given more tips beforehand, clear instructions on what was expected was not done.....* With regards the workshop process for developing the national advocacy plans, additional comments included, *the process was excellent, helped organise the presentation and detailed out the advocacy strategy, good as an introduction/brief exercise-a clear advocacy plan takes much longer, other comments included, not enough time and may be we could have been more effective if 11 presentations were not in a row, the process was found useful.*

Comments on the learning's from the country presentations included, *learning's included to be smarter with the objectives, there are many ways to achieve your aims/goals and using a variety of strategies, scanning of the environment where we plan to do advocacy in our issue, to strategise our goals and plan advocacy regarding the same, learned about issue brief , action –planning, policy brief , which are all useful and helpful, some of the inspiration is based on the lot of activities in other countries, a lot of similarities, stakeholder analysis,, primary and secondary target groups, approach to reach out to advocacy, lobbying with concerned groups for advocacy, presentation performance form, can compare, we need to come up with a way to work from a common SRHR platform*

With regards other working processes and methodologies, 20 (77%), of the participants gave a ranking of 4&5 for having sent the partners standardised presentation formats, 20 (77%), gave a ranking of 4&5 for group input into country presentations, 19(73%), gave a ranking of 4&5 for programme design and 10(38%), gave a ranking of 4&5 for time management, additional comments included, very helpful, because the organisers and the resource persons did not force the participants and the processes were flexible, other comments included, the guidelines given to prepare the PowerPoint, overlapped and 2 types- soft and hard copy- did not match, confused!, we could have had group discussions to save time and organised groups according to thematic concerns, main weakness was not enough time was planned for adequate discussion, short notice to prepare power point, some activities would have been good.

5. Meeting Preparations, overall admin and logistics

A total of 18 (69%) participants gave a ranking of 4&5 for the overall meeting preparations. On communications prior to the meeting, with regards partner presentations, 22 (85%) gave a ranking of 4&5, one participant however felt the *notice was too short.* 22 (85%) of the participants gave a ranking of 4&5 for the meeting kit. A total of 20 (77%) gave a ranking of 4& 5 for the attitude and

conduct of ARROW staff. Additional comments included *hats of to Azura and Su! and helpful and sweet*. On communications prior to the meeting with regards admin and logistics, 18 (69%), gave a ranking of 4&5, 20 (77%) gave a ranking of 4&5 for accommodation, 18 (69%), gave a ranking of 4&5 for claims and reimbursements, 15 (58%) gave a ranking of 4&5 for venue, 20(77%) gave a ranking of 4&5 for food, and a total of 22(85%), gave a ranking of 4&5 for admin notes. Additional comment included, *no admin note was received, had to ask for hotel address*.

6. Overall level of satisfaction, including comments on how the meeting could have been done better?

Comments by participants included, *Thank you so much , there are so many things to be learned, time not enough to review the updates on ICPD 1994-achievemnt, some country was very concerned about how to lobby same agenda/ issue of abortion, maternal mortality, integration with HIV/STI and FP, influence the donor to channelise the funds in integration and sustainable management, well done ARROW!, more time to enjoy the beautiful venue, timing was too tight, needed more energisers in between breaks, it was good plan to play basketball together, unfortunately it did not happen, meeting overall was excellently planned technically, with more time could have valuable comments, peer assist thus couldn't be fully utilised, venue should be more central, admin staff could be more responsible, though I know they tried hard, overall amazing team, main resource person, while good, had too much of a Washington DC-lobbyist focus, not very relevant sometimes.....*

Note

- Please note the evaluation on partner presentation has not been captured in the summary, based on the comment received by one of the participant, *no need to rank partner presentation, they are not a reflection of the workshop and we are all learning*
- Please note that ARROW team is working on the feedback received, to improve on the weaknesses, and further strengthen on our strengths, and we hope to do our best, in future meetings.