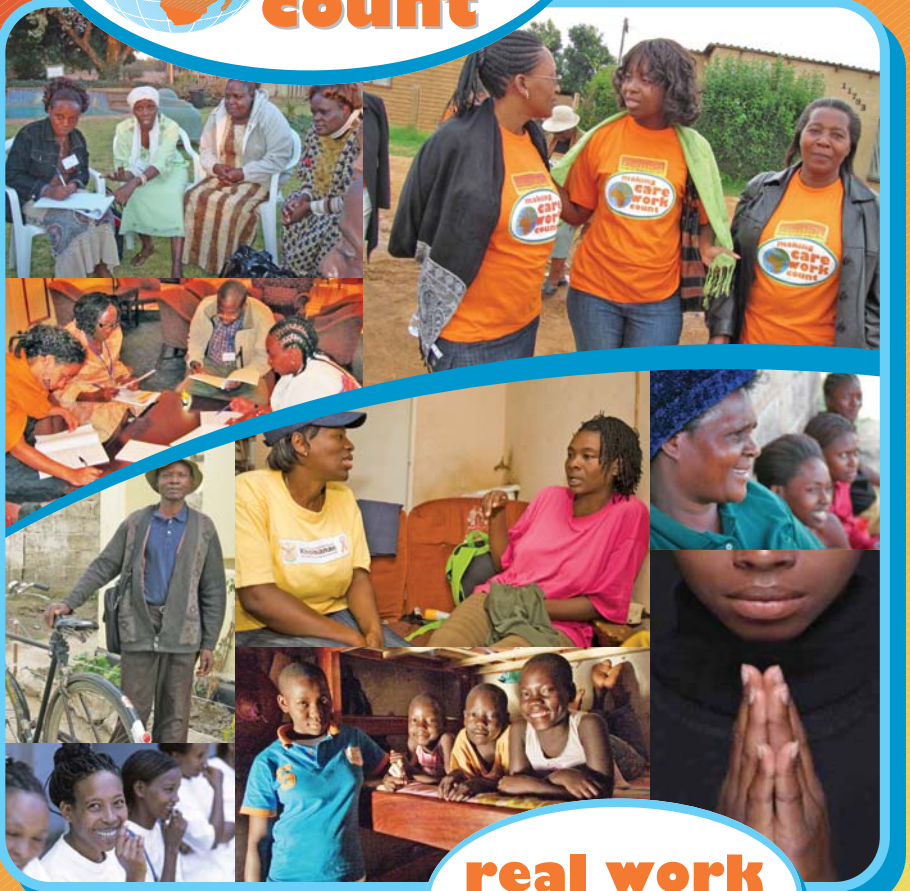
A POLICY DEVELOPMENT HANDBOOK

making care work count

VSO Sharing skills Changing lives

RAISA

GEMSA Gender and Media Southern Africa



real work real pay!

A POLICY DEVELOPMENT HANDBOOK ■ 2010

This is a joint publication of GEMSA and VSO-RAISA

With technical support from

And financial support of UKAID

Other sponsors of the project are:

BY: Lynette Mudekunye, Masimba Biriwasha and Dr. Sandra Musengi-Ajulu

ISBN: 978-0620-47906-6

DESIGN AND TYPESETTING: Gemini Concepts
Haidy Lee du Toit - haidy@geminiconcepts.co.za

PHOTOGRAPHS
Unless acknowledged otherwise, the photographs used in this Handbook are from GEMSA and VSO-RAISA archives and are used with the consent of the subjects.

CONTENTS

ACKNOWLEDGEMENTS 4

ACRONYMS 6

FOREWORD 7

CHAPTER 1: BACKGROUND AND CONTEXT 9
- Introduction 10
- Why a policy for care providers in Southern Africa? 10
- Linkages with the HIV and health sectors 15
- Why is care provision a gender issue? 18

CHAPTER 2: FRAMING A CARE WORK POLICY 25
- Introduction 26
- Framing Care Work Policy 26
- Care work practices in the SADC region 28
- A Case for Stand-Alone Care Work Policy 37
- What are the key principles that need to inform care work policies? 39

CHAPTER 3: COUNTRY MAPPING AND STAKEHOLDER ANALYSIS 45
- Overview 46
- Key activities 46
- Checklist 58

CHAPTER 4: BUILDING A COALITION 59
- Overview 60
- Key activities 62
- Checklist 68

CHAPTER 5: DRAFT POLICY FORMULATION AND IMPLEMENTATION 69
- Overview 70
- Key activities 70
- Checklist 78

CHAPTER 6: DEVELOPING AN ADVOCACY AND LOBBYING PLAN 79
- Overview 80
- Key activities 80
- Checklist 90

CHAPTER 7: MONITORING AND EVALUATION 91
- Overview 92
- Key activities 92
- Checklist 96

List of Boxes

Box 1:	Understanding key HIV and AIDS care work terms	12
Box 2:	Using evidence to influence policy making	27
Box 3:	What information to look for	47
Box 4:	Sample Key Questions	49
Box 5:	Joining an Existing Coalition	61
Box 6:	Example of a vision	61
Box 7:	Tips for Managing Coalitions	68
Box 8:	Understanding key Advocacy terms	81
Box 9:	Tips for developing and framing key messages	82

List of Figures

Figure 1:	The comprehensive continuum of care, WHO 203	15
Figure 2:	"Making Care Work Count" Policy Development Process	24
Figure 3:	Example of a Process of Policy Development	71

List of Tables (also available on CD-ROM)

Table 1:	Services undertaken by care providers	14
Table 2:	Global and African Commitments that Support Care Provision	17
Table 3:	Summary of findings of GEMSA's review of C&HBC Policy and Guidelines practices	30
Table 4:	Care Work policy in the SADC Region	36
Table 5:	Developing a stand-alone policy on care work for the SADC region	42
Table 6:	Planning and policy framework for C&HBC	43
Table 7:	Categories of stakeholders	52
Table 8:	Determining the main task of the coalition	64
Table 9:	Identifying resources for the advocacy and lobbying plan	82

List of Tools (also available on CD-ROM)

Tool 1:	Coordinating Partners Work Plan	56
Tool 2:	Checklist for Forming and Managing a Coalition	63
Tool 3:	Coalition Work Plan	66
Tool 4:	Example of a draft care work policy	76
Tool 5:	Sample advocacy action plan	86
Tool 6:	Monitoring the Advocacy Campaign Progress	93
Tool 7:	Advocacy Campaign Logic Framework	97

HANDBOOK RESOURCES (available on CD-ROM)

R1: GEMSA: Making Care Work Count Regional Report
R2: SADC Protocol on Gender and Development
R3: VSO-RAISA and WHO Africa, 2009. 'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'
R4: Drafting Policy or Policy Inputs
R5: Sample Code of Conduct for Care Providers
R6: Working with the Media
R7. VSO Participatory Advocacy: A Toolkit for VSO Staff, Volunteers and Partners
R8. Community Home-based Care in Resource Limited Settings: A Framework for Action
R9. Namibia National Policy on Community Based Health Care, March 2008

COUNTRY REPORTS (available on CD-ROM)

These include reports of the audit of country policies on care work.

CR1 Botswana
CR2 DRC
CR3 Lesotho
CR4 Malawi
CR5 Mauritius
CR6 Mozambique
CR7 Namibia
CR8 South Africa
CR9 Swaziland
CR10 Tanzania
CR11 Zambia
CR12 Zimbabwe

ACKNOWLEDGEMENTS

'Making Care Work Count: A Policy Development Handbook', is a joint publication of GEMSA and VSO-RAISA with technical support from Gender Links. In May 2010, GEMSA and VSO-RAISA signed a Memorandum of Understanding (MOU) to support care work policy advocacy in the Southern African Development Community (SADC) region.

We would like to acknowledge the following people whose contribution was invaluable to the development of this Handbook:

- Loga Virahsawmy (GEMSA Chair); Bongai Mundeta (VSO-RAISA Director) and Colleen Lowe Morna (Gender Links Executive Director);
- Jennifer Mufune (GEMSA Network Manager); Glenda Muzenda (GEMSA Network Coordinator); Pinky Magau (GEMSA Office Manager); Dorothee Swedi (GEMSA-DRC); Justice Maqelepo and Sophia Tlali (GEMSA-Lesotho); Ngeyi Ruth Kanyongolo (GEMSA-Malawi); Clementina Comate (GEMSA-Mozambique); Ncane Maziya (GEMSA-Swaziland); Perpetual Sichikwekwe (GEMSA-Zambia);
- Nakai Nengomasha of PADARE (Zimbabwe);
- Gcinile Buthelezi (Municipal Council of Mbabane Swaziland);
- Penzi Shikabi (SWAAZ);
- Esther Ntsayagae, John Botwselelo, Konosoang Nkuwatsana, Mamoseneke Letsappo (Ministry of Health Botswana);
- Anouchka Saddul (National AIDS Secretariat – Mauritius);
- Sarah Maongezi (Medical Women's Association of Tanzania);
- Dr. Christian Siboko (Programme National de Lutte Comtre Le Sida - Congo);
- Anna Mayimona Ngemba (UCOFEM/GEMSA);
- Konosoang Nkuatsana (Ministry of Health and Social Welfare);
- Gareth White (Mauritius);
- Natalie Rose (Care Work Country Researcher);
- Maria da Conceicao Lourence (Namibia Women's Lobby);
- Dr. Mungala Davi Soyjaudah (Ministry of Health Mauritius);
- Utombi Ginindon (Ministry of Health Swaziland);
- Gersham Kapalaula (Bertram Project Zambia Foundation);
- Judith Chitando (Zimbabwe AIDS Network),

- Silibele Mpofu (National AIDS Council – Zimbabwe);
- Charity Nshimbi (VSO-RAISA Programme Manager), Lloyd Masunda, Catherine Kabilo and Caroline Opinde and (VSO-RAISA);
- Amanda Bowe; Dominica Haule, and Sian Long (Consultants)

We would like to thank UKaid, who provided financial support to make this publication possible as well as Irish Aid, SIDA and Merck (MSD) for their support to the care work initiatives of the two organisations.

We would also like to pay tribute to the courageous and resilient care providers - mainly women and girls - across the SADC region. These selfless individuals continue to persevere in providing care to people infected and affected by HIV and AIDS with meagre resources.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community-based Organisation
C&HBC	Community and Home-based Care
FBO	Faith-based Organisation
GEMSA	Gender and Media Southern Africa
GFATM	Global Fund on AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
MDG	Millennium Development Goal
NGO	Non-governmental Organisation
PHC	Primary Health Care
PLWHA	People Living with HIV and AIDS
RAISA	Regional AIDS Initiative of Southern Africa
SADC	Southern African Development Community
SIDA	Swedish International Development Cooperation Agency
TB	Tuberculosis
UN	United Nations
UNGASS	United Nations General Assembly Special Session
VSO	Voluntary Services Overseas
WHO	World Health Organisation

FOREWORD

Care providers have a key role to play in the provision of care to people living with HIV and AIDS in poor and marginalised communities, filling in serious public health delivery gaps in many SADC countries. The value of unpaid care to communities is beyond doubt, but it exacts a high, often hidden cost, particularly to women and girls who are expected to be care providers. It is quite telling that research indicates that about 80% of care providers in the SADC region are women.

Yet, despite the fact that women and girls are at the forefront of care provision for people living with HIV and AIDS, there is very little of their massive contribution that is recognised at policy-making level. Though countries in the region have developed policies, guidelines and laws on HIV and AIDS community care, there are no provisions on processes and programmes that need to be put in place to alleviate the burden of HIV and AIDS care on women and girls.

Granted, some progress has already been made in raising the visibility of care work: in 2008, Namibia promulgated a stand-alone care work policy while civil society actors in South Africa are in the process of drafting a policy proposal to government. Furthermore, Botswana, Lesotho, and Swaziland currently provide remuneration to support care providers. But much more needs to be done in both acknowledging and addressing the impact of HIV and AIDS care work on women and girls.

Having said that, there is increasing evidence that the current state of C&HBC is unsustainable and promotes the marginalisation and impoverishment of women and girls who have to shoulder the burden of HIV and AIDS care provision. In light of this emerging evidence, a clear

public health and policy making agenda is required to promote programmes, services, and solutions for the problems faced by such care providers. Furthermore, the protection of women and girls involved in care provision for people living with HIV and AIDS is critical to the realisation of the SADC Protocol on Gender and Development Article 27 (c) signed by SADC Heads of States in 2008.

In an effort to put this critical issue on the public policy making agenda in SADC, civil society organisations have in recent years collected evidence to show that care work needs to be revamped in order to mitigate its impact on care providers. To this end, GEMSA launched the "Making Care Work Count" project in 2006 to bring issues of care work to the fore. In 2009, GEMSA conducted an analysis of HIV and AIDS care work policy instruments in twelve SADC Member States which revealed gaps in the gender provisions, recognition and support of care providers. Also, VSO-RAISA in partnership with WHO Africa conducted research in 2008/2009 in some countries in the SADC region that shows that care work invariably falls on the shoulders of women.

This Handbook, which is an outcome of a joint collaboration between GEMSA and VSO-RAISA, with technical support from GL, is quite timely in equipping Governments, civil society, and private sector actors with tools to raise the profile of care work in public policy making processes. With better support, there is no doubt that C&HBC can continue to play its frontline role in the HIV and AIDS response without putting the lives of care providers at risk or pushing women and girls further down into the clutches of disempowerment.

Magdeline Mathiba-Madibela
SADC
Head Gender Unit

BACKGROUND & CONTEXT

Care providers attending to client at home © VSO-RAISA

Key Points

- Across Southern Africa, unpaid, voluntary, informal networks of care providers have emerged as a critical vanguard in the provision of care to sick people.
- Unpaid care work and its negative impact, particularly on women and girls who are at the forefront of the provision of care, is largely unrecognised in many SADC country policy-frameworks.
- Care providers, mainly women and girls, play an important role in community awareness raising, including support for HIV prevention, HIV testing and treatment adherence.

chapter one

Introduction

The plight of care providers looking after people living with HIV and AIDS (PLWHA) has increasingly gained prominence in recent years but much work still needs to be done to ensure that their concerns are adequately addressed at policy making and legal levels. Many care providers are not only poor but they operate in environments that are often unsafe and unhealthy, and are often excluded from decision making processes. Care providers, mainly women and girls, have to forgo income generating activities so that they can provide services to clients. In spite of the fact that care providers constitute the frontline of care to PLWHA at community level, they are largely invisible in the global and national AIDS funding and policy frameworks.

Why a policy for care providers in Southern Africa?

In 2006, GEMSA launched the Making Care Work Count project in an effort to raise increased awareness about the plight of care providers which culminated in the provisions for the "appropriate recognition" of care work by SADC governments. Article 27 (c) of the SADC Protocol on Gender and Development by the Heads of State in August 2008 stipulates:

> *"State parties shall by 2015: Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care-givers, the majority of whom are women, allocation of resources and psychological support for care-givers as well as promote the involvement of men in the care and support of People Living with HIV and AIDS."*

In April 2009, GEMSA conducted a "policy analysis" of care work in the following twelve countries: Botswana, Democratic Republic of Congo (DRC), Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (refer to **R1** on CD-ROM for the complete report). The study revealed that many gaps still exist in country policies regarding the issue of unpaid care work. Most importantly, it revealed that the

policies are largely blind to the plight of women and girls who have to shoulder the burden of care for people living with HIV and AIDS in poor and marginalised communities in the region.

Further Reading:
Resource 1:
GEMSA: Making Care Work Count Regional Report, July 2009

Meanwhile, in 2008/2009, VSO-RAISA and WHO Africa conducted extensive consultations with key actors in nine countries – Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe (where VSO RAISA operates) and Botswana, Lesotho and Namibia on care work.

According to the research[1], the feminisation of TB, HIV and AIDS has resulted in women and girls bearing the burden of infection, care and support in the region. This is compounded by the absence of national volunteering frameworks and policies across the SADC region, as well as the lack of standardised ongoing training and support for care providers.

The evidence collected by GEMSA and VSO-RAISA both points to the need for policy and legal frameworks that concretely ensure support to care providers, mainly women and girls. While countries in the region have policy instruments on C&HBC, there is very little consideration of the gendered dynamics of care work that further marginalises and impoverishes women and girls in the SADC region.

Policies and programmes that both raise the visibility of the plight of millions of women and girls in care work as well provide much needed financial and material support are required to stem this anomaly.

Unless the disempowerment of women and girls involved in care work is addressed at a policy making level, the ideals of Article 27 (c) in the SADC Protocol on Gender and Development Protocol will not be realised (refer to **R2** on CD-ROM for the complete Protocol). In light of the emerging evidence, there is a need for socio-economic and legal frameworks that will ensure the protection of the lives and livelihoods of care providers.

Further Reading:
Resource 2:
SADC Protocol on Gender and Development

Box 1: Understanding key HIV and AIDS care work terms

Care: The full range of services provided to sick patients by family members in the home and community or by secondary care providers from community home-based care programmes; including prevention education, psychosocial support, cooking, cleaning, feeding, helping with toilet needs, the administration of remedies and treatments, and elements such as love and healing.

A care worker/care provider: This is someone who serves and assists people who are sick. In Southern Africa, many care providers provide home-based care (HBC) largely for people living with or who are affected by HIV and AIDS. Care providers may act independently or as members of broader community organisations. They may fall into one or other of the following categories:

- Primary care providers, who are typically family members (such as children, spouses or grandparents). These care providers are not normally paid
- Secondary care providers, who are typically people associated with an organisation that provides care work as a service and normally receive some incentives and stipends.

Community home-based care (C&HBC): This refers to the care that sick patients receive from community health workers, neighbours or volunteers and care providers connected to programmes supported by government, NGOs, churches or other civil society organisations. Home-based care (HBC) refers to the care that these patients receive in their homes from relatives, friends and other members of the household.

Universal Access: This refers to access for all people all over the world to education and counselling, multi-sectoral care and support services, and health services, including services that will: prevent the transmission of HIV; support persons living with HIV, their families and those who care for them, in living longer with HIV and slowing the onset of AIDS related illnesses; and help AIDS-affected families in mitigating the effects of the illness and death on their own households and communities.

There is a need for policy-legal means to create rights, capacities, and/or opportunities for millions of women and girls that are shouldering care work. The purpose of this phase of the "Making Care Work Count" Campaign is to lobby for policy and legal tools that fully recognise the economic and social rights of care providers and protect them from poverty and marginalisation caused by the provision of care to sick people at community and familial level.

Care Provider washing client's feet © GEMSA

State of care providers in the SADC region

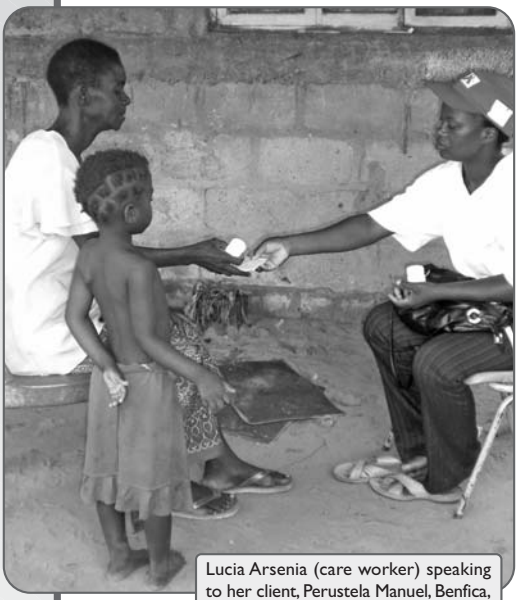
Across Southern Africa, unpaid, voluntary, informal networks of care providers - composed mostly of women - have emerged as a critical vanguard in the provision of care to sick people (see **Box 1: Understanding key HIV and AIDS care work terms**). As public health systems across the region face numerous challenges including undercapitalisation, competing national priorities, an ongoing brain drain of health care workers, and an overwhelm from diseases such as malaria, TB and HIV and AIDS; care providers, albeit with minimal support, are filling in a healthcare gap left by governments. However, unpaid care work, particularly its impact on women and girls, is yet to be adequately considered in policy making processes.

In fact, unpaid care providers are invisible in the regional and global AIDS infrastructure. Furthermore, because unpaid care work is usually done silently within the home, policy makers often assume that there is a limitless supply and rarely take the issue seriously in policy and decision making processes.

The services undertaken by care providers[2] are many and varied, demanding a lot of time and specialist skills. Table 1 presents a list of services, although not exhaustive, provided by care providers in the region.

Table 1: Services undertaken by care providers

Prevention	Treatment	Care and Support
• Condom distribution • Family Planning Education • Counselling for HIV Testing • Infant Feeding Guidance • Education on Infection Prevention and Control • Education on ART • Community Education on STIs • Community Education on HIV Testing • Home Testing • Palliative Care	• Adherence Support • Refilling Prescriptions • Treatment Follow-up • Treatment of Minor Ailments • Training household members in Treatment Literacy and Adherence • Facilitating referrals of clients to health centres / professionals • Palliative Care	• Providing Psychosocial Support to clients and their families • Provision of transport to clients • Physical Care • Nursing Care • Training household members in Care and Support • Assisting with household chores • Nutrition Support • Referring clients and their families to social services and other agencies • Resource Mobilisation



Lucia Arsenia (care worker) speaking to her client, Perustela Manuel, Benfica, Maputo, Mozambique © GEMSA

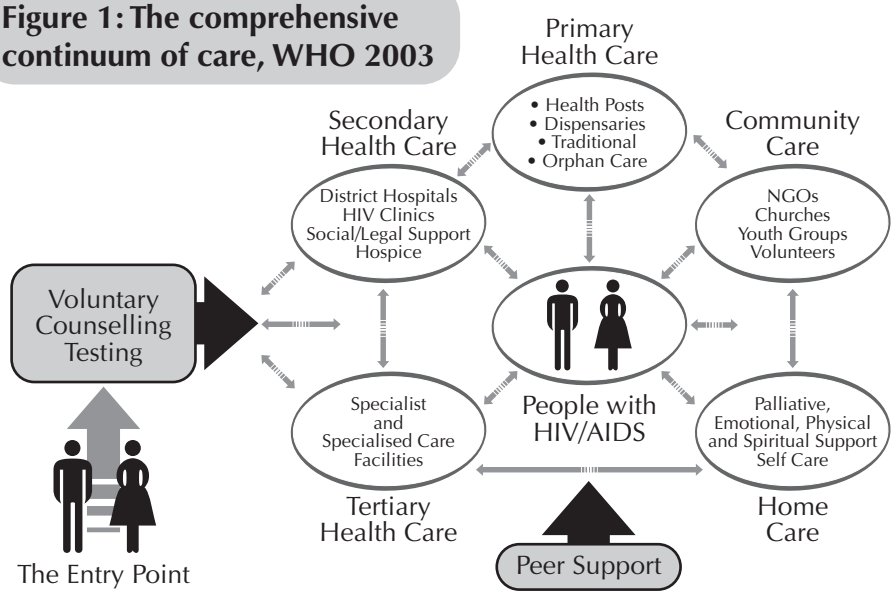
Thus, while the adoption of the SADC Protocol on Gender and Development Article 27 (c) in 2008 was a laudable development, the facts on the ground clearly demonstrate the need to not only develop policies but to also cost, enforce and monitor policy implementation aimed at addressing the plight of care providers. Specifically, governments in the region have a responsibility to create environments that recognise and ensure the protection of the lives and livelihoods of care providers, particularly women and girls, who are doing so much to support public health systems with very little support.

Linkages with the HIV and health sectors

It is now commonly recognised that C&HBC is an essential part of a health response, partly through necessity because of the strain that HIV and resource constraints place on health services and also because community care is recognised as a positive alternative to health centres or hospital based care.

Home-based care is the link between care within the home and the first point of contact with the health service. Care providers play an important role in community awareness raising, including support for HIV prevention, HIV testing and treatment adherence. They can identify serious illnesses early and often facilitate access to the appropriate health care at the right time. They can also reduce stress and provide comfort, enhancing quality of life. However, this requires formal recognition of the invaluable role that care providers provide. A care work policy that acknowledges the gendered dynamics of HIV and AIDS care work is key toward improving the continuum of care.

Figure 1: The comprehensive continuum of care, WHO 2003



The continuum of care fits within a broader global commitment to coordinated development support (demonstrated in the Paris Declaration of Aid Effectiveness Principles) and the commitment to the 'Three Ones' of HIV response. The principle of 'Three Ones' (one national strategic plan, one coordinating body and one monitoring and evaluation framework) is to enhance a comprehensive and coordinated response that addresses the holistic requirements of the HIV situation in a country. However, attention to gender in the 'Three Ones' is still weak and there are still negligible technical and financial resources for gender in national responses. This has a profound impact on the way that caring for people living with HIV and AIDS is provided. The GEMSA regional review argues that policies governing the rights of care providers should be incorporated within the 'Three Ones', aligning strategies and resources with international, regional and national gender-equality commitments.

Community and home-based care is also an essential element of health system strengthening. A health system is the whole set of laws and frameworks, organisations, human resources and actions that work together to promote, restore, or maintain health. There has been growing attention to the need to fund the whole system, not just particular elements (such as hospitals) or particular diseases (such as HIV) in isolation. The health system strengthening approach recognises the need for strong linkages between public, private and civil society sectors.

Furthermore, there are various initiatives that have begun to address issues related to care work from a gender perspective (see **Table 2: Global and African Commitments that Support Care Provision**). For some countries, an important entry point for resourcing of C&HBC is the Global Fund on AIDS, TB and Malaria (GFATM). In 2008, the new GFATM guidelines provide a greater focus on gender. Proposals are required to address gender inequity. They encourage proposals that explicitly decrease the burden of disease for those most at risk and mitigate the impact of the disease. They argue for scaled up services and interventions that reduce gender-related risks and vulnerabilities to infection and address structural inequalities and discrimination. The gender guidelines – and requirements on countries to demonstrate gendered analysis and proposals – is a strong opportunity to present the case for 'making care count'.

Table 2: Global and African Commitments that Support Care Provision

Global and African Commitments that Support Care provision	
2000	**Millennium Development Goals** included commitments to halving poverty, including the need to achieve full and productive employment and decent work for all, including women and young people (MDG 1), promote gender inequality and empower women (MDG 3) and halt and begin to reverse the spread of HIV (MDG 6).
2004	**UN Secretary General's Report on Women and Girls and HIV in Southern Africa** highlights the gender imbalances. One of the recommendations is to address gender inequity in care provision.
2008	**SADC Gender Protocol** adopted by Heads of State in August 2008 stipulates: "State parties shall by 2015: Develop and implement policies and programmes to ensure appropriate recognition of the work carried out by care-givers, the majority of whom are women, allocation of resources and psychological support for care-givers as well as promote the involvement of men in the care and support of People Living with HIV and AIDS." Article 27 (c)
2008	**Ouagadougou Declaration on Primary Health Care and Health Systems in Africa** emphasises the importance of strengthening community-based responses to health systems in Africa. It reaffirms the Alma Ata Declaration of 1978 that declares that health is a fundamental human right and that governments are responsible for the health of their people. The Declaration tasks African Member States to promote inter-sectoral collaboration, take action on economic, social, demographic, nutritional, cultural and environmental determinants of health; commit to implementing human resource strategies for health.
2009	**Commission on the Status of Women (CSW) Fifty-third session** focused on the equal sharing of responsibilities between women and men, including care provision in the context of HIV.' The global community put forward a number of recommendations to help influence and strengthen government policies on care work.

Source: www.un.org/womenwatch/daw/csw/53sess.htm#agreed

Why is care provision a gender issue?

As public health systems have been severely weakened in the region, much of the HIV and AIDS care burden has fallen on women and girls. Most care at the home and community levels is provided by women, who perform care duties with limited training or resources and in very difficult conditions. Traditionally, women and girls have been responsible for care work while men provided material support such as money, food, shelter and water. This trend has continued in the current practice of care work. The non-participation of men in the actual provision of care to people living with or affected by HIV and AIDS has resulted in an increased burden of care on women and girls. The greater involvement of men and boys in providing care has its challenges as articulated below:

To make matters worse, the current pattern of HIV infection is that women, especially young women, continue to be the most vulnerable to infection, the least able to protect themselves and the last to get treatment and care. Women account for half the people living with HIV worldwide and nearly 60 per cent of those infected in sub-Saharan Africa. Furthermore, the impact of HIV continues to be more severe on women.

Gender inequalities continue to affect women's decision-making and risk-taking behaviour, and vulnerability to HIV infection is often beyond a woman's individual control. In many SADC countries, there are more than twice as many new infections in young women as in young men. The former Secretary General of the United Nations, Koffi Annan emphasised the gender issue as it relates to

> *"The involvement of men as care providers is particularly important because of the traditional role of men as providers of their homes. If their homes suffer because of them providing voluntary work as care providers, it puts them in bad light and hence most would rather not get involved in voluntary care work since it is seen as a detractor from their engaging in economically productive work."*
>
> GEMSA Focus Group, Zomba, Malawi

care work and impact of HIV and AIDS highlighting:

> *…today, as AIDS is eroding the health of Africa's women, it is eroding the skills experience and networks that keep families and communities going. Even before falling ill, a woman will often have to care for a sick husband, thereby reducing the time she can devote to planting, harvesting and marketing crops. When her husband dies, she is often deprived of credit, distribution networks or land rights. When she dies the household will risk collapsing completely, leaving children to fend for themselves. The older ones especially girls, will be taken out of school to work in the home or farm. These girls deprived of educational opportunities will be even less able to fend for themselves against AIDS… If we want to save Africa from two catastrophes (HIV/AIDS and famine) we would do well to focus on saving Africa's women.*
>
> Kofi Annan, former UN Secretary General

GEMSA's analysis of care work-related policies in the region also identified that many of the policy frameworks in the region did not take into account the issue of gender disparity in care work. This observation is supported by findings of the VSO-RAISA and WHO Africa study[3] that revealed that in six SADC countries (Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe); at least 72% of secondary care providers are females. This could be explained largely by the division of labour based on traditional gender roles and the perception of volunteering and non-economic activities. First, the conventional division of gender roles in societies assigns the role of care providers to women. Secondly and also related to the first point, care provision is often seen as an informal voluntary work and not necessarily considered as a formal economic activity. Despite increasing interests in HBC work among men, it is often noted that men prefer paid work and get involved when there is a financial incentive.

So despite their relative success and impressive outreach and coverage, C&HBC programmes are faced with many challenges. According to VSO-RAISA and WHO Africa's study (refer to R3 on CD-ROM for the complete

research report), these challenges make the effective scaling up of HIV prevention, treatment, care and support; and the roll out of Primary Health Care (PHC) services difficult. This negatively impact on the rights and safety of care providers, the quality of care, and the safety of people being cared for. Women's rights to health, economic participation, non-discrimination and access to fair labour practices are seriously infringed upon as there is no mention of the strategies and programmes at a socio-structural level to ensure the protection of lives and livelihoods of female care providers.

Further Reading:
Resource 3:
VSO-RAISA and WHO Africa, 2009. 'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'

In order to create an enabling environment for the delivery of PHC services and scaling up HIV prevention, treatment, care and support; and to reduce the burden of HIV and AIDS care on care providers in the SADC region; VSO-RAISA and WHO Africa's research calls for the following specific actions[4] among others:

- Actively involve care providers in the review and formulation of C&HBC policies, standards and guidelines.
- Allocate sufficient resources in the national budgets to translate policies and guidelines on C&HBC into simpler languages; and to distribute these policies and guidelines extensively, in order to allow communities and implementers to understand and easily access these important documents.
- Enforce the implementation of safety policies that protect and support care providers who are infected, injured or killed during the course of providing PHC services in C&HBC programmes. This is largely because most care providers are exposed to infection as they do their work without the needed tools for work such as gloves and masks in the situation of the chronically ill and TB.
- Provide technical assistance to C&HBC implementers who engage and utilise care providers to deliver PHC services so that they develop and implement workplace policies that address the needs and rights of care providers; and ensure that these policies are applied appropriately.

- Monitor all organisations delivering PHC services through C&HBC programmes to ensure that they are complying with national policies and take appropriate action to strengthen the capacities of C&HBC Managers and implementers in recording, reporting and utilising data for improved management.

Who is this handbook for?

The handbook is targeted at GEMSA and VSO-RAISA's country programme officers who will be responsible for the roll out of the programme in the SADC region. Local facilitators who can make use of this handbook come from civil society organisations, PLWHA, labour, lawyers, women's groups etc and individuals who may be interested in promoting the economic and social rights of care providers.

The handbook is written in such a way that it facilitates different countries to develop policies that are informed by local realities, political and cultural sensitivities but at the same adhering to key principles that will facilitate the lobbying for policy and legal frameworks to ensure that care providers receive material and financial support required to effectively do their work.

Care workers out working © GEMSA

The Handbook is intended to:

- Act as an easy reference guide that will enable GEMSA and VSO-RAISA country offices to initiate, advocate and lobby for care provider policies;
- Provide good examples of policy to inform this work; and
- Identify appropriate methods for evaluating policies and their implementation.

Structure of the handbook

The Handbook lays out key steps that need to be taken to develop a policy. The steps should be considered 'iterative' and will be determined by country realities. Advocacy and lobbying for policy development is a spiral rather than linear process. This Handbook is therefore not a guide that must be strictly followed as it may happen that you may skip some steps and then return to other steps more than once as you develop your policy.

Constance Setlhabi and Dikgang Monagang. Botswana Retired Nurses Society, Tlokweng © GEMSA

How to use this Handbook

This Handbook takes readers through the key steps in advocating for the development, adoption, implementation and enforcement of a care providers' policy.

The components in this process include (see **Figure 2: Making Care Work Count Policy Development Process**):

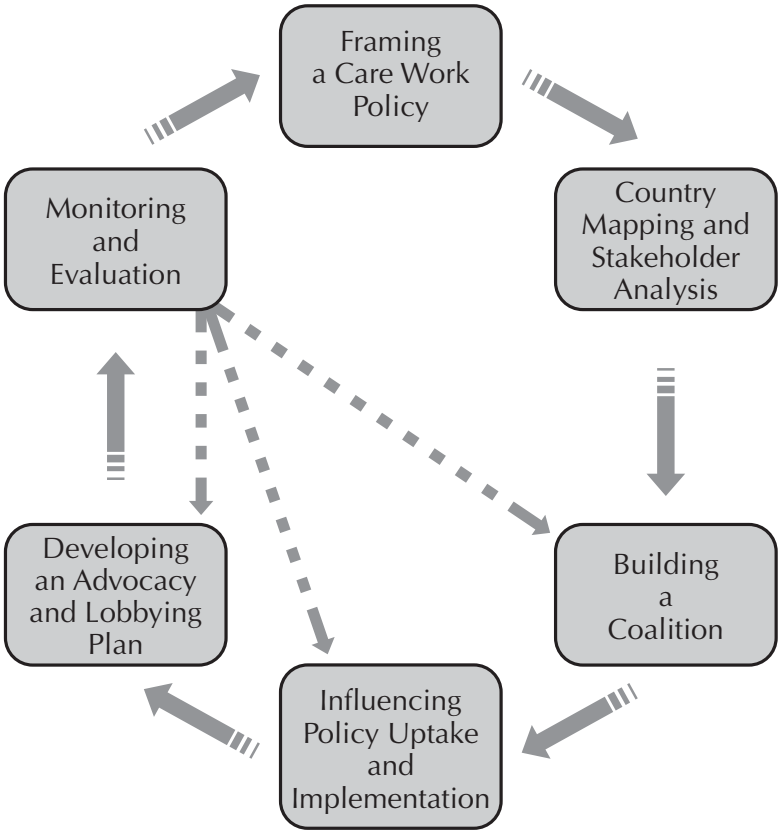
- **Country Mapping and Stakeholder Analysis** which provides guidance on how to identify priority advocacy issues and potential stakeholders to participate in the process;
- **Building a Coalition** where steps to better understand comparative advantages of each partner are provided and which will help define clear roles and responsibilities as well as developing a common advocacy agenda;
- **Influencing Policy Uptake and Implementation** examines the research and analysis that is needed on existent care work-related policies;
- **Developing an Advocacy and Lobbying Plan** provides guidance on how to implement and advocacy strategy, including advice on advocacy, lobbying, campaigning, resource mobilisation and media work; and
- **Monitoring and Evaluation** explains the steps that are required to monitor and evaluate the effectiveness of advocacy and policy implementation.

At the end of the Handbook are a number of core source materials and contacts and a reference section for further reading. Users of the Hand-book are encouraged to document experiences as the policy is developed. This will be useful for learning and sharing with others who are undertaking advocacy and lobbying for care providers.

Each step includes the following elements:

- Purpose of the step and what you should have in place when the step is finalised;
- Key activities needed to complete the step;
- Source materials for undertaking the activities; and
- Additional materials that may be useful, for handouts and as background information.

Figure 2: "Making Care Work Count" Policy Development Process



1 VSO-RAISA and WHO Africa, 2009. 'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'

2 VSO-RAISA and WHO Africa, 2009. 'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'

3 VSO-RAISA and WHO Africa, 2009.'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'

4 VSO-RAISA and WHO Africa, 2009.'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'

FRAMING A CARE WORK POLICY

A care worker helps to wash her client's clothes © GEMSA

Key Points

- In developing policies on care providers, it is advisable to draw lessons from other countries with similar experiences but must be located in a country's specific realities.
- It is import to ensure that care providers and PLHWA are involved at every level of developing the policy.
- There is a need for government to develop an integrated policy framework that addresses the issue of care providers.
- While this handbook advocates for certain key principles to be incorporated into the development of stand-alone care work policies; this does not suggest that there may be other key principles that are considered important for inclusion in such a policy neither does it not prevent inputs into existing policies dealing with care work issues.

chapter two

Introduction

Given the gravity of the challenges facing care providers, SADC governments have to develop stand-alone policies that will influence HIV and AIDS programming and ensure the protection of the social, economic and legal rights women and girls involved in care work. Existing laws, policies and guidelines need to be updated in light of emerging evidence on the situation of care providers.

This Chapter provides a framework to determine the key conceptual issues that should be considered in drafting a care work policy. The purpose of presenting this framework is to provide civil society actors with a starting point to develop text for care work policies that are both integrated and comprehensive and address the existent gendered dynamics of HIV and AIDS care work. Proposed policies must be informed by country realities, cultural and social sensitivities as well as a strong evidence base.

Framing Care Work Policy

Attention to framing, that is, how policy problems are defined, how the solutions are constructed, and who has a voice in that process is important in efforts to influence government policy-making processes in the SADC region. Building a frame about care work-related issues is a complex inter-subjective process that must involve many different actors.

As outlined earlier in Chapter 1, care providers face numerous challenges that need to be addressed in a comprehensive and holistic manner. A stand-alone policy can help to increase the visibility of care providers as well as direct the flow of resources to the community level. The aim of the policy will be to support the real needs of the care provider workforce and improve the quality of care provided to people living with HIV and AIDS.

Framing the issues that need to be included in a stand-alone care work policy will require the involvement of different stakeholders, including labour unions, women's groups, faith based institutions, children's organisations, PLWHA, care providers, lawyers, health professions, donors, policy makers among others.

Policy processes ideally involve different stages, from agenda

setting to formulation, costing to implementation. Because influencing government policies is a non-linear process, it is important to have several tools at hand that can help to facilitate the process. One way of doing this is to have a strong evidence base in determining what needs to be included in a policy.

Evidence based policy advocacy seeks to achieve an appropriate balance between ideals and relevant empirical evidence in order to influence decision-making that can potentially have an impact of people's lives. Policy decisions need to be better informed by available evidence and should include rational analysis. Policy based on systemic evidence can produce better outcomes (see **Box 2: Using evidence to influence policy making**).

This Handbook advocates for civil society in the SADC region to lobby governments to develop care work policies that address the plight of care providers in a comprehensive manner.

Box 2: Using evidence to influence policy making

GEMSA, in partnership with several civil society organisations that make up the Southern African Gender Protocol Alliance undertook an advocacy campaign that resulted in the adoption of the SADC Protocol on Gender and Development by the Heads of State in August 2008.

The success of influencing the SADC Heads of State to adopt Article 27 (c) of the Protocol involved evidence based policy advocacy: including conducting a situation analysis of existent policies, research into the issues affecting care providers, lobbying, campaigning, negotiation, identifying opportunities and putting concerns into a language acceptable to policy-makers without compromising the real needs of care providers.

Care work practices in the SADC region

The current state of care work in many parts of Southern Africa is unsustainable and promotes poverty and inequality. This is largely because many governments in the region address the issue of care work in different pieces of policy instruments and guidelines. Furthermore, there is a general lack of adequate evidence on the cost of care work or numbers of care providers in the SADC region.

Thus, proper positioning of the need for a care work policy is critical in the advocacy process where such policies should have mechanisms to protect women and girls who are at the forefront of care provision. Ideally, governments must develop **stand-alone** policies that address the issue of care work.

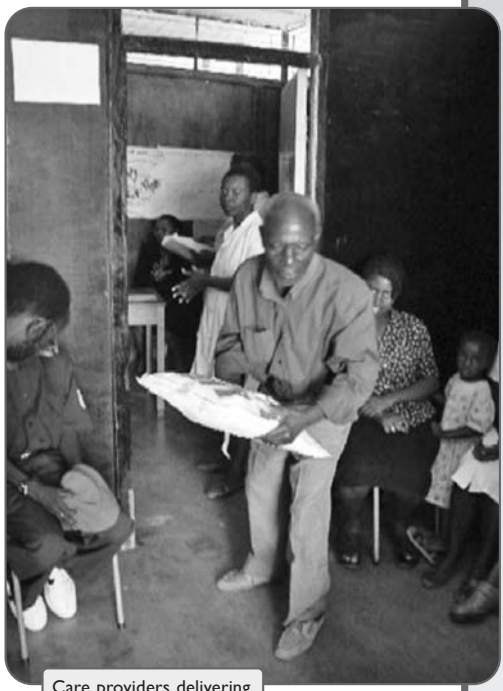
The study by VSO RAISA and WHO[5] highlighted that strengthening TB, HIV and AIDS C&HBC programmes entails

Male care provider helps feed a child © GEMSA

reducing the burden of care on care providers; most of whom are women, girls and older persons who work voluntarily and play a significant role in these programmes. Unfortunately, these care providers are largely unrecognised, not compensated and hardly supported; and their rights are not respected. Many are extremely burdened by this care work; which manifests itself in a number of ways that include physical, mental/emotional and economic stress. This burden results in poorer quality of care provided, and compromises the health and rights of the care providers and their clients. This is compounded by the absence of care providers' participation in the formulation or review of C&HBC policies in many SADC countries.

GEMSA conducted an audit of policies in 12 countries in the SADC region (see Table 3: Summary of findings of GEMSA's review of C&HBC Policy and Guidelines in 12 SADC Countries[6]). The audit was a follow up to an advocacy campaign that resulted in provisions for the "appropriate recognition" of care work by the SADC governments.

According to GEMSA's policy analysis[7], though governments in the region have signed onto the SADC Protocol on Gender and Development, there is a need to scale up the implementation of policies, especially in the arena of care work. In addition, women's enormous involvement in care work needs to be adequately acknowledged in the SADC region.



Care providers delivering food parcels © VSO-RAISA

Table 3: Summary of findings of GEMSA's review of C&HBC

Country	Remuneration	Logistic and Material Support
Namibia	New CBHC policy calls for a monthly incentive of N$250-N$500 (roughly USD 31-62).	Under the new policy, all care-givers will require an identity card, t-shirt, shoes, umbrella, a home-based care kit, some form of transport, communication funds and a monthly, monetary incentive.
Botswana	At present only donor organisations provide financial incentives for C&HBC volunteers working at NGOs. The government feels that by remunerating care-givers, the spirit of volunteerism would be compromised.	Government provides C&HBC volunteers with transportation allowances of P151 (roughly USD 22) per month and clinical supplies.
Tanzania	No policy	Tanzania Commission for AIDS gives funds to registered C&HBC organisations to sustain their projects and C&HBC kits.

Policy and Guidelines practices		
Training/Professional Recognition	**Psychosocial Support**	**Gender Equality**
Under the new policy, the government will re-train all care-givers using a standardised manual. Government will accredit those who pass the training through the Namibia Qualifications Authority.	The new policy attempts to address the psychological needs of care-givers. In the draft guidelines, the Ministry of Health and Social Services requests that all C&HBC organisations promote stress management techniques, help care-givers adjust to the pace and approach to work, provide peer counselling, & establish a support network.	The new policy acknowledges the gender disparity in care work and encourages the involvement of men.
Government currently has no mandated, minimum level of training. Nurses train C&HBC volunteers at the clinics on issues of tuberculosis, adherence, diet and how to care for patients. Normally the training lasts about a week. As new issues arise, the clinic provides care-givers refresher courses. Many care-givers working for NGOs receive training from either clinics or other civil society organisations.	The government provides psychosocial support through supervisors at the clinic or through the social welfare office. Moreover, as part of Ministry of Health's monitoring of C&HBC, government representatives often visit volunteers to discuss their challenges. C&HBC organisations often facilitate discussions for volunteers to share challenges and frustrations.	Not specified
The Ministry of Health and Social Welfare (MoHSW) last trained care providers in 2005 and training continues to be the same despite the changes in the area of care work. Care Work is not recognised as a profession in Tanzania.	There is no policy document that exists on psychosocial support for care-givers. The evaluation report on C&HBC has looked into support for care-givers. MoHSW requests that all C&HBC organisations promote stress management techniques, help care-givers adjust to the pace and approach to work, provide peer counselling, and establish a support network.	No policy

Country	Remuneration	Logistic and Material Support
Zimbabwe	No policy. Government recommends communities mobilise funds for care-giver costs. The government feels that by remunerating care-givers, the spirit of volunteerism would be compromised.	The new C&HBC guidelines recommends incentives to include uniforms, bicycles, food packs, monetary allowances, free medical treatment, support for income generating projects, raincoats, umbrellas, part time employment in hospitals, and funeral assistance.
Swaziland	The current C&HBC policy calls for a monthly incentive of E200 (roughly USD 25) for Registered Health Monitors (RHMs). However, Baphalali Red Cross Society care-givers are remunerated E100-E110 monthly, and are paid in kind or through donations.	All RHMs and care-givers receive C&HBC kits and uniforms as a requirement for easy identification within the community, an identity card, t-shirt, shoes, umbrella, a home-based care kit, and a monthly, monetary incentive as above.
South Africa	There is a policy framework document that exists however, the extent of implementation in this area is not known.	The Department of Social Development (DSD) gives food supplements and parcels.
Zambia	No policy	No policy

Training/Professional Recognition	Psychosocial Support	Gender Equality
The new C&HBC guidelines espouse for training on basic care using adult learning techniques and utilising a standardised training procedure. Also noted is the need for prevention education in terms of accidental exposure such as pricking and TB/HIV infection.	The new C&HBC guidelines recognise that care-givers need appropriate psychosocial support to prevent stress and burn out.	No policy.
The Ministry of Health and Social Welfare (MOH&SW) last trained care providers in 2005 and training continues to be the same despite the changes in the area of care work. Care work is not recognised as a profession in Swaziland.	There is no policy document that exists on psychosocial support for care workers. The evaluation report on C&HBC has looked into support for care-givers MOH&SW requests that all C&HBC organisations promote stress management techniques, help care-givers adjust to the pace and approach to work, provide peer counselling, and establish a support network.	No policy.
DSD and Department of Health (DOH) need to make this training and professional recognition criteria clear as it seems ambiguous at present.	There is a document within the policy framework though the extent of implementation is unclear.	Gender inequality is noted within the policy framework documents for C&HBC.
No policy that recognises care-givers as professionals except the third line of care- givers (professionals like nurses, clinical officers etc). Care providers are trained by qualified trainers from the Ministry of Health (MoH) and other entities. Care-givers receive a certificate	No policy	No policy

Country	Remuneration	Logistic and Material Support
Malawi	No policy	Limited support for C&HBC from government.
Lesotho	No policy, however, the Prime Minister has ordered that a monthly stipend of 300 Maloti (roughly USD 37) be paid to all Community Health Workers (CHWs).	Registered CHW's get access to resources such as health kits.
Mozambique	The operational manual suggests that care workers should receive an amount calculated as 60% of the minimum national salary.	The operational manual mentions the volunteer kit and allocation of some basic materials. In practice though neither the Ministry of Health (MoH) nor the donors provide this material for care workers.
Mauritius	No specific policy for HIV/AIDS. Policy exists for government officials who work with elderly.	HIV/AIDS National Strategic Framework (NSF) makes provision for improving training, equipment and staffing capacity of government structures.
DRC	No policy	No policy

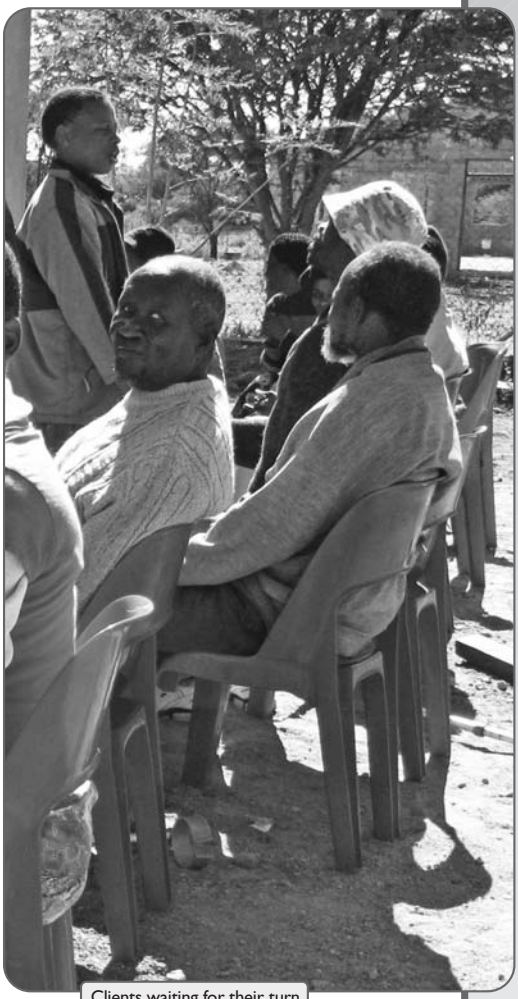
Training/Professional Recognition	Psychosocial Support	Gender Equality
of attendance after training. C&HBCs are registered under the Registrar of Societies. C&HBC organisations are also required to register with the DHMT in their area of operation.		
Existing training and standardised training manual.	Commitment demonstrated on paper for C&HBC by government.	No policy.
Government is planning to train all CHW's including care- givers in order to professionalise the cadre and afford it recognition.	The National Guidelines on C&HBC recognises the challenge of emotional, physical strain and stress experienced by care-givers; the lack of resources and care-givers' inability to diagnose symptoms. The guideline calls for income generating activities which can support C&HBC.	The National Gender and Development Policy advocates for the improvement and expansion of gender-sensitive home-based health care.
The operational manual mentions training and capacity building however little is known of implementation.	No policy.	No policy
• No policy. NSF makes provision for training of government officials involved in HIV/AIDS.	No policy	No policy
No policy	No policy	No policy

The current scenario in many countries in the SADC region with the exception of Namibia is that there are several policy instruments that seek to address the situation of care providers (see Table 4.) At the time of writing the handbook, HIV and AIDS civil society organisations in South Africa were in the process of drafting a stand-alone care work policy titled, "Community Care Worker Management Policy Framework". The aim of the draft policy is to provide an effective and efficient occupational workforce to support a comprehensive multidisciplinary C&HBC services. However, both the Namibian and the South African draft policies do not adequately address the issue of women's involvement in care work.

Table 4: Care Work policy in the SADC Region

SADC Member State	Stand-alone Care Work Policy as at 1 July 2010		
	Yes	Draft stage	No
Angola			X
Botswana			X
Democratic Republic of Congo (DRC)			X X
Lesotho			X
Madagascar			X
Malawi		X	
Mauritius			X
Mozambique		X	
Namibia	X		
Seychelles			
South Africa		X	
Swaziland			X
Tanzania			X
Zambia		X	
Zimbabwe		X	

SADC governments have significantly made progress in developing policies and guidelines that address the issue of C&HBC. From the analysis, it emerged that the issue of care workers' recognition, training, psycho-social and financial support is high on the agenda of policy makers. With the exception of DRC, most of the countries have policies and guidelines on the management of care providers. However, as per GEMSA's policy analysis, government commitment to the drafting and implementation of C&HBC policy must be backed by action as well as resources and political will. Furthermore, there is a need for greater recognition of the contribution of women and girls to HIV and AIDS care work in policy frameworks.



Clients waiting for their turn with care provider © GEMSA

A Case for Stand-Alone Care Work Policy

The proposed stand-alone care provider policies must be informed by country realities and the voices of care providers. They must call upon decision makers to take urgent and practical action to ensure that the social, economic and legal rights of care providers involved in HIV and AIDS programmes are recognised as an essential foundation in achieving universal access to HIV and AIDS prevention, treatment, care and support in the Southern Africa region.

Rising to the challenge: The Namibian example

To date, Namibia has emerged as a leading country rising to the challenge of meeting the requirements of the SADC Protocol 27 (c). In 2008, the government of Namibia approved the National Policy on Community Based Heath Care (CBHC), a stand-alone policy developed by its Ministry of Health and Social Services. The goal of the Policy is "to empower and motivate communities to initiate, strengthen and own community actions and household practices that will promote health, prevent illnesses and provide palliative care in order to reduce morbidity and mortality and improve the quality of life of all Namibians."

The key principles that are considered important for implementing the Policy include gender equality, availability and accessibility, affordability, community involvement, sustainability, justice, inter-sectoral collaboration and quality of care. The key strategies to implement the Policy includes providing *support for care providers* (accredited training through the Namibian Qualifications Authority, resource materials, supervision, recognition and reimbursement for costs incurred doing care work); strengthening human resources (development of CBHC guidelines, access to initial and on-going training, resource mobilisation for incentives) and *integrated management of CBHB services* (stakeholder involvement, monitoring and evaluation, maintaining health information).

At an institutional level, the Policy articulates the roles and responsibilities of key ministries, namely, Ministries of Health and Social Services; Education; Agriculture, Water and Forestry; Regional and Local Government, Housing and Rural Development; Gender Equality and Child Welfare; Defence; Information and Communication Technology as well as the National Planning Commission. The Policy also articulates the roles and responsibilities of local authorities and Village Development and Village/Community/Clinic Committees; NGOs/FBOs/CBOs; higher education institutions and development partners.

At a resource level, the Policy requires that all qualified care providers have access to training, tools and information, education and communication material

that will enable them to provide quality care. In addition, the Policy stipulates that care providers should have the necessary equipment, supplies and home-based care kits to provide care. The Policy also articulates that: care providers have an agreed description of duties and expectations. Furthermore, care providers must be recognised and be rewarded by CBHC organisations, government and community leaders. The Policy further requires that qualified care providers should have identification cards as well as T-shirt, hat and umbrella. Finally, care providers should receive remuneration for services provided and be partially reimbursed for costs incurred in carrying out their duties.

Monitoring and evaluation of the implementation of the policy largely encourages the CBHC programmes to develop appropriate indicators to monitor progress and measure impact of the policy on achieving the Policy's goal. In addition, the Policy makes special reference to the need to develop indicators to monitor the guiding principles of community involvement, gender equality and key partner collaboration.

Source: Republic of Namibia Ministry of Health and Social Services, National Policy on Community Based Health Care, March 2008

It is important to state that best practice at the policy making level does not automatically translate to best practice at the implementation level. In Namibia, many challenges still exist regarding the implementation of the policy, including a full acknowledgement of the role played by women and girls in care work. But, since policy making is a key step in ensuring government responsibility, identifying good policy principles is critical. Stand-alone policies need to take sustain carers in their role as the primary providers of healthcare at the community level.

What are the key principles that need to inform care work policies?

Strengthening support for care providers is both cost-effective and compassionate public policy, and a clear requirement in Southern Africa. From the GEMSA audit and the VSO-RAISA study, the following emerged as the **key principles** that need to inform care work policies:

1. **Remuneration:**
   People doing the work of government have a right to be financially rewarded. On a practical level, programmes are likely to fail and standards of care to drop if care providers leave to earn income to support their own families. In addition, it is argued that if there was remuneration more men would enter care work which would ease the burden on care provision on women and girls and increase gender equality.

2. **Logistic and Material Support:**
   Community home-based care (C&HBC) kits are crucial for service delivery. In many countries, there is no policy to provide kits and care providers often lack a regular supply. Other support that would improve the quality of care and the lives of care providers include informs for identification in the community, bicycles, food packs, monthly monetary allowances, soap, free medical treatment, financial support for income generating projects, raincoats, umbrellas, agricultural inputs, part time employment in hospitals, funeral assistance, stationery and transport allowances.

3. **Training and Professional Recognition:**
   Few governments have policies that standardise and regulate the training provided to care providers. Training varies in length and content. There are also gaps in quality control and supervision. This puts both patients and care providers at risk of harm. Protocols of training and accreditation should be developed through a governing body within the country to regulate and standardise the training.

4. **Psychosocial Support:**
   Care for care providers is rarely given the priority it deserves, and "burnout" is a serious problem. The best way to prevent burnout is to reduce stress. Much of the stress experienced by care providers working with people living with HIV is related to the nature of the illnesses that people face compounded by stigma; stress may also be caused by organisational factors such as the way a community home-based care programme is designed and managed.

5. Gender Equality:
The gender dimensions of HIV should be recognised and catered for. Women are more likely to become infected and are more often adversely affected by the HIV epidemic than men. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV. Greater participation of men in care provision needs to be an integral component of HIV and AIDS care work programmes.

6. Public Private Partnerships:
There is a need to advocate for stronger Public Private Partnerships (PPP) in the delivery of PHC services through C&HBC programmes and to facilitate stronger linkages between these programmes on one hand, and the providers of special support and social protection programmes, on the other, in the SADC region.

Table 5 provides some integral issues that need to be considered in stand-alone policies for care work in the region to meet the requirements as articulated in the SADC Protocol Section 27 (c). It is important to note that while these issues are considered integral, country realities may place less emphasis on these or may point to other issues that need to be included in a stand-alone policy.

Lucia Arsenia (Care Worker) visits her client, Luisa Fenias and daughter Ana Augusto Novela in Mozambique © GEMSA

Table 5: Developing a stand-alone policy on care work for the SADC region

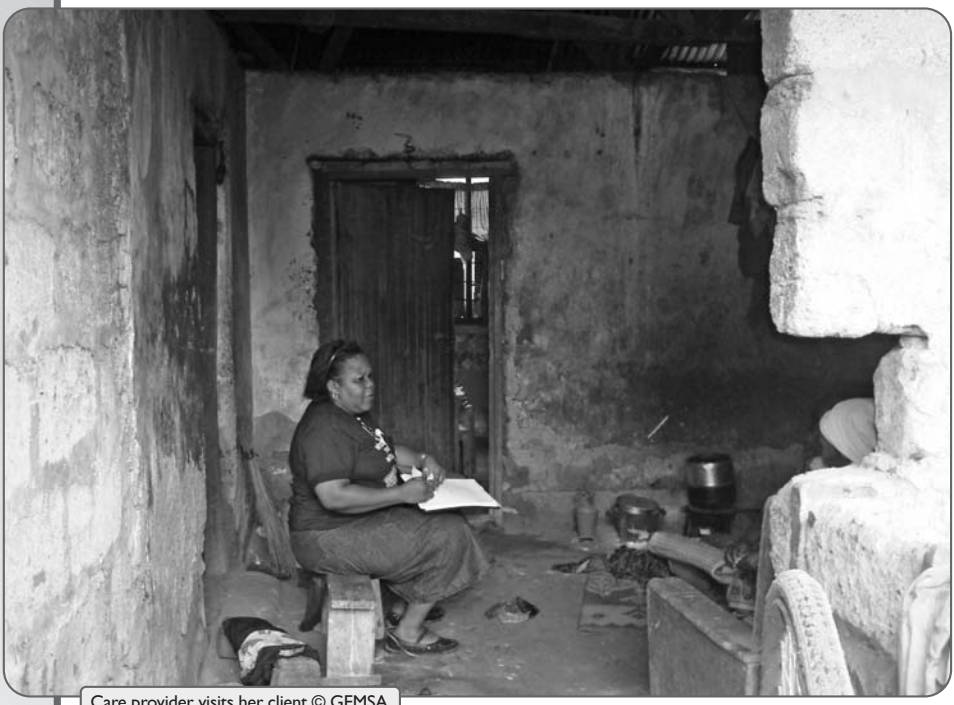
Key principles	Issues to consider
Remuneration	• Standard remuneration for care providers needs to be established. • Terms and conditions of service for care providers need to be outlined
Logistic and Material Support	• Support for care providers needs to be an integral component of home-based care programmes, and there is a need to ensure consistent funding for sustained periods. • Ensure the promotion of universal precautions among care providers, including the availability of essential supplies such as fully equipped home-based care kits. • Ensure consistent supply of basic tools such as uniforms, shoes, soap, bicycles and full, standard HBC kits.
Training and Professional Recognition	• Foster the development and delivery of care provider training protocols and professional certification of care providers. • Develop training packages for care providers so that they increase and have up-to-date knowledge about how to deliver AIDS care in the most effective ways. Training in treatment literacy should be a compulsory component of care provider training. • Provide ongoing education and support programmes for care providers. • Develop a professional standard for care providers. • Promoting the legal protection and empowerment of care providers
Psychosocial Support	• Recognising physical and psychological symptoms among care providers should be a public health priority. • Require assessment of care provider needs as well as patient needs at the time of hospital discharge; provide appropriate care provider training to ensure a safe transition from hospital to home. • Improving access to appropriate mental health services and medical care
Gender Equality	• Promote the involvement of men in the provision of care and the protection of women
Private Public Partnerships	• Advocate for government and donor agencies to partner with the private sector to ensure coordination and prevent fragmented support to care providers

While the SADC Protocol articulates five core principles, it is important to state that these are not exhaustive but provide a frame for advocating governments to fulfill regionally agreed protocol in national legislation and policies. Further to these key principles, WHO[8] has identified eight discrete categories systematic approach for policy-makers, senior administrators and government decision-makers to follow in developing the overall policies and guidelines for C&HBC.

Table 6: Planning and policy framework for C&HBC

Category		
Nature of the programme	• Purpose, goals and objectives of C&HBC • Target population	• Location • Time frame
Eligibility criteria	• Age • Disease category • Degree of disability • Relationship of care providers • Knowledge of diagnosis • Number of C&HBC hours	• Ability to pay • Degree of family support • Provision of physical and emotional care • Provision of housekeeping duties • General state of family and home
Eligibility assessment	• Assessment tool (universal or contextual) • Who will be the assessor?	• Measurement of the level and type of care
Benefits	• Cash allowance, service provision or combination • Maximum and minimum benefits • Waiver system • Medicines and supplies • Food provision	• Transport • Respite and day care services • Counselling • Basic nursing care • Assistance with housework
Programme operation	• Government-run or joint operation • Responsibility for service delivery • Care planning	• Education • Quality assurance
Financing	• Funded through general taxation • Cost sharing	• Funding by other organisations • Cost containment
Coverage	• Percentage of the population covered • Locations	• Disease categories and target populations • Levels of disability
Cost	• Cost of services • Hourly cost • Ratio of paid to unpaid workers • Education	• Medicines and supplies • Transport • Food supplements

According to WHO, responses to the issues raised in this framework should reflect the differing C&HBC needs within each country, programme or community setting. Not all governments and donor agencies in resource-limited settings can address all of the issues and questions raised in this framework. However, each country has to decide what can be included (or not).



Care provider visits her client © GEMSA

5 VSO-RAISA and WHO Africa, 2009. 'Scaling up HIV Prevention, Treatment, Care and Support in Community and Home-based Care Programmes and Reducing the Burden of HIV and AIDS Care on Carers in SADC'
6 Nataly Woollett, GEMSA: Making Care Work Count Regional Report, July 2009
7 GEMSA Regional Report, 2009. 'Regional Report: Making Care Work Count; A Policy Analysis'
8 WHO, 2004: Community Home-based Care in Resource Limited Settings: A Framework for Action

COUNTRY MAPPING AND STAKEHOLDER ANALYSIS

Care provider with children © VSO-RAISA

Key Points

- Country mapping and stakeholder analysis is a key step that provides an overview of policy developments in a given country as well as identifying stakeholders that can be involved in the advocacy process.
- A country mapping and stakeholder analysis report is supposed to inform the direction of the policy advocacy process.
- Developing a work plan is critical to ensure that potential stakeholder understand their roles and responsibilities.

chapter three

Getting started

It is essential that you are able to clearly identify and articulate the issues before embarking on any advocacy campaign. Take some to reflect on the country's policy environment by asking the following key questions[9]:

- Is the problem you have identified important to society?
- How could changes in policy help resolve the problem?
- What type of policy change is needed (legislation, regulation, legal decision, or other)?
- What are the financial implications of the proposed policy change?

Overview

The country mapping and stakeholder analysis exercise is essential for identifying new developments in policy making as well as organisations that can be incorporated into the advocacy and lobbying process. The activities in this step take you through the process of:

- Deciding what information you need in order to effectively advocate for a care provider policy;
- Identifying where and how to get existing information;
- Identifying the information gaps that need to be filled;
- Identifying the key stakeholders;
- Producing a country mapping and stakeholder analysis report; and
- Completing a work plan.

The output of this phase is the formulation of a country mapping and stakeholder analysis report which will detail the country's situational analysis that is related to care work policies as well as detailing the relevant stakeholders that need to be included in the policy development process.

Key activities

Deciding what information you need in order to effectively advocate for a care provider policy

This activity entails that you provide a brief description of what stage your country is at in developing and implementing policies that recognise and support the economic and social well-being of care providers. Please refer to your country reports and other existing literature to assist you

with this activity (see **Box 3: What information to look for**) with the most important questions to ask including:

- Is there a care provider policy in your country? Are there other policies for similar paraprofessionals, such as village health workers, ECD practitioners, paralegals, community police, youth and community workers?
- What legislation might affect care providers (for example, basic conditions of employment, health and safety)?
- What laws or practices affect the rights of patients, for example right to confidentiality?

Box 3:
What information to look for

You need to:

- Identify priority problems and what the underlying dynamics of the situation might be;
- Explore what the current capacities are to respond to the problem;
- Considers relevant services; and
- Identify current and potential stakeholders who may relevant information for you.

ACTIVITY: Identifying policies

Complete the matrix to identify the care work policies that exist in your country.

	HIV Policy	HIV Strategic Plan	C&HBC Policy	Gender Policy	C&HBC Guidelines	Volunteer Policy	HIV Policy	Other: Specify
YES								
NO								
DRAFT								

Identifying where to get existing information

To assist you with identifying policies, guidelines, strategic and legal frameworks that impinge on care work it is important to know **where** this information can be found and **how** to get it.

Identifying the information gaps that need to be filled

Once you have done the policy search, you can then identify what information is missing from existing policies, guidelines, strategic and legal frameworks. Consider 'is this information essential?'

Examples of where to find information	Examples of how to get information
• Academic reports on the health sector, • Annual HIV seroprevalence surveys, • Demographic Health Surveys • UNGASS reports, • Country Statistics Offices • Modes of Transmission surveys. • The Ministry of Health • HIV and AIDS Networks • Evaluation reports by government or non-government C&HBC programmes; • National monitoring systems that include C&HBC; • National audits of C&HBC programmes. • Parliamentary oversight committee on health proceedings, • Legal rights groups including women's rights associations • Interviews with selected key respondents	• In-depth interviews • Desktop research (literature reviews) • Focus groups • Opinion polls • Surveys and questionnaires • Field visits and observations

This can be done by reviewing these policies and any other policies that are similar from your country. It is important to cross check that the questions in the situation analysis will answer all the areas of focus for the policy using the questions in **Box 4: Sample Key Questions** as a guide.

Box 4: Sample Key Questions

- What is the HIV prevalence situation?
- What is the level of health service coverage for HIV and AIDS (include public sector, mission health sector, NGO)?
- What is the situation for human resources for health?
- Are there significant changes planned for the health or HIV response over the next few years?
- Does the National Strategic Plan on HIV prioritise community-based responses?
- Is there funding available for C&HBC? What are the types of funding available? Is there information on budget allocation of health resources to C&HBC?
- What is the profile of C&HBC providers?
- What is the nature and type of support that care providers get and from whom (remuneration, supplies, training etc)?
- Are there standards and norms for care providers?
- How are care providers recognised and acknowledged within the country (awards, training, media reporting etc)?
- Is the private sector involved in C&HBC support?
- Is there recognition of the role of women and girls? Are there policies or programmes that seek to mobilise males as care providers?

If the information **is essential**, it will be necessary to actively fill in the information gaps, if there are any. This is likely to require further resources of people, time and sometimes money.

ACTIVITY: Identifying information gaps

Complete the following checklist to identify what information is missing.

Does the policy or guideline address the following key principles:	Yes	No	How can this information be found?	Resources required
Remuneration			• Individual interviews with care providers • Focus group • Discussions with care providers and patients • Interviews with Ministry of Health and Social Welfare, C&HBC donors and implementers	• Contact with C&HBC group • Network members with research skills to volunteer time • Data collection costs • Network member can assist Technical advice – find health sector economist who is able to help e.g. health systems researcher based at university
Logistic and Material Support				
Training and Professional Recognition				
Psychosocial Support				
Gender Equality				
Private Public Partnerships				

Remember that it is important to keep records of any interviews/focus group discussions/meetings/ discussions that you may conduct as this information may be used at later stages of the process.

Identifying the key stakeholders

It is important to carry out an analysis of stakeholders[10] early in the process, in order to decide how to involve or consult them. Once stakeholders have been identified and categorised, decisions need to be taken on the level and type of their involvement in the strategy process.

There are four broad levels of possible involvement in the process and these also assist you to decide **when** the stakeholder should participate:

1. Full involvement
2. Partial involvement
3. Consultation
4. No involvement

The following questions could be considered to help deliberations:

- What benefits could be received from the stakeholder's participation?
- What drawbacks could there be in terms of certain stakeholders' participation?
- Who should be involved at each stage?

Once you have identified the stakeholders, it is important to indicate **how** you will engage them to participate in the process. This can be done using methods such as: focus groups, individual meetings, questionnaires, telephone conversations etc. Stakeholder engagement and participation must fully reflect the rights and needs of the disadvantaged, and therefore it should involve them as fully as possible in the process. Table 7 provides you with examples of stakeholders.

Researcher consults with care provider in Malawi © GEMSA

Table 7: Categories of stakeholders

Category of stakeholder	Example(s)
Persons directly involved in providing care	• C&HBC providers (primary & secondary)
Persons receiving support from care providers	• PLWHA
Persons providing support to care providers (financial and non-financial)	• Government • Private sector • Civil society organisations (local & international including NGOs & FBOs) • Organisations funding care work • UNAIDS, UNICEF, WHO etc
Persons formulating policies on care work-related issues	• Key Government ministries (e.g. Health, Gender, Labour, Social Development / Welfare, Education, Finance) • Parliamentarians • Policy analysts • Legal sector (e.g. Human rights, labour)
Persons influencing broader work and health issues	• Trade unions • Media • Academia • Policy
Other	• Includes stakeholders against the policy as well as those who are undecided on issues related to care work. These may need to be further engaged to increase awareness of care work-related issues.

Note: The categories and examples are not exhaustive

ACTIVITY: Stakeholder Assessment and Engagement Plan

1. Begin by brainstorming as many stakeholders that would be useful for this process and list these on a flip chart.
2. Follow up by identifying the people and organisations that are involved in the policy decision-making process.
3. Next, rate the stakeholders in order of importance (**3 = Very important; 2 = Important; 1 = Not important)** for the process including those that may not support the policy.
4. Complete the stakeholder assessment by filling out the matrix below with the names of the stakeholders that are considered very important for the process.

Stakeholder name	Interests	How to be engaged	Level of participation	Resources required
Persons directly involved in providing care				
Persons providing support to care providers				
Persons formulating policies on care work-related issues				
Persons influencing broader work and health issues				
Other				

Producing a country mapping and stakeholder analysis report

This report will serve as a reference document that will inform your advocacy campaign. It is advisable that this report should not be longer than 10 pages as its purpose is to spell out the key situation, highlighting areas of relevance to the policy/guidelines drafting or amendments.

You can refer back to the question in **Box 4: Sample Key Questions** to assist you with putting this report together.

The contents of the report can include but not limited to:

- An overview of the HIV prevalence rate indicating population and demographic characteristics
- The level of health services coverage for HIV and AIDS including public, private, faith-based/mission health sectors, NGOs, CSOs as well as the human resources for health and HIV and AIDS
- An overview of the country's strategic plan on HIV and AIDS highlighting the key focus areas, any significant changes planned for the health or HIV response over the next few years, as well as if there are any community-based responses/C&HBC
- An analysis of the existent policies, guidelines, strategic and legal frameworks that address the issue of care work in the context of HIV and AIDS
- A profile of C&HBC in country highlighting involvement by different players (public, private, CBOs, CSO etc), spread (geographical) of C&HBC initiatives, type of funding available (if any), govern ment responses to C&HBC in terms budget allocation of health and funding resources, standards and norms for care providers
- A profile of C&HBC providers including demographics, services provided, support provided to care providers (type and by whom), how care providers are recognised and acknowledged in the country (awards, training, media reporting) as well as if there is recognition of the role of women and girls and if there are any programmes to mobilise male involvement as care providers
- An analysis of the gaps, if any, that are in the policies,

guidelines, strategic and legal frameworks based on the six principles of Remuneration; Logistic and Material Support; Training and Professional Recognition; Psychosocial Support; Gender Equality; Private Public Partnerships
- A stakeholder assessment and engagement plan

Completing a work plan

It is important to complete a work plan that will broadly guide how to undertake the stakeholder engagement process and the other steps of the care work policy advocacy campaign described in this Handbook before you begin the work. It is important to remember that this work plan is largely an internal tool for use by coordinating partners, in this case, GEMSA and VSO-RAISA who will lead this step of the advocacy process in each country. A broader work plan will need to be completed and this is done in the component **Building a Coalition**.

Care provider and her clients © VSO-RAISA

Use **Tool 1** to assist you in completing an internal country work plan

Tool 1: Coordinating Partners Work Plan

Step	Main Activity(ies)	Lead person(s)	Output(s)
Country mapping and stakeholder analysis	Deciding what information you need in order to effectively advocate for a care provider policy		Policy audit
	Identifying where and how to get existing information		
	Identifying the information gaps that need to be filled		
	Identifying the key stakeholders		
	Producing a country mapping and stakeholder analysis report		Stakeholders engagement plan Country situation report
Building a coalition	Establishing a coalition to lead the advocacy campaign		Workshop Coalition
	Agreeing on the work of the coalition		Coalition Work plan
	Managing the coalition		

Time frame	Budget	Outcome(s)	Technical assistance (Yes/No). If yes, who/from where?
		Increased knowledge and awareness care work within HIV and AIDS context	
		Increased support for debate around care work within HIV and AIDS context	
		Increased knowledge and awareness care work within HIV and AIDS context	
		Increased support for debate around care work within HIV and AIDS context	

Checklist

The following questions could be helpful to check whether the key issues have been considered:

- Does the country situation analysis identify the key issues that cause the problem?
- Does the country mapping analysis clearly identify implications of the existing policy or legislation and the practice on care work?
- Does the stakeholder engagement plan reflect the findings of the country situation analysis?
- Does the situational analysis consider the issue from all different stakeholder perspectives?
- Have you collected any missing but necessary information?
- Is the country mapping and stakeholder analysis report aligned to the advocacy project objectives?
- Is there capacity to undertake the work and is the completed work plan realistic and achievable?

Care provider attending to client © VSO-RAISA

9 This section has been extracted from the VSO Participatory Advocacy: A Toolkit for VSO staff, volunteers and partners, 2009, page 27

10 Extracted and adapted from the VSO Participatory Advocacy: A Toolkit for VSO staff, volunteers and partners, 2009, page 38

four

BUILDING A COALITION

A focus group discussion with care providers in Namibia © GEMSA

Key Points

- Building a coalition is a key step for ensuring wider civil society and public support for the lobbying of care work policies.
- The coalition building process will be informed by the stakeholder analysis and should be representative to include the relevant government ministry(ies); care providers representatives; beneficiaries of care provision services; policy advocacy organisations; labour unions; and other human rights, faith-based, gender, HIV and AIDS organisations.
- A coalition needs to be properly managed in order to achieve success.

chapter four

Getting started

Advocacy coalitions are groups of organisations and individuals working together to achieve changes in policy, law, or programs for a particular issue. Such coalitions require a clear vision of where they are going and why and be able to dedicate time and other resources to the process. Building the coalition is an integral part of the process and requires careful planning as more often than not, you may only have one opportunity to convince people to join the initiative.

> *"When you see something that is wrong, no matter how big the problem is, think 'Who else would like to change this? How can we work together?"*
>
> Kofi Annan, former
> UN Secretary General

Overview

Building and maintaining a coalition is important. By gener-ating public support for care providers and linking their rights and concerns to other important social and economic topics under consideration by policymakers (such as poverty alleviation, economic justice, legal empowerment, integrated livelihoods support, gender equality and budgeting, social accountability, human rights, social accountability and job creation), a coalition can potentially garner partnerships that will help in changing the knowledge, attitudes, and practices of major decision makers. At the same time, a coalition can help ensure that more appropriate and representative policies and resource allocations are in place for care providers.

This Handbook primarily focuses on providing guidance on how to establish a new coalition to lead the advocacy campaign for care work policy in the region. However, if it emerges during your country mapping and stakeholder analysis that there is an existing coalition doing similar work, then you might join that coalition to avoid duplication (see **Box 5: Joining an Existing Coalition** for some tips).

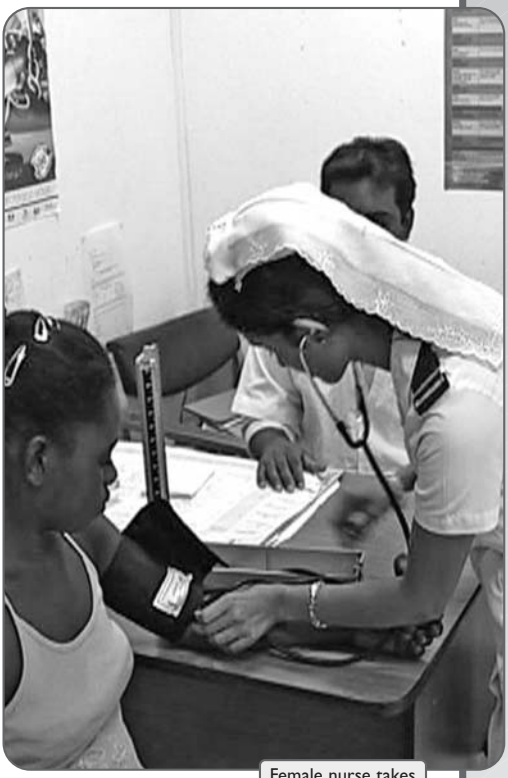
The focus of this step of the process is to provide you with key activities that can assist you to identify who could or should be in an advocacy coalition and how to identify a common set of principles for working together to advocate for a care provider policy. The activities in this step take you through the process of:

- Establishing a coalition to lead the advocacy campaign;
- Agreeing on the work of the coalition; and
- Managing the coalition.

Box 5: Joining an Existing Coalition

Before joining an existing coalition, assess whether:

- The coalition represents your interests adequately
- The coalition has done work to date and in terms of what
- There is compatibility between the position of the coalition and your position on the issue of care work policy
- The resources that you may need to contribute to the coalition can be justified in terms of meeting your goals
- The stakeholders in the coalition are representative for the purpose of your advocacy campaign
- The coalition's advocacy strategies are suitable for your advocacy



Female nurse takes a patient's blood pressure © GEMSA

The key outputs of this step is the formation of a coalition and the drafting of a coalition work plan. In the event that there is an existing structure/coalition working on the issue, it would be suggested that you join it and provide your inputs through it.

Key activities

Establishing a coalition to lead the advocacy campaign

The coalition building process will be informed by the stakeholder analysis and should be representative to include the relevant government ministry(ies); care providers representatives; beneficiaries of care provision services; policy advocacy organisations; labour unions; and other human rights, faith-based, gender, HIV and AIDS organisations. Establishing a

coalition (also see **Tool 2: Checklist for forming and managing a coalition**) to lead the advocacy campaign will focus on:

- **Engaging the stakeholders:** This entails planning and inviting the relevant stakeholders to attend a workshop to sensitise them about the campaign that will advocate for a care work policy in the country. This is a good opportunity to share with them the country situation analysis and work towards a common understanding of the mission and goals of the advocacy campaign. Remember that your stakeholder engagement plan will give guidance as to when the respective stakeholders should be engaged.
- **Agreeing on guiding principles of the coalition:** While engaging stakeholders at the workshop, take this opportunity to agree on what the principles of the coalition will be. The guiding principles include agreeing on the coalition's name; vision (**see Box 6: Example of a vision**) and goals; member roles and responsibilities; decision-making and communication structures; governance; coordinator or secretariat/steering committee) functions; funding and fundraising strategies, if relevant etc.
- **Signing of Memorandum of Understanding (MOU):** An MOU should be signed by the stakeholders as this will assist the coalition to work towards its mission and goals more effectively because of the commitment of all stakeholders. You may not be able to get commitment to the coalition by all the stakeholders at the end of the first workshop as some may need to go back and discuss with their own constituencies. However, it is important to set a reasonable date by which the necessary MOU must be signed.

Box 6: Example of a vision

(Name of country) must develop a policy to recognise how important care providers are; mobilise both men and women to be care providers and provide adequate training, equipment, professional and psychosocial support to the care providers for them to give quality care.

Tool 2:
Checklist for Forming and Managing a Coalition

The checklist below can be used to consider whether you have covered all the essential steps in forming and managing a coalition.

Forming and managing a coalition - checklist

I Formation stage

- Establish a clear purpose or vision - Involve individuals and organisations that share the vision.

II Maintenance/Growth Stage

- Define clear, specialised roles and establish clear norms
- Have a loose organisation and develop a good communication system
- Share leadership that build trust
- Encourage wide participation by all members - Compile a skills inventory, including the skills/expertise of individual members and what resources members can offer (meeting space, internet access, media contacts etc).
- Make a list of who is in your coalition and make sure that you all have the contact details

III Organisation

- Divide into subgroups/task forces to take on specific tasks according to expertise. Spread responsibilities across all members to reduce workload and avoid burnout.
- Promote participatory planning and decision making. This will foster trust and collaboration among members.
- Keep members motivated by acknowledging their contributions.

IV Meetings/Documentation

- Meet only when necessary but make the meetings known well in advance.
- Set a specific agenda and circulate it ahead of time. Follow the agenda and keep meetings brief. Finish meeting on time. Rotate meeting facilitation role.
- Keep attendance lists and record meeting minutes for dissemination after meeting.
- Discuss difficult issues openly during meetings.

Agreeing on the work of the coalition

The coalition needs to be involved in the development of the advocacy campaign and in engaging with the relevant policy makers to convince them of how necessary it is to develop a care work policy. The coalition needs to:

- **Specify the main task of the coalition**: Based on the outcome of the country mapping exercise, the coalition will need to determine whether a policy exists or not (see **Table 8: Determining the main task of the coalition**). The identification of the task will assist the coalition to agree on its work guided by the agreed coalition guiding principles.
- **Develop a work plan:** A work plan must be developed based on the main task of the coalition. The work plan will identify the main activities; time frames; expected outputs; assign roles and responsibilities; budget (time, human, money); outcomes. The work plan must be realistic and must be agreed upon by all members of the coalition to ensure successful implementation.

Table 8: Determining the main

	Country Mapping and Stakeholder Analysis
If there is a policy and / or it needs to be amended	Conduct a review of existing policies, guidelines, strategic and legal frameworks that address the issue of care work in the context of HIV and AIDS based on the key principles
If there is no policy	Conduct a review of existing policies, guidelines, strategic and legal frameworks that address the issue of care work in the context of HIV and AIDS based on the key principles
If there is a policy draft	Conduct a review of existing policies, guidelines, strategic and legal frameworks that address the issue of care work in the context of HIV and AIDS based on the key principles

Facilitators should take into consideration that care work in the context of HIV and AIDS

task of the coalition		
Partnership Building and Strategy Development	**Influencing Policy Uptake and Implementation**	**Developing an Advocacy and Lobbying plan**
If there is a need to formulate amendments, join existing networks and participate or build a coalition to advocate on the issue	If there are policy shortcomings, develop appropriate recommendations based on the key principles	If there is a policy, develop an advocacy roll out plan based on the existing policies, guidelines, strategic and legal frameworks
Build a coalition to advocate on the issue	Prepare a Draft Care Work Policy	Develop an advocacy roll out plan
If there is a need to formulate amendments, join existing networks and participate or build a coalition to advocate on the issue	If there are policy shortcomings, develop appropriate recommendations based on the key principles	Develop an advocacy roll out plan based on the existing policies, guidelines, strategic and legal frameworks

may already be in an existing policies, guidelines, strategic and legal frameworks and the emphasis is to strengthen the recognition of the key principles identified above within policies, guidelines and other legislative frameworks.

ACTIVITY: Formulating the coalition work plan

Use **Tool 3** to assist you in completing a country work plan for the coalition.

Tool 3: Coalition Work Plan

Step	Main Activity(ies)	Lead person(s)	Output(s)
Influencing policy uptake and implementation	Understanding the country's policy process		Draft policy/ policy inputs
	Identifying where the policy should be located		
	Formulating the draft policy or policy inputs to existing policy		
Developing an advocacy and lobbying plan	Developing and framing key messages		Advocacy and lobbying plan
	Identifying Resource needs		
	Developing the implementation plan		
Monitoring and Evaluation	Monitoring the progress of the overall campaign against the agreed milestones		Monitoring plan
	Evaluating the impact of the overall campaign		Logic framework

Managing the coalition

Managing a coalition can be a challenging task especially where it requires commitment from members over a long period. It is useful to assign a coordinator and/or secretariat/steering committee to ensure that the coalition members are kept informed of activities and excited about the work of the coalition. **Box 7: Tips for Managing Coalitions**[13] provide some useful information that can be used by the coalition.

Time frame	Budget	Outcome(s)	Technical assistance (Yes/No). If yes, who/from where?
		Development of care work policy/improved care work policy in each country Adoption and implementation of care work policy/improved care work policy in each country	
		Increased knowledge and awareness care work within HIV and AIDS context Increased support for debate around care work within HIV and AIDS context	
		Strengthened policy/guidelines that improves the lives of care providers from a social, economic and heath perspective	

Box 7: Tips for Managing Coalitions

These are tips for working successfully in coalitions and can be applied to your coalition whenever applicable:

- Create a member database (name, organisation, type and focus of organisation, contact details, etc.). Update the database when new members join the coalition, members leave the coalition, people change or contact details change. Be sure to circulate the updated database to all the coalition members and encourage them to use the database to share important information.
- For specific tasks and activities, it might be beneficial to form subgroups that report back and are accountable to the larger coalition.
- When conflicts or disagreements arise, it is important to deal directly and openly with these. It is helpful to establish dispute procedures in advance.
- Establish a clear communication system. Member organisations should be kept aware of developments and changes in the coalition on a regular basis.
- Fill expertise gaps by recruiting new members or upskilling current ones.
- Network to broaden the coalition's base of support (co-operate with other coalitions and alliances, or broaden the coalition to gain a wider base of support).
- Plan events incorporating credible spokespersons from different partner organisations.
- Plan well ahead - coalition action can be cumbersome.
- When the coalition has successes, celebrate and spread the glory.

Checklist

The following questions could be helpful to check whether the key issues have been considered:

- Is there a need to form a coalition? If yes, who needs to be part of the coalition?
- Do coalition members have similar and compatible goals?
- Is there an existing coalition working on the issues? If yes, how can you join?
- Has the coalition's task been clearly identified?
- Is the coalition work plan achievable?

11 Extracted from the VSO Participatory Advocacy Toolkit for VSO Staff, Volunteers and Partners, 2009
12 Adapted from the Policy Project Advocacy Manual
13 Extracted from the VSO Participatory Advocacy Toolkit for VSO Staff, Volunteers and Partners, 2009, page 94

DRAFT POLICY FORMULATION AND IMPLEMENTATION

Care providers discuss care work in Botswana © GEMSA

Key Points

- Influencing the policy formulation and implementation requires an under standing of the public policy making processes.
- Draft policy formulation must be informed by key principles to ensure recognition of care providers, mainly women and girls.
- Preparing a policy draft can help to facilitate the policy advocacy process with key policy makers.

chapter five

Getting started

Policy formulation is a high level overall plan or course of action embracing the general goals and acceptable procedures of government body. Consider what the objectives of your advocacy campaign are before beginning to draft policy.

> *"I think of our work like holding up a candle of hope to other people. But unless we also protect that candle, it will burn out."*
>
> *Care provider, Namibia*

Overview

The policy environment covers a range of different aspects: policies in existence that need updating; draft policies; common practice that is 'accepted' but does not have a policy or laws to back it up. Traditional law and custom also have significant impact on policies and practice. The rapidly changing face of HIV and the impact of HIV on family and community care provision make it essential to consider all of these aspects.

The activities in this step take you through the process of:

- Understanding the country's policy process;
- Identifying where the policy should be located; and
- Formulating the draft policy or policy inputs to existing policy

The output of this step based on the activities that will be followed is the development of either a draft stand-alone care work policy or draft inputs into existing policies or draft policies dealing with care work-related issues.

Key activities

Understanding the country's policy process

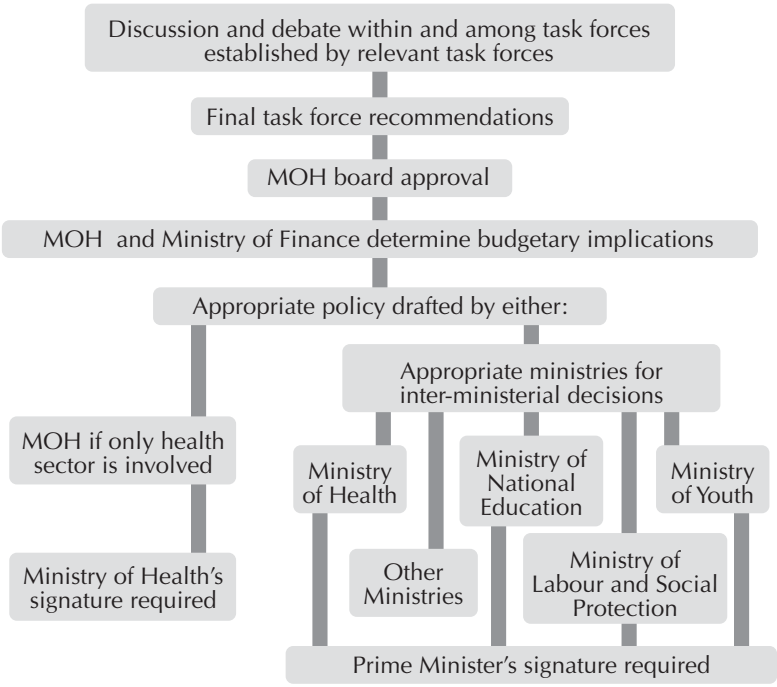
The first step is to discuss within the coalition what you understand the policy process to be. If you do not already have experts in this area, invite an external speaker to give you information in the following areas:

- How are ideas or issues generated for new or revised policies?
- How is a proposed issue intro-

duced into the formal decision-making process?
- What is the process for discussing, debating, and, perhaps, altering the proposal? Who are the players involved?
- How is the proposal approved or rejected?
- If approved, what are the steps to move the proposal to the next level of decision making?

Based on this discussion, make a 'policy development' chart (see **Figure 3: Example of a Process of Policy Development)** and use this as a guide for your process.

Figure 3: Example of a Process of Policy Development



Identifying where the policy should be located

It is not always obvious which institution should be responsible for implementation, oversight and monitoring of a care provider policy. It is essential to clarify where this will be located – in which ministry or through which strategic process.

If there is already a draft policy located in a ministry or a poor policy that needs to be improved or strengthened, this step may not be necessary to consider in depth. However, it is always useful to reflect on the questions:

- *Based on your review of existing legislation and policy, where does a policy to provide minimum standards of support for C&HBC providers best fit?*
  - Which of your potential policy makers is already responsible for coordinating community home-based care? Is there any related policy already being formulated that care provider issues could be incorporated into?

- *Where will it be easier to get the policy passed?*
  - Often the Ministry of Health is considered to be the ministry responsible for provision of HIV-related prevention, treatment and support in the health sector. However, you may decide, for example, that the Ministry of Local Government is the most logical because it has the power to allocate budgets at a district level and coordinate local community-based responses. You may prefer to opt for a ministry that has a more powerful group of advocates at Cabinet level.

- *Who will have the power (including resources, capacity and will) to ensure that it is implemented?*
  - Once a policy is passed, the lead institution has to translate the policy into action. This requires a level of political will and also financial and human resource capacity to move the policy forward. For example, although a Ministry of Gender may have the political will to push the policy through, they may not have the human resources or the political leverage to require other ministries to fulfil their obligations. Although a Ministry of Health may have the technical capacity to

administer the policy, they may face opposition internally from trained health personnel who do not wish to see scarce budgets spent on 'volunteers'.

Below is an example of how a coalition might select a location for the policy:

Ministry or institution	Rationale for being located here	Main advantages	Possible disadvantages
Ministry of Health	The lead ministry for HIV-related treatment and support and with the technical knowledge and oversight for the continuum of HIV care	Links C&HBC to the broader continuum of care; Able to provide technical oversight and coordination and ensure that quality of care is foremost	Risk that care providers are treated as health service employees and be required to undertake other tasks than those they are doing
Ministry of Women or Gender	Commitment to 'making care work count' is likely to be strong	Links to other strategies that promote gender equity and make care work count	Often lacks human and financial resources to pass through policies May be hard to get 'stronger' ministries to account to this ministry as lead agency
National AIDS Council or Commission	The need for a care provider policy in SADC is largely due to the impact of HIV	Central coordinating body for all HIV prevention, treatment and care support, often with the responsibility for monitoring the response	May lack legislative power that Ministries have ; Focus on HIV and excludes other chronic illnesses

Other possible institutions might be:

- **Ministry of Public Works** – may be suitable in countries where there is a stipend system as part of an Expanded Public Works programme, or that leads on skills development and vocational training;
- **Ministry responsible for Social Protection/Social Welfare/Social Development** – may be suitable where a social protection policy is being implemented at macro level and where support for community-based 'social safety nets' is a core part of the programme; or
- **Ministry of Local Government** – in decentralised contexts, district administration may be the place where budget responsibility for health care and community response lies.

ACTIVITY: Selecting a location for a care work policy

As a coalition, brainstorm your own possible institutions and complete the table below:

Ministry or institution	Rationale for being placed here	Main advantages	Possible disadvantages

Having identified the institution that you would like to target, you now need to consider which individuals (or sectors) will be able to take the policy through the formal adoption process. You may wish to bring in an external adviser with detailed knowledge of the institution. In your coalition, ask yourself 'What is the decision making process and which people are in a position to submit, authorise and approve a care provider policy?' Decide who your key **targets** (targets are people who have the power to introduce a care provider policy) are and how they will be reached, and draw up a table such as the example below:

Target	Approach – direct or indirect	What action do we need to take to reach this person?
Minister of Gender	Indirect	Engage with special adviser on HIV within the Ministry of Gender – s/he can advise on the details of policy processes
Permanent Secretary/Director General, Ministry of Gender	Direct	S/he is very approachable; write a formal request for a briefing and prepare a 2-page summary of the situation analysis, emphasising the current ministry policy
Director, Community and District Health Services, Ministry of Health	Indirect	Presentation at HIV Coordinating Task Force; request to present situation analysis findings

Formulating the draft policy or policy inputs to existing policy

In the process of advocating for a policy on care providers it is also necessary to develop the first draft of the policy or policy inputs for consultation and then usually at least a second draft before the final draft can be agreed. Often a consultant is identified to actually draft the policy but the coalition should be involved to ensure all of the crucial issues are covered.

A draft policy or policy inputs must take into consideration the six principles being advocated in this Handbook as well as those that a country considers to be relevant for its context. Tool 4 is an example of a draft policy for care providers based on Namibia's stand-alone policy:

Tool 4:
Example of a draft care work policy

A Goal
To empower and motivate communities to initiate, strengthen and own community actions and household practices that will promote health, prevent illnesses and provide palliative care in order to reduce morbidity and mortality and improve the quality of life of all citizens. In addition, the focus is to prevent HIV transmission and to reduce the impact associated with HIV/AIDS on the infectedand affected.

B Objectives
1. To empower communities to increase awareness and knowledge and improve attitudes and practices related to the prevention, treatment, care (including curative and palliative) and rehabilitation of most common diseases.
2. To set standards for C&HBC to ensure the effective implementation of quality programmes.
3. To avoid unnecessary hospital admission and strengthen the existing referral systems.
4. To solicit support for the communities and care providers by highlighting the value of C&HBC to all citizens.

C Primary Principles
Equity, availability and accessibility, affordability, community involvement, sustainability, justice, inter-sector collaboration, multi-disciplinary and collaborative research, monitoring and evaluation, and quality of care.

D Strategies
- Support for community health care providers (this includes accredited training, resources, supervision, recognition and reimbursement for costs).
- Promotion of self care and recognition of stress involved in care work (training in managing the stress of the work and methods of self care, creation of peer support groups, ensure continuity of care for care providers).
- Promotion of community involvement and participation.
  Engage men in C&HBC: through information and awareness-raising, government can promote care work as everybody's responsibility; holding men's forums and requesting the church, traditional leaders and other respected male community authorities to discuss the important role of men in care work.
- Strengthening of human resources such as:
  - Guidelines and supervisory tools
  - Training of trainers. Courses to be accredited by the National Qualifications Authority
  - Re-fresher training

- Performance and attendance certificates, and an agreement between the C&HBC organisation and the community home care provider (CHCP) of duties and incentives
- Resource mobilisation
- Appropriate guidelines and practices on decentralisation and integration of C&HBC
- Integrated management of C&HBC services, improved monitoring and coordination, as well as greater decentralisation.
- A strengthened C&HBC and welfare information data bank within the Health Information System (HIS) in order to reflect a true profile of the community needs and developmental activities.

E Responsibilities of Other Ministries

Ministry of Education

- Approve unit standards for training which can then be accredited by the National Qualifications Authority
- Make provisions for older care workers who have experience in lieu of education
- Sensitise and mobilise community members on health issues
- Promote health information literacy

Ministry of Agriculture, Water and Forestry

- Provide technical support on agricultural and development issues and sensitise communities on clear water and nutritious foods
- Promote food security and nutrition initiatives

Ministry of Regional and Local Government, Housing and Rural Development

- Support and monitor C&HBC activities
- Coordinate linkages between communities and different service providers through Regional Coordinating Committees

Ministry of Gender Equality and Child Welfare

- Identify families in need of health care
- Provide technical support concerning women and children
- Provide additional assistance for OVC
- Promote and actively recruit men to be involved in care work

Ministry of Information and Communication Technology

- Promote awareness of C&HBC and government policies related to care work
- Show weekly/monthly C&HBC programmes by facilitating discussions
- Promote gender equality in care work

National Planning Commission

- Strengthen the partnership between government and civil society organisations involved in care work

Funding/Support

- All ministries must mobilise resources, as well as support from community and private organisations and development partners to fund the C&HBC programme.
- Gender sensitive budgeting should be considered.
- Funding for C&HBC organisations is the responsibility of all stakeholders.

- Permanent staff members trained in supportive supervision will manage, support, supervise and evaluate all care providers. This individual and their team will provide technical, emotional, spiritual and administrative support.
- Ministries will regularly replenish training tools, as well as the home-based care kits (which has basic medications and supplies).

Provisions for care providers

- Recognition and rewards from the C&HBC service organisations, government and community leaders.
- An identification card and other means of identification e.g. a t-shirt, hat, and umbrella etc. which boost community confidence and promote the programme.
- A contribution towards expenses incurred, e.g. transporting clients/communication costs.
- Agreed description of duties and expectations.
- Remuneration that is agreed upon with the C&HBC organisation and reflects the level of quality services provided and hours served.

Monitoring and Evaluation

All C&HBC groups should develop appropriate indicators and tools for monitoring and evaluating change. Ideally organisations should track the policyís guiding principles of community involvement, gender equality, psychosocial support, training and collaboration between partners. They should also report the number of patients reached, the quality of service delivery, the satisfaction of care workers and what impact the work has achieved.

Activity: Develop a Draft Policy or Policy Inputs

Develop a Draft policy or policy inputs. Make use of Resource 4: Drafting Policy or Policy Inputs as well as Resource 5: Sample Code of Conduct for Care Providers available of the CD-ROM

Checklist

The following questions could be helpful to check whether the key issues have been considered:

- Is your policy/policy inputs development process aligned to the country's policy formulation system?
- Have you identified where the policy should be located?
- Does your draft policy or policy inputs reflect the country's situation and context in terms of care work?
- Does the draft policy or policy inputs reflect the six principles being advocated for by this project?
- Have you identified the most effective way to approach your target and indirect targets to get the policy adopted?

DEVELOPING AN ADVOCACY AND LOBBYING PLAN

Care providers discuss care work in Botswana © GEMSA

Key Points

- It is important to have mechanism in place to convince policymakers of the need for policy review, adoption and enforcement.
- There is need to identify resources that are required for the policy and advocacy process.
- Developing key messages for the advocacy process and the tools that will be utilised to reach out to the media is critical for the success of the policy advocacy process.

chapter SIX

Getting started

Think about the last government-led HIV and AIDS advocacy campaign that was implemented in your country. Reflect on:

- What was the key message?
- Did it change your knowledge, behaviour, and attitude?
- Do you believe it was effective? Why or why not?
- Did it address the gendered dynamics of HIV and AIDS?

The purpose of reflecting on a past campaign is to provide you with an opportunity to reflect and hopefully assist you as you develop your advocacy campaign for your country.

Overview

This step is essential for everyone using this handbook. The draft policy developed by your coalition is only able to translate into a real policy if you can convince key stakeholders to support the draft policy and take action to turn this into a real policy. The key definitions used in advocacy work are presented in **Box 8: Understanding key Advocacy terms**. The activities in this step take you through the process of:

- Developing and framing key messages
- Identifying resource needs
- Developing an implementation plan

The key outputs of this step are the formulation of an advocacy and lobbying plan campaign that will need to be implemented and this will be guided by the developing an implementation plan.

Key activities

Developing and framing key messages

Plan your messages carefully (see **Box 9: Tips for developing and framing key messages)**. All advocacy messages should have at least the following parts:

- A statement of what is required e.g. care providers who provide the bulk of care and support for the estimated xxx people living with HIV and AIDS in xxx (name of country) need training, psychosocial support and remuneration if they are to provide quality service.
- Evidence e.g. the number of care providers in country xxx caring for the number of ill people and how much burden they take from the State, how much training they receive, etc

- A case study – short story of one care provider and the clients that s/he may be taking care of.
- What is called for – specify the exact policy request.

Box 8: Understanding key Advocacy terms

Advocacy: A process that tackles disadvantage by working with communities and key stakeholders to bring about changes in policy, process, practice, and attitudes in order to ensure communities' rights are recognised and realised. The aim is to actively support disadvantaged people to influence the decisions that affect their rights and lives.

Lobbying: The term 'lobbying' is sometimes used interchangeably with 'advocacy', but there is a distinction. Advocacy is an umbrella term and there are a number of activities that can contribute to a successful advocacy strategy. Lobbying and campaigning are two activities that can be part of advocacy work. 'Lobbying' is seeking to influence decision-makers on behalf of a particular interest. The term often refers to efforts to influence legislation but private companies, donors and other large institutions are also often lobbied. Lobbying is usually carried out by a small number of people, who are experts in their subject.

Audience: The person selected to receive your message (could be a direct or indirect target)

Messages: Main points that you want to get across in your advocacy, to support your ask

Opponents: Groups or individuals who counter or oppose your policy change aim

Policy windows: Brief periods when there are unusual opportunities for policy change

Target: The policy maker to whom your advocacy message is addressed because they have the best opportunity to make policy change (also known as a primary target)

Indirect Target: The person selected to bear influence on your advocacy target.

Box 9: Tips for developing and framing key messages

- Choose the messengers of each activity carefully – who is the best suited messenger to be in contact with that particular audience?
- Who will the audience listen to?
- Who has the most persuasive power with that audience?
- Whose voice will sway the audience most effectively? Though the coalition members are devoting time and energy to this process they may not be the most effective messengers.
- Consider choosing messengers from the broader coalition members to have the most impact.
- Choose messengers that can effectively deliver the message for each audience.
- Prepare the messengers carefully and rehearse their presentations.
- Remember that an email invitation to a meeting is also a message.
- All communication must be prepared carefully and come from the most effective messenger to have the intended impact.

Identifying Resource needs

The next step in developing an advocacy plan is to identify the resources that are available as presented in Table 9. Brainstorm on the resources that already exist in your network and identify how you will fill the gaps. Remember that policy formulation is not straight forward and quick. Be ready to change course when necessary and be ready to develop a plan B when your original plan is not leading to the intended outcome!

Table 9: Identifying

Resource
Staff time
Means of communication (computers, access to email, telephones, photocopier, fax machine)
Money or in-kind support
Resources to pay for expertise

Why it is important?	How are you going to get it?	Cost
• Disseminate information • Conduct research • Make appointments with relevant targeted stakeholders • Develop fact sheets • Write and read documents and comment on them • Organise petitions, marches and other advocacy events • Participate in the whole process and to draft the policy	• Hosting a meeting or workshop • Conducting a press briefing • Inviting a policy maker and / or the media to an event	
• To identify which communication is necessary for which advocacy purposes	• Developing a communications plan	
• To host planned meetings with the targets of advocacy or to consult widely on the draft policy for instance • To host other large workshops or conferences related to the policy development process	• Hosting a meeting or workshop with care providers, NAC etc • Conducting a press briefing • Inviting a policy maker and / or the media to an event • Accessing existing information such as country situation analyses; audits of C&HBC organisations and programmes • Accessing existing materials for training, psychosocial support and existing programmes to mobilise men and provide materials and professional support to care providers.	
• To write up a situation analysis • Send out information sheets to members and to targets of advocacy, • Develop posters, placards, media messages etc • Draft the policy or policy inputs		

Developing the implementation plan

This would involve identifying the target audience that you seek to influence and garner support for the policy. This could be done through: lobbying, campaigning and media. The coalition needs to identify what is the most efficient process for advocating for policy. This depends on what exists already in the country. It may be necessary to engage in mass awareness raising of the issues – with the broader public as well as with policy and decision makers. It may be that there are already policy processes afoot to which it is possible to join the policy for care providers.

Talking care work © GEMSA

Case study: Different levels of advocacy activity

SAfAIDS has identified three levels of activity[16]:

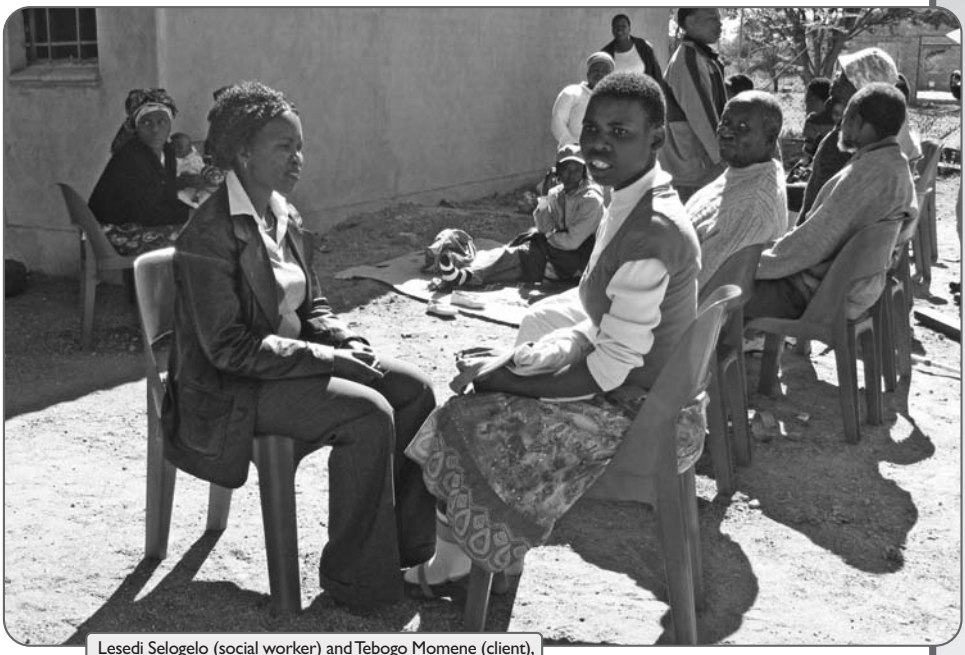
Low Profile Activities: Small meetings with policy makers and presentation of fact sheets, position papers;

Medium Profile Activities: Writing letters to the press; making contributions in meetings; drafting policy and presenting it to relevant policy makers; inviting a high profile decision maker to an event at local level that highlights the contribution of care providers and the need to provide sufficient support to them and being sure that this is covered in the media; press releases; debates in the media; drama

High profile activities: Conferences; public rallies; media campaigns - press conferences, media interviews; petitions and protests; legal action; street theatre; flyers.

ACTIVITY: Developing an Advocacy and Lobbying Plan

Use Tool 5 as well as Resource 6: Working with the Media (on the CD-ROM) to develop your Advocacy Plan and Lobbying Plan



Lesedi Selogelo (social worker) and Tebogo Momene (client), Botswana Retired Nurses Society, Tlokweng © GEMSA

Tool 5:
Sample advocacy action plan

Focus Area or Intended Outcome	Activities	Preparation / Sub activities
Convincing Coalition members of need for policy Agreement on the need for care provider policy by at least xxx organisations	Email outlining the issues and invitation to meeting to discuss it Meeting to discuss issues,	• Database of all possible organisations to invite • Email Attachments with specific information • Telephonic and personal Follow up to invitation especially for key people • Facilitator • Briefing notes for participants • Speaker • Note taker / documenter • Communication to members after the meeting
Convincing Policy Makers of the need for this policy	One on one meetings with policy makers A, B, C Inviting critical policy maker to an event with care providers Workshop with policy makers on care provider policy	• Making appointments for the meeting(s) • Preparing briefing notes or presentations for the meeting(s) • Preparing materials to leave with the policy maker(s) • Briefing the team(s) that will participate in the meeting(s) and planning who will do what in the meeting(s) • Writing up the outcome of the meeting(s) and sending this back to the policy maker(s) • Follow up communication • Invitation and follow up • Invitation to key coalition members to also be present • Agenda for the visit • Briefing all that are involved in the visit • Inviting the press to cover the visit or issuing a press statement after the visit • Follow up communication with the policy maker after the visit • Planning venue and logistics for workshop • Invitation to policy makers and coalition members • Planning a march of care providers during the workshop • Agenda for the workshop • Hand outs in the workshop • Documenting outcomes of the workshop • Dissemination of outcomes timeously
Agree areas to be covered in the policy Agreed draft policy developed	Workshop with policy makers and coalition members	(This may be the same the workshop in the step above and the sub activities are the same as above) • Email with all issues in simple and clear language • Follow up to all for responses

Person Responsible	Time Frame	Budget / resources	Milestones
			Meeting arranged with commitment from at least 60% of intended target group to attend Broad agreement on the need for a care provider policy reached at meeting
			Policy maker A agrees to discuss the need further Policy maker B agrees to discuss the need further Policy maker C agrees to discuss the need further Policy makers A, B and C agree to the need for a policy
			Agreement by key stakeholders on the outline of the draft and issues to be incorporated

Focus Area or Intended Outcome	Activities	Preparation / Sub activities
	Email correspondence on areas that need clarification	• Draft position paper / policy and consult with coalition on this • Circulate draft to all relevant people • Have one on one meeting with key role players / decision makers • Collect and collate comments
	Agreed position paper /draft policy circulated amongst all members for comment Meeting to finalise draft policy	• Redraft policy to incorporate comments from sub activity above • Invite all players to a meeting • Organise venue and logistics • Agenda for the meeting • Facilitator • Document outcomes • Circulate final draft for approval
Broad national agreement on policy	Organise local level meetings with representative groups of care providers in all parts of the country	• Circulate draft policy to organisations working with care providers and arrange for local level consultations • Arrange meetings • Prepare presentation of policy in local language • Document the discussions • Collect outcomes to the coalition
	Present final draft at a national conference / meeting or	• (This may be as a side activity at a meeting called for a related purpose or at a meeting organised specifically to discuss this policy – depending on available resources) • Prepare presentations • Document outcomes
	Discuss the draft policy through the national media and ask for comments	• Prepare presentations for print, audio and visual media in all national languages • Invite comment with easy to reach telephone number, fax and email as well as to locally based representatives of the coalition
	Circulate final draft to all interested parties nationally	• Prepare final draft of policy • Check with legal and policy experts • Circulate to policy makers & nationally

Person Responsible	Time Frame	Budget / resources	Milestones
			Second draft policy
			Third draft policy circulated
			Consultations with care providers conducted and views collated
			National consultation on draft policy conducted and comments collated
			Final draft policy submitted to policy makers for final approval

Checklist

The following questions could be helpful to check whether the key issues have been considered:

- Is your policy/policy inputs development process aligned to the country's policy formulation system?
- Have you identified where the policy should be located?
- Does your draft policy or policy inputs reflect the country's situation and context in terms of care work?
- Does the draft policy or policy inputs reflect the six principles being advocated for by this project?
- Have you identified the most effective way to approach your target and indirect targets to get the policy adopted?

Care providers receiving bicycle and materials to perform care work © VSO-RAISA

15 Extracted from the VSO Participatory Advocacy Toolkit for VSO Staff, Volunteers and Partners, 2009, pages 6 & 54

16 SAfAIDS, 2007: Tools for Planning and Implementing a Successful HIV and AIDS Treatment Advocacy Campaign. Page 23

MONITORING AND EVALUATION

Care provider wearing "Making Care Work Count" T-shirt © GEMSA

Key Points

- It is important to have mechanism in place to convince policymakers of the need for policy review, adoption and enforcement
- There is need to identify resources that are required for the policy and advocacy process.
- Developing key messages for the advocacy process and the tools that will be utilised to reach out to the media is critical for the success of the policy advocacy process.

chapter seven

Getting started

Developing an advocacy campaign is challenging at times but can be very rewarding if you are able to achieve your objectives. Before you begin the advocacy campaign spend some time reflecting on:

- What do we want to achieve by embarking on this process?
- How will we know if we are meeting our objectives?

Overview

The activities in this step take you through the process of:

- Monitoring the progress of the overall campaign against the agreed milestones
- Evaluating the impact of the overall campaign

The key outputs of the activities below include firstly, the development of a Monitoring Plan that will assist you to report on the progress of your country's policy development process. The other major output is the development of your country's Logic Framework which will assist you in measuring the overall impact of the advocacy campaign.

Key activities

Monitoring the progress of the campaign against the agreed milestones

The Coordinator and/or Secretariat/ Steering Committee will be responsible for monitoring.

Monitoring will focus on collecting information and communicating the status of the advocacy to coalition members by providing monthly status reports on the various work and implementation plans for the country.

The coalition must meet regularly (at least quarterly) to monitor progress of the overall campaign to determine if the milestones as informed by the time frames presented in the various work plans. If the activities are not achieving the intended milestones, it may be useful to firstly, review your coalition to assess whether another key stakeholder should be included that previously you may not have included. Secondly, it may be useful to review whether your policy influencing process needs to be revised. A review of any of these two components of the process will require that you review your advocacy and lobbying plan to incorporate any revisions that may have been made.

There are times when factors outside the control of the coalition may hasten the policy making process e.g. a large donor is interested in supporting large scale programmes for care providers but requires a policy framework. There are also times when external factors such as drought or floods distract attention to other more urgent issues. It may be pointless to continue with this policy process at that time but could be followed up on again when the situation permits.

ACTIVITY: Monitoring the advocacy campaign

Use Tool 6 below to monitor your country's progress.

Tool 6: Monitoring the Advocacy Campaign Progress

Component	Output(s)	Time frame		Completed		Reason for delay, if any	Additional information, concerns, issues
		Start date	End date	Yes	No		
Country mapping and stakeholder analysis	Policy audit						
	Stakeholders engagement plan						
	Country situation report						
Building a coalition	Workshop						
	Coalition formed						
	Coalition work plan						
Influencing policy uptake and implementation	Draft policy/policy inputs						
Developing an advocacy and lobbying plan	Advocacy and Lobbying plan						

The coalition needs to meet on a regular basis and the following matrix needs to be completed by each country and submitted

Activity	Scheduled Meeting Dates	Meeting held		Reason for delay, if any	Additional information, concerns, issues
		Yes	No		
Coalition meeting					

ACTIVITY: Monitoring the advocacy campaign

Use checklist below to monitor your country's progress. Other information to be monitored on a monthly basis can include[17]:

Information to be monitored	Description including number, audience reached, etc
Significant communications received	
Advocacy material produced and distributed	
Use of advocacy material, reports, arguments etc	
Capacity building of coalition to carry out coalition	
Public speaking engagements on the issue	
Media monitoring (press releases sent out, media coverage)	
Mass campaign events or activities e.g. petitions	
Any changes in your target's actions, opinions or attitudes	
Any policy changes on your issue Other, specify	
Description including number, audience reached, etc	

Evaluating the impact of the overall campaign

The coalition must do an evaluation at the end of each major step of the advocacy campaign process to decide whether it achieved the intended objectives efficiently and effectively before moving on to the next component so that they use the experience to improve the campaign. For instance, if the activity is a one on one meeting with a key policy maker to persuade the policy maker of the need for a care provider policy, or at least to engage with the issues, then the evaluation asks the following:

- Did the policy maker agree that there is a need for a policy and will s/he be supportive of this process?
- If not, as a second best position

did the policy maker agree to participate in an event with care providers to be exposed to the issues?

If the activity did not achieve its intended objective, question why by asking for example:

- What was planned for that did not happen?
- Was the messenger the correct one?
- Was the planning for the activity adequate? Did the coalition understand the target audience correctly?

So in the example above, if the policy maker did not agree to support the policy, ask:

- Was sufficient information presented?
- Was it in the right format?
- Did the members of the delegation that met with the policy maker have good contacts with the policy maker? Perhaps you need to ask someone that knows the policy maker personally to have an informal discussion with them before the next meeting. Perhaps you should target an influential officer in the policy maker's office rather than the policy maker directly. Perhaps you need to build up a louder national voice on the issues through a media campaign before you approach this official the next time.
- Is it a problem of budget to implement the policy?
- Was it a bad day to be meeting with the policy maker who had another important meeting and whose mind was not on the issues being presented?

Similarly if the objective was achieved, review what was good in the planning and implementation of the activity and build on this for future activities. If the meeting went well review what factors contributed to this – was it the planning for the meeting in terms of arrangements for the time and venue? Was it the presentation that was made and the presenter?

Was it the materials that were presented? If things went well, use this information to inform your other activities.

In planning for each activity think about how its impact will be evaluated and be sure to do this in the implementation. At the end it is worthwhile for at least the coalition to conduct an

evaluation of the whole process. The evaluation can focus on process questions such as:

- Was this done effectively and efficiently?
- Could it have been done better?
- How did the coalition and the broader coalition work together? What worked well and what could have been better?
- Which advocacy activities worked the best? Which were the most problematic? Why?

The overall campaign can be evaluated using the advocacy campaign logic framework that has been developed for this campaign (**see Tool 7: Advocacy Campaign Logic Framework).** Remember to celebrate successes – along the way and at the end. Policy advocacy is a difficult process and it must be fuelled by recognising that there is progress even if it seems to be very slow. Documenting the short evaluations of each activity, the monitoring of progress being made and the final evaluation are crucial to inform future advocacy for implementation of the policy.

Checklist

The following questions could be helpful to check whether the key issues have been considered:

- Have you developed a monitoring and evaluation plan with indicators that are clearly linked to the objectives of the advocacy project?
- Are sufficient resources allocated for planned monitoring and evaluation activities?
- Is there an agreed documented data management system that helps reporting requirements to be met?
- Is there a communications system in place that will assist your country share on the progress of the project with members of the coalition and other external stakeholders?
- Is there an agreed evaluation framework in place?

17 Extracted from the VSO Participatory Advocacy Toolkit for VSO Staff, Volunteers and Partners, 2009, page 78

Tool 7: Advocacy Campaign Logic Framework

SITUATION
Needs
Stakeholder engagement

Priorities
Consider: mission, resources
Intended Outcomes

INPUTS	ACTIVITIES	OUTPUTS
What was invested?	**What was done?**	**What was produced?**
Staff Partners Time Research Technology Materials and Equipment Money	Country mapping and stakeholder analysis Partnership building workshop Policy/Policy input formulation Designing of advocacy and lobbying plan	Country situation report Coalition Draft policy/policy inputs An advocacy and lobbying plan

OUTCOMES

Short Term	Medium Term	Long Term
What were the short term results?	**What were the medium term results?**	**What are the ultimate impact(s)?**
Learning:	**Action:**	**Conditions:**
Increased knowledge and awareness care work within HIV and AIDS context Increased support for debate around care work within HIV and AIDS context	Development of care work policy/improved care work policy in each country Adoption and implement-ation of care work policy/ improved care work policy in each country	Strengthened policy/ guidelines that improves the lives of care providers from a social, economic and health perspective

About GEMSA

The Gender and Media Southern African (GEMSA) Network is an umbrella organisation of individuals and institutions who work to promote gender equality in and through the media.

About VSO-RAISA

Voluntary Service Overseas (VSO) is an international development agency that works through volunteers. Our vision is a world without poverty in which people work together to fulfil their potential. The VSO-RAISA (Regional AIDS Initiative of Southern Africa) is an initiative that works to tackle the impact of HIV and AIDS in South Africa, Mozambique, Malawi, Zambia, Zimbabwe and Namibia. The VSO-RAISA framework works in the programme areas of prevention, treatment, care and support and mitigation of socio-economic impact using tools that include volunteer placements, small grants, exchange visits, national capacity building workshops and regional conferences.

2323 GEMINI CONCEPTS: 2 083-306-3229

GEMSA:
28 marcia Avenue, Cyrildene,
Johannesburg, 2198
Tel: +27 (0)11 622 6597
Fax: +27 (0)11 622 8674
E-mail: carework@gemsa.org.za
Website: http://www.gemsa.org.za/

VSO-RAISA:
357 Visagie Street, Kutlwanong
Democracy Centre, Pretoria, 0002
Tel: +27 (0)12 320 3885
Fax: +27 (0)12 320 7894
E-mail:
Website: http://www.vsointernational.org/