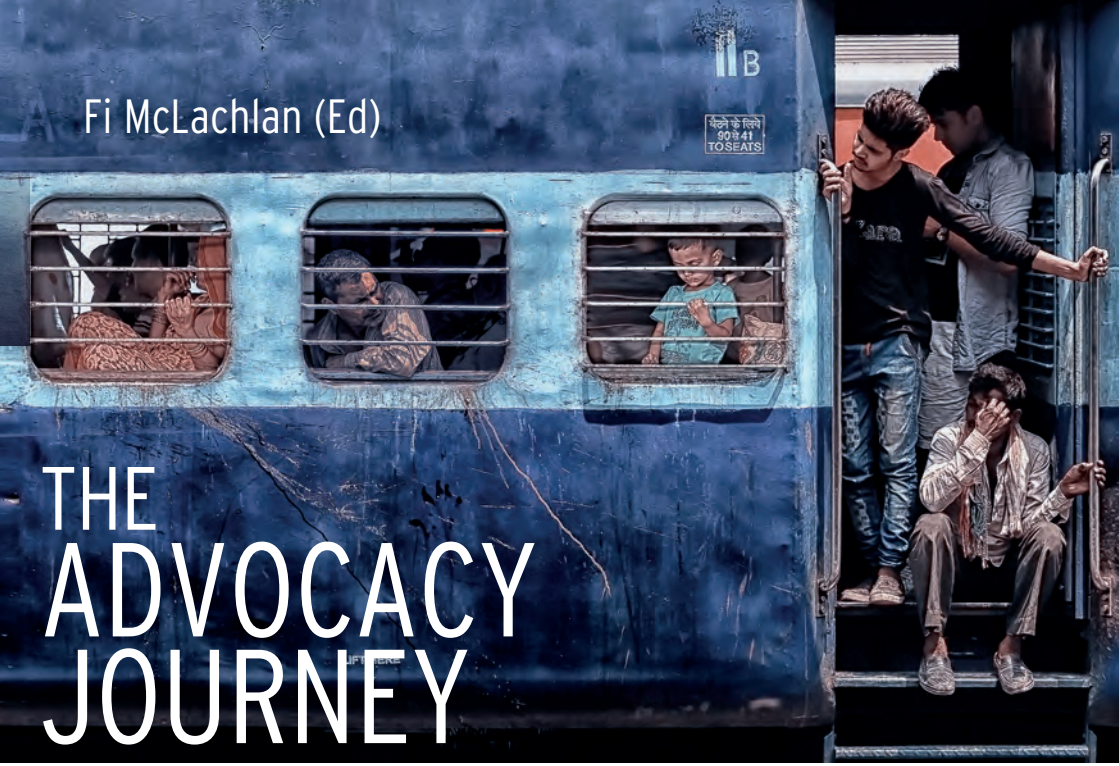
Fi McLachlan (Ed)



THE ADVOCACY JOURNEY

ENGAGING IN ADVOCACY FOR GLOBAL HEALTH

Fi McLachlan (Ed)

THE ADVOCACY JOURNEY

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CMF
Christian Medical Fellowship

The Christian Medical Fellowship

The Christian Medical Fellowship (CMF) is a network of doctors, nurses, midwives, and students in the UK and Ireland, connected to over 100 national Christian medical, nursing, and midwifery organisations around the world. Many CMF members are involved in international health, and some are working long-term in less developed countries.

The Advocacy Journey: engaging in advocacy for global health

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FOREWORD

For years, the Christian Medical Fellowship (CMF) has been at the forefront of speaking out on bioethical issues in the UK. However, we also have a good number of people working in global health and mission in many different parts of the world outside of the UK. In addition, people experiencing health challenges from many parts of the world now reside in the UK. This led us to ask: how can CMF further advocate on global health issues?

The CMF Global team includes an ongoing working group who together devised the journey to date. This group currently comprises Becky Macfarlane, Sam Leinster, David Smithard, Ruth Butlin, Sally Venn, Diana Pereira, Sonia Quane, Mark Pickering, and Fi McLachlan (and it is open to new members). Our journey led us to listen to our members, learn from their experiences, and seek to address gaps in our learning about how to engage in advocacy work. This small working group of CMF members and staff researched what was already being done and what we could learn from others similarly motivated by their Christian faith. We are thankful to all those who contributed to our survey, participated in discussions, and provided examples. We are thankful, too, to other organisations who made their materials available and gave time to help us in our learning.

The request from members was for a resource to enable people to think further about our responsibilities as Christian healthcare professionals and how to work practically alongside others to effect changes and impact healthcare across the world. We also want to help individuals gain motivation and ideas for further engagement, and to influence healthcare provision in specific contexts. Thank you to those who have written in response to this request.

As we worked throughout the COVID-19 pandemic of 2020-2021, the group was consequently challenged about advocacy in practice. The working group engaged as best we could from the UK with those able to influence or make decisions on issues such as access to healthcare in our own country, the equitable distribution of vaccines and equipment, and maintaining aid funding.

We continue our journey as an organisation in our advocacy efforts. However, our prayer is that each person reading this handbook will take further steps in their own journey into advocacy alongside those most in need. We seek to reflect the heart of our compassionate God who cares for the most marginalised, the powerless and the weak. May we prove faithful in this task, wherever we work.

Fi McLachlan, Head of CMF Global
October 2021

INTRODUCTION TO ADVOCACY

Advocacy is a social phenomenon that can be defined in many ways. For the purposes of this handbook, the working definition is as follows:

> *Influencing the decisions, policies and practices of powerful decision-makers to address underlying causes of poverty, bring justice, and support good development.*[1]

This can seem rather big, but it helps to break it into manageable parts that can be tackled by individuals and organisations. Advocacy can take place on multiple levels. Tearfund, a Christian humanitarian charity, has produced a very helpful Advocacy Toolkit[1] which presents six levels of advocacy as:

- International
- Regional
- National
- Provincial
- District/local authority
- Community/village

Advocacy involves both 'being a voice for the voiceless' as well as 'giving the voiceless a voice'. The word 'advocacy' has Latin origins; '*advocare*' literally means 'to call out for support'. Anyone with a voice, no matter how small, can call out for support. We all have a part to play in advocacy, and we should recognise the opportunities to step in and bring light. Advocacy is supported by things like fundraising and activism. However, these are not strictly 'advocacy' in and of themselves. Advocacy is a set of organised activities with the aim of influencing decision-makers. This can look different depending on the situation. Examples of advocacy include writing a letter to your local politician, training people to know and exercise their rights, or starting a public campaign. Advocacy is about putting an issue on policymakers' agendas, offering solutions, and supporting change for the better. This will often involve holding authorities accountable.

Identifying the 'powerful decision-makers' is only half of the work because to influence them, we must also figure out to whom these decision-makers answer. Broadly speaking, in a democracy, politicians respond to voters, while in a business, executives respond to their board of directors and shareholders.

Tearfund expands on the potential role of an advocate in a table on page 13 of their Advocacy Toolkit. We have reproduced a simplified version here to illustrate how diverse advocacy can be:

- **Represent** – speak on behalf of people
- **Accompany** – speak with people
- **Empower** – enable people to speak for themselves
- **Mediate** – facilitate communication between people and decision-makers
- **Model** – demonstrate a policy or practice to people or decision-makers
- **Negotiate** – confer with a decision-maker to settle something
- **Network** – bring people together to speak jointly
- **Lobby** – persuade a decision-maker to do something
- **Mobilise** – encourage people to take action to influence a decision-maker
- **Bargain** – negotiate the settlement of something

If you try to do everything, you will probably end up doing nothing. Hence you will often find that advocacy tackles specific issues in specific ways. That is not to say that people's lives cannot be changed for years to come by the efforts made. Successful advocacy offers hope. Unsuccessful advocacy is a springboard for future efforts. We must follow God, reflect his heart, and serve others no matter how impossible a happy ending looks. Thank God, he guides us in all this.

Jeremiah declared:

> *This is what the Lord says: Do what is just and right.*
> *Rescue from the hand of the oppressor the one who has been robbed.*
> *Do no wrong or violence to the foreigner, the fatherless or the widow,*
> *and do not shed innocent blood in this place*. (Jeremiah 22:3)

Thankfully, we serve a God who is an expert at delivering from the hand of the oppressor. He calls, leads, and helps us to 'do what is just and right', to be advocates. This handbook is written to inspire and assist Christians hoping to get involved in advocacy.

Following this introduction, we explore:

- Advocacy in health
- Role of the healthcare professional
- The theology of advocacy
- Micro-advocacy
- Macro-advocacy
- Befriending the media
- Evaluation
- Tackling barriers to advocacy
- Advocacy stories

May this be a helpful tool for all.

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ADVOCACY IN HEALTH

Advocacy is especially important in health because of the special relationship between health and justice. Health affects all aspects of an individual life by its particular impact on opportunities. Ill health often negatively impacts cognition, which is hugely significant when considering the future of a child. Ill health affects one's ability to work, which is a serious problem for those with insecure work with little to no financial safety net. Inequities in health are a justice issue when they are associated with an unfair practice or lead to inequities in population outcomes.

An inequity differs from an inequality. Inequities are avoidable inequalities. They arise from poor decisions, deliberately unfair or not, that create uneven economic, social, and political opportunities. Advocacy has the power to influence those poor decisions to bring about equitable policies and practices.

Health justice reaches beyond communities and individual nations. It is a global issue. Location, income, race, and gender all impact health outcomes within and between countries. Health advocacy includes ensuring access to care, creating system change, and addressing health inequities. International efforts, particularly financial assistance, are constantly under threat of being withdrawn or used inefficiently. Healthcare workers can contribute to the work that needs to be done to improve those international efforts. Poor governance, corruption, and cultural exclusion are common examples of the factors that lead to inequity in healthcare.

As healthcare workers, we regularly see the clinical impact of poor health. But If we look up past our scrubs for a moment, we may see that the wider determinants of health include poor governance, corruption, or cultural exclusion. So even if we feel we cannot change the clinical environment for our patients, we can advocate for workers' rights, gender equality, or access to education. Sometimes influencing the conditions people live and work in has a more significant impact on health outcomes.

However, by joining the dots with the broader social determinants of health, we can start to consider how we can play a role in health prevention from an equity approach. The right course of action depends on the situation, our individual capacity, and God's calling.

As healthcare workers, we can sometimes fall prey to myths about advocacy such as 'it requires all my time', 'it never works' or 'it is not my job'. None of that is true. This handbook will take us through different aspects of advocacy with many practical examples given by other Christian healthcare workers, junior and senior, who have given it a go. You can jump ahead to the advocacy stories at the end of this booklet for some encouraging examples. Working in healthcare can be challenging enough without trying to change the world, but we must remember that we are Christian workers, filled with a Spirit of power, love, and self-discipline.[1]

> *Let us not become weary in doing good, for at the proper time we will reap a harvest if we do not give up.* (Galatians 6:9)

FURTHER READING

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ROLE OF THE HEALTHCARE PROFESSIONAL

The Christian Medical Fellowship is a membership organisation made up of doctors, nurses, midwives, and students. Members sign our statement of faith outlining their belief in Jesus Christ and indicating their discipleship and desire to follow his way of life.

All are also committed professionally to codes of conduct and oaths that seek the best for the patients they serve. Healthcare professionals are equipped with a body of knowledge and skills that enable them to provide the best and most appropriate healthcare. Patients often look up to or revere health professionals as people who have the knowledge they do not possess. This can result in trusting that 'the doctor knows best'. Additionally, in certain cultures, people in a professional position may be put on a pedestal by virtue of their perceived authority.

As we think about advocacy and the responsibility we have as Christ-followers when we witness conditions that negatively impact health, the question we must ask is how do we make the best use of our knowledge, skills, access, influence, and relationships for the benefit of those we serve?

In this section, we seek only to highlight the responsibilities we have to serve the best we can to improve our patients' health outcomes. Just because we have technical and clinical knowledge does not necessarily mean we 'know what is best'.

Listening to patients is critical. Hearing their viewpoints and understanding their life circumstances enables us, with other support, to begin to address their concerns and the underlying causes of their ill-health. However, simply to be a 'voice for them' could well do them a disservice. We can undermine their growth in the ability to speak out for themselves. It could well serve to highlight the (self) importance of the clinician to the detriment of the person in need.

Enabling people to identify their concerns and speak out for themselves, especially if it can result in change, will lead them to a greater sense of achievement and self-worth. Therefore, we have a role in helping our patients or their local communities find their voice. Our role might simply be to provide factual information about the health risks they face. We should be working with them to articulate their own solutions, encouraging them to be confident in approaching those in power who need to act to alleviate poor conditions or services.

Very often, our role as clinicians may be to be a voice alongside our patients or communities. This could mean endorsing their requests when we have the opportunity, making the most of our access to Ministry of Health staff or other people in power. But we should do this respecting the wishes of our patients rather than promoting our own views.

We do need to be mindful of the limitations of being a foreigner in a host country. This may afford opportunities for influence in certain cultures (dependent on their views towards outsiders). However, in no way should we dare to be presumptuous or giving a hint that we think we know what is best.

As it says in Scripture:

> *In your relationships with one another, have the same mindset as Christ Jesus: who, being in very nature God, did not consider equality with God something to be used to his own advantage, rather he made himself nothing…he humbled himself.* (Philippians 2:5-8)

There may be times when we can speak on behalf of others, but let us not do so in a superior way. Instead, let us recognise that we come to serve and can in no way fully understand the culture in which we are called to work.

THE THEOLOGY OF ADVOCACY

Lament as the impetus for advocacy

I call on the LORD in my distress,
and he answers me
Save me, LORD,
from lying lips
and from deceitful tongues.

What will he do to you,
and what more besides,
you deceitful tongue?
He will punish you with a warrior's sharp arrows,
with burning coals of the broom bush.

Woe to me that I dwell in Meshek,
that I live among the tents of Kedar!
Too long have I lived
among those who hate peace.
I am for peace;
but when I speak, they are for war. (Psalm 120)

Advocacy always springs from lament.

As our hearts are grieved by suffering, injustice and the chaos and confusion of our fallen world, we yearn for change and long for what is better.

There has been a tendency among evangelical Christians, particularly in North America, Europe, and Australasia, to focus on personal salvation through Christ's atoning death, his resurrection, and the coming of the Holy Spirit into the believer's life. For the individual believer, the penalty of sin is paid, and the power of sin is overcome. When with Christ for eternity, the presence of sin will be no more.

However, it is clear from the Bible that God is concerned not just with the individual's own sin but with the impact of sin on the whole created order. And particularly on the lives of those who are sinned against. Those who love and serve him must inevitably share in his grief and yearning.

In Psalm 120, the psalmist is distressed and cries out to God (v.1) for rescue from human lies and aggression (v.2). He is a man of peace (v.7) and truth, knowing that God will punish those who use words to deceive (vv.3-4). He stands against those who use lies and manipulation to create an atmosphere of hostility and suspicion for their own interests, which results in destructive conflict (vv.5-7).

If we share in God's grief at the lies, injustice and violence in our world, we surely cannot be silent or collude with these. We, therefore, need to ask ourselves about the role of Christians in advocacy. Is God commanding us to speak up to those with power and influence whose actions or inactions result in the suffering of the oppressed and exploited?

A sense of responsibility for serving the poor and speaking up regarding the underlying injustices that caused, maintained, and deepened their poverty characterised many Christians in the 18th and 19th century. They were motivated and sustained by their faith in Christ and their experience of his protection and guidance in their work. Some of their names are still familiar to Western Christians. John Newton and William Wilberforce were well-known for their campaigning against the transatlantic slave trade. Elizabeth Fry worked on behalf of women prisoners and their children and for prison reform. Sojourner Truth risked her life to advocate for the abolition of slavery and for the rights of African Americans and women. Lord Shaftesbury fought for proper treatment of the mentally ill and to replace child labour with education. Harriet Tubman escaped slavery and spent the rest of her life leading hundreds of slaves to freedom and fighting for abolition. Charles Finney, an American pastor and evangelist, stood against racism and slavery and for women's rights.

In the late 19th and early 20th century, however, evangelical leaders in the USA and the UK separated evangelism from social action and social justice, a change that has been coined 'The Great Reversal'. This was apparently due to concerns that liberal theology had created a social gospel that denied the need for personal repentance and faith. However, the change in perspective fitted conveniently with a more individualistic approach that tended to focus more on personal morality and less on responsibility for our neighbour, ignoring the reality of social evil.

Over the past fifty years, there has been a renewed awareness of a responsibility for social action and social justice among evangelical Christians in Western nations. This has been expressed in consensus documents such as the *Lausanne Covenant* (1974),[1] *An Evangelical Commitment to Simple Lifestyle* (1980),[2] *Transformation: the Church in Response to Human Need* (1983),[3] and the *Micah Global Declaration on Integral Mission* (2001).[4]

As Tim Chester writes in *Justice, Mercy and Humility: Integral Mission and the Poor*:

> *Work among the poor must embrace work on the causes of their poverty. Often these causes have to do with structural injustice and the abuse of power. Poverty is a product of marginalisation and oppression. It is the result of oppression. This should be no surprise to those with a biblical doctrine of sin, for sin is deep and pervasive. It is both personal and structural… we are discovering afresh the Bible's condemnation of social injustice and its call to speak up for the oppressed*.[5]

The Bible's teaching as the basis for advocacy

It is impossible to read the Bible without a sense of responsibility to the poor and disadvantaged. The New Testament writers take for granted a knowledge of the Old Testament. Here, God commanded his people Israel throughout their history to defend, protect and support the poor,

the orphan, the widow and the stranger.[6] Those who oppress and exploit the vulnerable or show indifference to their suffering are under his judgement.[7]

Those who belong to Christ, whether Jew or Gentile, are no longer under the Old Testament ceremonial law but are still under the moral law.[8] Jesus commanded his disciples to do good, and the New Testament writers constantly remind their readers of this.[9] Love always delights and rejoices in truth and justice.[10] God's people who have influence are specifically commanded to speak out on behalf of the voiceless.[11] They should not be surprised when their concern for the disadvantaged makes them unpopular.[12]

Personal discipleship to Christ as the foundation of advocacy

The letter of James, the brother of Jesus, causes us to reflect on our own lives and how we respond to poverty, discrimination, and oppression. Our awareness of our own need for a Saviour, our commitment to Jesus Christ as Lord, our own vulnerability and pain, and our confidence in his coming Kingdom enables us to have a distinctive approach to the evil and suffering in our world.

Response to God's Word

We must humbly accept the Word of God, which rescues us from self-righteous, hypocritical anger. We must constantly loath and repent of our own sin, especially of evil and foolish words which make our claim to be a Christian worthless.[13]

Reality of faith

We must demonstrate the genuineness of our faith and our wisdom by giving humble, practical help and comfort to those in need. We need to be striving for peace, being teachable, considerate, and impartial, refusing to align ourselves with godlessness.[14]

Repentance from self-interest

Not all complaint is correct in God's eyes. Fighting our own corner, envy, nationalistic or ethnic pride, the pursuit of power and prestige are all demonic and bring disorder.[15] God will judge a grumbling, complaining attitude[16] and any lack of integrity or transparency.[17]

Rest and trust in God in your own suffering

When we ourselves suffer, are oppressed, or exploited, we are to demonstrate patience, determination, and contentment. We should be looking forward to Jesus' return, confident in the Lord's compassion and mercy, prayerful, thankful and living in supportive and honest fellowship.[18]

Riches are a danger

The Bible's words are uncomfortable for those of us who have wealth. We can easily be presumptuous, self-confident and arrogant.[19] God is not blind to the exploitation of the poor that sustains our lifestyles.[20] Favouring or showing partiality towards those with wealth, power and influence in our lives and churches will incur his wrath. We must not lord it over others.[21]

The *Micah Declaration* states that:

> *Too often the church has pursued wealth, success, status and influence. Advocacy presents us with a subtle form of this temptation. We must beware lest influence becomes an end in itself. We are advocates for and with the poor. And to stand with the poor is to stand with the marginalised and despised.*[22]

Tim Chester writes:

> *CB Samuel told the [Micah] consultation: "If you choose to be irrelevant, you are not out of touch. You are where most of the world is. The poor of the world are not relevant. When we become the scum of the earth we become what the poor already are". We follow a Lord who exercised his lordship through service, whose strength lay in his weakness, whose glory was revealed in his shame, whose triumph was won through his defeat…We subvert the claims of the powerful in the name of our servant King…We have no greater influence than when we come [in prayer] before the God of the universe.*[23]

Summary

As Christians, we are called by the name of Christ. We are children of God our Father who are filled with his Holy Spirit. We are to have his heart for those who are poor, vulnerable and oppressed, to speak for others while not being surprised when we ourselves suffer and are excluded in this world. It is because we fear the Lord that we serve and speak up for our fellow human beings with courage and love, acknowledging and repenting of any ways in which our own lifestyle or actions contribute to their suffering, identifying with them rather than being ignorant or indifferent to their plight. We do not seek worldly influence or power but rejoice in the expectation that when Christ returns, the meek will inherit the earth.[24]

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MICRO-ADVOCACY

Introduction

Advocacy at government level – 'macro-advocacy' – is vitally important in working towards the goal of achieving full health potential for all. However, achieving justice in health and healthcare requires support and action across the whole health system.

Although policies and laws provide the enabling structural environment in which services can be designed and delivered, implementation requires commitment from those delivering healthcare at a community level and from individuals and families themselves.

This section of the toolkit will explore the nature of health advocacy at a community and individual level – '*micro-advocacy*'.

The need for micro-advocacy in health and healthcare

Access to safe, effective healthcare is a key determinant of health. Lack of access to healthcare can lead to death and disability. Equally, access to inappropriate healthcare can impact individuals' lives and life chances not only directly, through death and disability, but also indirectly through catastrophic health costs, which can drive whole families into poverty.

Despite the creation of policies and programmes at the international and national level, the benefits of these frequently fail to reach those who need them most. This fact was recognised in the setting of the Sustainable Development Goals. The 193 United Nations Member States pledged to ensure that 'no one would be left behind' and to 'endeavour to reach the furthest behind first'.[1]

A United Nations Development Programme discussion paper on 'What does it mean to leave no one behind?' makes the following claim:

> *People get 'left behind' when they lack the choices and opportunities to participate in, and benefit from, development progress.*[2]

It is helpful to consider the implications of this statement in the context of health and healthcare.

People get 'left behind' in *health and healthcare* when they lack the choices and opportunities to participate in, and benefit from, *healthcare and healthcare progress*.

The following factors put people at risk of being 'left behind':

- Discrimination
- Geography – isolation and distance from facilities
- Governance – poor or unjust governance systems that do not protect individuals
- Socio-economic status
- Health illiteracy
- Shocks and fragility – eg natural disasters and catastrophic health costs

Those who are, or who are at risk of being 'left behind', are often 'without a voice' and powerless to change their situation. Taking and making opportunities for advocacy at a 'micro-level' can change the lives of individuals, families, and whole communities.

Prudent and value-based healthcare

Prudent and value-based healthcare principles are increasingly being applied across the UK in the ongoing development of healthcare systems that meet the changing needs of the UK population.[3]

These principles can form a useful framework for considering health advocacy goals for the poor and marginalised in the UK and globally.

The four principles of prudent healthcare are:

Co-production

- Health professionals and individuals are equal collaborative partners
- Individuals are not passive recipients of care but active co-producers of health

Care for those with the greatest health need first

- In many cases, this involves prioritising care for the poor and marginalised

Do only what is needed and do no harm

- Avoid exploitative, corrupt healthcare which promotes profit over health need

Reduce inappropriate variation through evidence-based approaches

- Effective and cost-effective interventions which are consistent with current guidelines and evidence

Underpinning these four principles is the focus on the individual and '*what matters to them*'. This is a vitally important concept to emphasise in the context of micro-advocacy. The aim is to allow the voice of the individual to be heard, not the voice that the advocate believes is, or should be, the voice of the individual. Drawing alongside and understanding individuals and communities is fundamental to achieving appropriate outcomes in the context of health advocacy.

The principles of prudent and value-based healthcare echo the 1978 Alma Ata Declaration on the importance of primary care:

Essential care; based on practical, scientifically sound and socially acceptable methods and technology; universally accessible to all in their community through their full participation; at affordable cost and geared towards self-reliance and self-determination.[4]

Micro-advocacy geared towards self-reliance

Compassion towards the poor and marginalised in society can drive a tendency to want to 'fix' their problems for them, rather than working with them to facilitate the more difficult journey of finding and applying solutions for themselves. It is well recognised in all areas of community development and individual healthcare that this can lead to dependency, loss of self-worth, and work against the goal of long-term health improvement.

The principles of 'Assets Based Community Development' provide a useful framework to guide the practice of micro health advocacy.

The four key elements of Assets Based Community Development[5] are:

1. Identify and mobilise the capabilities, skills, and resources of the individual and community.
2. As much as possible, look for resources and solutions from within the community and not from outside.
3. Seek to build and rebuild the relationships among local individuals, community leaders, healthcare providers etc.
4. Only bring in outside resources when local resources are insufficient to solve pressing needs.

In the context of health and healthcare, an assets-based approach to advocacy would include the following actions:

- To identify and mobilise existing capabilities, skills, and resources:
  - Support health-promoting practices to avoid illness and promote self-care for minor illnesses, for example
    - Hand-washing, latrine use, drinking clean water, social distancing, mask-wearing etc, etc.
    - Exercise to prevent illness and self-manage existing health problems (for example, pain from osteoarthritis, rehabilitation following a stroke etc.)
    - Homemade oral rehydration solution for the management of diarrhoea
    - Use of malaria bed nets and maintenance of environmental cleanliness

- To identify and access resources and solutions from within the community:
  - Encourage uptake of existing health and healthcare provision – vaccination, feeding programmes, antenatal services etc.
  - Facilitate community mobilisation to support latrine building programmes, provision of clean water sources, road building, self-help groups

- Building relationships with:
  - Community leaders
  - Local allopathic healthcare providers
  - Traditional healers

- Bringing in outside resources only when local options are not available

In the context of micro-advocacy, the primary goal would be to identify the need and empower the community to speak for themselves to bring in appropriate resources to meet that need.

Micro-advocacy in practice

All interactions with individuals in the context of healthcare provision are opportunities to encourage, support, and empower. By supporting individuals to understand and take control of their health and wellbeing, healthcare professionals are facilitating a process of self-reliance and acting as health advocates.

However, there is far greater potential for micro-advocacy at the individual and community level than simply relying on the opportunities created by 'reactive' healthcare. A systematic, planned approach to working with communities can have a far greater impact. A team-based approach where healthcare professionals provide leadership, vision, and training can significantly increase the potential of a single individual to transform the lives of the poor and marginalised in society.

The basic principles include working with communities using 'participatory approaches', a focus on increasing 'health literacy', and facilitating access to existing health and social care services for those who need them.

Participatory approaches

As stated earlier, understanding individuals and communities is fundamental to supporting them in identifying and addressing their health needs. Working with communities using 'participatory' approaches allows the advocate to facilitate the advocacy process by enabling the community to identify problems and solutions for themselves.

A summary table of a selection of methods is given opposite:[6]

TECHNIQUE	METHOD	
Simple, direct observation	Visit, drink tea, walk the paths, talk to community members.	Involve community members in the observation Share observations
Semi-structured interviews	Checklist of questions, but allow answers to emerge through free-flowing conversation	Key informants to include: **Gate-Keepers**: those who decide what new people and new ideas are acceptable to the community **Caretakers**: those to whom people turn when they have problems **News-Catchers**: those who always know what is going on **Brokers**: those who know key people and can get things done
Focus groups	Six to twelve people from a similar background who discuss a topic under the guidance of a trained facilitator	Three helpful questions: ■ What are the problems? ■ Where are the skills and resources within the community to address these problems? ■ What additional resources from outside the community would help to address the problems?
Community mapping	Past, present and future mapping to describe the history and desired future	Issues raised in mapping can be further discussed in focus groups or community meetings and contribute to planning
Seasonal health calendars	Describes seasonal patterns of activities	Useful for planning
Daily activity charts	Describes daily patterns of activities	Gives a powerful picture of community life and raises many ideas for discussion and action

Increasing health literacy

Lack of understanding of basic health messages disempowers and creates opportunities for healthcare exploitation and directly contributes to poor health.

Health teaching at the individual and community level can provide knowledge and skills that prevent disease and enable individuals and communities to choose healthcare appropriately. It supports 'co-production' in health and enables more effective shared decision making in individual health consultations.

Supporting access to existing healthcare facilities

In many cases, the poor and marginalised lack access to healthcare through ignorance of existing services or discrimination based on gender, caste, or religion. An important role of local health workers is to support individuals to directly access services appropriate to their needs.

Many books and online resources give a wealth of practical information on approaches to community development in the context of healthcare and health advocacy. Specific methods, examples and additional references can be found in the book *Setting Up Community Health and Development Programmes* edited by Ted Lankester and Nathan Grills.[7]

Conclusion

In caring for individual patients and their families, health professionals are confronted by health inequalities on a daily basis. Addressing the underlying causes of health inequalities can seem overwhelming in the context of pressing and immediate health needs. However, recognising the potential and opportunity for 'micro-advocacy' as an extension of the clinical role can be a transformative experience for patients and their communities as well as the health professionals themselves.

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MACRO-ADVOCACY

Macro-advocacy: addressing issues at national/international levels

Issues of poverty and injustice are often recognised at a local level through their impact on individuals with whom we come into contact. However, their root cause often lies at a higher level in the political structure. Ignoring the underlying cause is the policy equivalent of treating a patient symptomatically while ignoring the pathological process that is giving rise to the symptoms. Advocacy at a local level is important and may help to improve the situation, especially if it is carried out in close collaboration with the involved community and results in empowerment of that community. However, in most situations, advocacy at a local level will have limited effect, and real change will only come about if the national issues are addressed.

> *Should these biblical values be implemented by a few inspired individuals, or by laws which aim to protect individuals and communities who are 'excluded'?* asked Andrew Tomkins in his CMF Rendle Short Lecture, *...but it is not that one or other is needed, both have a place.*[1]

Some issues, such as climate change, demand an international response. However, advocacy on these issues at the national level is still necessary to ensure that the government engages with the international agreements and implements their recommendations.

Principles of advocacy

The principles of effective advocacy at the macro-level are the same as those for more micro-level advocacy.

1. Identifying the (real) issue

The call to advocacy will arise because an obvious problem comes to your attention. For example, there may be a high incidence of diarrhoeal illness

in a particular village, or the number of girls entering secondary education in a district may be below the national average, or youth unemployment in a shantytown may be over 90 per cent, or refugees in a camp organised by an international NGO refuse vaccination.

The first step is a careful assessment of the situation. This will involve collecting information from a wide range of sources. Obviously, you will need to talk to the leaders of the affected community. However, their assessment should be checked by talking to as wide a range of the other community members as possible. It is also good practice to meet with local authority figures. Who these are will depend on the country's governance structures and may include civil servants, local chiefs, local councillors, or Members of Parliament.

In some cases, the underlying problem may be cultural and be based on local traditions. In other cases, the root cause may be related to national laws and policies and their implementation. The latter may take a variety of forms.

a) There may be no laws or policies relating to the problem. It does not feature in the government agenda.
b) Some clear laws and policies should solve the problem, but they are not being implemented. The failure of implementation may be the result of inadequate resources or may be the result of lower-level officials deliberately ignoring or contravening the policies.
c) The problem is an unintended consequence of the national laws and policies.
d) The national laws and policies are actively responsible for the situation of concern.

Clearly, the strategy for advocacy will vary depending on the underlying cause or causes of the issue.

2. Research and analysis

Reliable information is the most crucial strategy in approaching governments and major NGOs, so thorough research and careful analysis are fundamental to preparing an advocacy campaign. The research may be secondary or 'desk-based' and rely on published material such as government statistics, academic reports and international agreements. It may be primary or 'field research' in which new data is generated by appropriately designed studies of the causes and potential solutions to the issue in question. The data may be quantitative, setting out the exact size of the problem, or qualitative, providing an accurate picture of the issue's impact on people's lives. The analysis must be carried out with integrity, avoiding any exaggeration or special pleading.

The research should address several questions:

a) What is the actual measurable extent of the issue?
b) What impact is the issue having on the affected community and individuals?
c) What factors are giving rise to the issue?
d) At what level are these factors controlled (local, district, province, national)?
e) What is needed to correct or mitigate the problem?
f) Who has the power to take the necessary action, and what type of authority and resources do they possess?
g) Are there other agencies interested in this issue with which we may form a collaborative alliance?
h) Is advocacy the most appropriate response to the issue, or are direct aid or development initiatives more likely to be needed?

It may become apparent that the issue of concern is part of a much larger issue. For example, the failures of the Ministry of Health to deliver an agreed vaccination programme may be part of an overall breakdown of governance within the government. While tackling the larger problem may

be beyond the available resources and expertise, it is still worth taking action on the initially identified issue.

3. Planning

Once a clear and comprehensive understanding of the issue has been formulated, a plan of action can be drawn up. The first step is to define the outcome that you want to achieve. As the old adage has it, 'if you aim at nothing, you are bound to hit it'. The intended outcome should be detailed and precise. You should be able to evaluate it.

Next, you should define the actions that need to be taken to achieve that outcome. These are sometimes referred to as the outputs of the advocacy programme. For example, there is a high level of diarrhoeal illness in a district. Your research has found that the problem is due to the poor quality of the water supply due to a failure of management at the local water purification plant. The outcome of an advocacy programme would be a reduction in the level of diarrhoeal illness. The outputs would be a supply of pure water and a reorganisation of the management of the purification plant. Once this is decided, it is possible to plan the actual activities needed to bring this about.

The first decision is about the type of advocacy most likely to be effective in the cultural and political context. As a general rule, local voices are more likely to be listened to than those of foreigners, but there may be occasions when the advocacy of an outsider who the government recognises as having particular expertise may be effective. It is essential to involve the local partners in this discussion and to act on their advice. In general terms, you must decide whether you will advocate for the community, with the community, or empower the community to be the advocates by providing training and support. In many cases, a combination of these approaches will prove to be the most effective.

Once you have reached agreement on who will do the advocating, the next question is who should be the primary target. Within most democracies, authority is distributed among the legislature, who are responsible for deciding laws and policies, the executive responsible for implementing the laws and policies, and the judiciary responsible for ensuring that the laws and policies are being applied fairly and correctly. If dealing effectively with the issue in question requires some change to the law, the target should be the legislature, which is the body with the power to enact or amend laws. If the issue has arisen because the existing laws have not been implemented or applied, the target should be the executive. If existing laws are being flouted or broken, then the judiciary is the appropriate target.

The situation is more difficult under totalitarian governments who are less likely to respond to reasoned arguments and more likely to meet protest with repression. Nevertheless, make an effort to identify a sympathetic ear within the hierarchy.

Targeting the legislature

When the issue arises from a flaw in the law or a lack of relevant laws, the most appropriate target is the legislature or parliament. There a several possible approaches to targeting the legislature. An effective campaign may use more than one approach:

a) Identity members of the legislature who are sympathetic to the cause that you are promoting. Initial contact can be made with the member who represents your local constituency or with a member who has spoken publicly on the issue. They will be able to identify others who are sympathetic. These members can be encouraged to raise the matter in parliament and supplied with the relevant information supplied by your research.
b) Organise a campaign of letter-writing to all members of the legislature. This involves mobilising many members of the public

and encouraging them to write to or email their own constituency representative. This does require a pre-existing network of people that can be mobilised and is most commonly used by membership organisations comprising individuals who already have an interest in the issue. However, it is a strategy that church networks could also use. This will raise awareness of the issue among the members of parliament and may prime them to support the issue when more actively engaged members raise it.

c) Organise awareness-raising events for members of parliament and send invitations (along with concise briefing materials) to each representative. This is particularly effective if it is linked to major events such as International Women's Day or International Religious Freedom Day.

Targeting the executive

If the fundamental problem is a failure to implement laws and policies that already exist, the target should be the executive, that is, the ministry responsible for the area in question. Where there are overlapping responsibilities, for example, between the Ministry of Health and the ministry with responsibility for the environment, both ministries should be approached. Again, several strategies can be used:

a) Requesting a meeting with the Minister concerned. This is more likely to be granted if you can show a reason why they should listen to you. This may be because of special expertise (either from your own professional background or derived from the research that you have carried out) or because you represent a sufficiently influential group. You may not immediately be granted an audience with the Minister, but you may be offered a meeting with one of the civil servants in the department. This opens the door to presenting the case and potentially starting the process of addressing the issues.

b) Writing an open letter to the Minister concerned. This should be sent to the Minister and at the same time published widely in the media. It helps if prominent members of the community are signatories to the letter.
c) Organising a petition to the Government. Church networks and social media are helpful in this.

When targeting the legislature and the executive, it is helpful to look for 'windows of opportunity'. Elected members are especially prone to listen to public opinion in the period running up to elections. Good advocacy ensures that your side of the debate is clearly heard. Other windows of opportunity relate to high profile news events or international special interest days.

An essential part of the approach to the legislature and executive is the presentation of an authoritative brief on the subject of the advocacy programme. This should include a detailed description of the issue(s) involved, the impact on the population in general and the affected community in particular, and the actions that need to be taken to solve the issue. All of this should be supported by as strong an evidence base as can be developed.

Targeting the judiciary

Where the root cause of an issue appears to be a misapplication of the law or deliberate breaking of the law, the remedy lies with the judiciary. Advocacy in this area is a highly specialised role, and you should seek advice from organisations with relevant expertise.

4. Identifying allies and collaborators

Advocacy at a national level is unlikely to be a solo effort. An essential part of the research phase of advocacy is identifying other organisations with similar viewpoints on the issue in question. Forming alliances with these

organisations will enhance the impact of the message to the target audience and provide additional resources for research and delivery of the message. Forming an alliance around a specific issue does not imply affirmation of all that the other organisation stands for. An excellent example is Care Not Killing, an alliance of organisations with differing world views and objectives, but which are united in their opposition to any alteration in the laws on assisted dying. They have (so far) been successful in their campaign against the legalisation of assisted suicide across the UK.[2]

5. Taking action

Once the plan has been agreed upon, it will need to be implemented. This will require considerable commitment on the part of those individuals tasked with delivering it. It is a task that should not be entered into lightly. Recognising a need is not the same as being called to meet that need, so prayerful thought should be given, preferably with trusted Christian friends, before taking on the task. Once the calling is confirmed, go forward trusting God (Joshua 1:8,9).

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BEFRIENDING THE MEDIA

Reasonable, intelligent, and moral demands have never changed policy on their own. This is because policy is political. Politics is power-based, not evidence-based. In an increasingly digital age, media coverage is an excellent tool for bringing power down from the policymakers to the people. Thus reasonable, intelligent, and moral demands are given power and can change policy. If this sounds overwhelming, don't worry! Not every cause needs huge media attention for decision-makers to take notice and do something. In this section we will take you through identifying and engaging potential media outlets for your cause.

To use media effectively, you must know your target audience to find the best way to reach them. Note that your audience may change depending on the purpose you have for them, even if the cause remains the same. For example, those with political power to vote on a petition to the government may differ from those you hope to contact for stories of lived experience.

Make a good assessment of your next step, who you need to reach to achieve it, and what media outlets those people have contact with. Be honest with yourself about your social reach and consider starting locally. When aiming at a local audience, try to use local data where possible and/or relevant. Engage the local community by asking for their thoughts on the issue and for testimonials. Advocacy is arguably about influencing public opinion as much as it is about influencing policymakers. What might start with a faithful few could grow into a campaign with international voices, but most likely, it will remain a small local movement. Even when advocating for national issues, there can be value in achieving district or regional change before tackling a national policy or practice.

Social media

Social media is a versatile tool that you can use as the foundation of your media presence or simply as a means of disseminating your message. If Facebook, for example, is popular with your audience, then consider setting

up a Facebook page. These are free and can be much easier to manage and update than a website. You can use Facebook groups to grow and direct a community of dedicated people to advocate for the cause. Email lists and WhatsApp groups are also effective for this purpose. Consider if these may be better for your audience. Instagram is also an excellent tool for sharing visual content such as infographics.

One medium is more manageable, but it may also be good to use multiple media depending on the audience's size and type. You can also use social media to disseminate a message. You can harness this by encouraging your current audience to share the messages with their circles on social media. An example can be sharing an event you are organising. Remember that an image, such as a digital flyer, is more likely to be shared than a plain text post. However, if you are going to use plain text, try to keep the message as short as possible. Don't forget to ask people to follow you on social media and share your page with their friends.

Radio and news outlets

This can be a great way to spread a message, especially to those not already engaged with you. Media outlets may be more likely to connect with you if you approach them with the information you want them the share rather than making them do the work. Do not expect them to readily take up your request if all you have to say is 'this is an important issue.' That may be true, but there are probably many important issues competing for their attention, so try to offer a unique or new angle if you can. Your message does not have to be radical. In fact, polarising messages may be better spread on social media than radio or news outlets. Even if you cannot capture the attention of a big station, a small local station may be all that you need to get the message across to potential allies. Local stations are also more likely to work with you more than once. This may mean that instead of using them to promote something like a one-off event, you can use them as a platform to talk about the advocacy issue more

regularly. Radio stations are particularly good for this. If possible, a trusted member of the local community should speak at the interviews. Avoid jargon! Remember that you are speaking to people who may not have heard of you or your cause before. The attitude of a station towards your message may be negative, but do not be discouraged. They are public-facing, so their response may reflect how they think the public will receive the message. By exploring the honest cause for the negative response, you may gain better insight into the barriers to achieving change for your advocacy issue.

Written content

So far, we have discussed multimedia friendly platforms, but we mustn't forget the 'old-school' ways. Newspapers, blogs, and emails can also be used to grow a cause. Advocacy journalism is a fact-based art. Perhaps you can approach a local paper with a proposal. As you would with the news stations, remember to be confident and full of information. Do not approach them with a dissertation or with propaganda.

Start with a brief description of what you want to talk about and why it is important (not just for you but also for the other people you are hoping will read what you write). You could start with a local story for a local newspaper in the local language. If you don't speak the local language, perhaps try to find someone to translate what you write. If you are in an international community, you may find that there are newspapers in multiple languages. Take advantage of that if you can and write in other languages too. Bear in mind that newspapers in different languages may bring a different audience.

The joy of newspapers is that you may not have to write the story yourself. For example, if you invite a friendly reporter to one of your events, they may do the hard work of pitching to a senior and write it for you. The not-so-joyful side of newspapers is the fact that they may not accept your story at all.

Approach this the same way you would any other rejection and consider the factors that lead to that decision. Get some feedback if you can.

Thankfully, you are not at the mercy of newspaper editors when it comes to writing. You could start a blog! This takes some technical know-how, electricity, and an internet connection. But do not fret if you do not have frequent access to the technology. You certainly do not need to have access to a computer for hours on end to write a blog; you could write it out on paper then type it into a WordPress blog page when it is ready. You can generate a mailing list from all of the platforms discussed, but blogs are especially easy because they are designed to do that. With a mailing list, you can identify and mobilise the faithful few who can form or join your advocacy group.

Using calendar holidays

Focused, concentrated, and well-timed pressure may be better than quick attention that gets lost in today's trend-culture. Utilising calendar holidays related to the advocacy issue is a good way to bring possibly hidden issues to the mainstream in a powerful way. For example, having an event to raise awareness of the problems with female genital mutilation on International Women's Day (March 8th) side-steps some psychological barriers and helps capture audience attention. You could use these days to boost uptake of calls to action, such as signing a petition or partaking in a protest. Try to plan follow-up steps that will keep the audience engaged after the calendar holiday. You could advertise a regular event, circulate an advocacy calendar, or direct people to your social media page.

FURTHER READING & RESOURCES

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EVALUATION

Monitoring and evaluation

There are several reasons why planning an advocacy project should include designing the evaluation of the programme from the beginning. It is obviously essential to know if the project has made any difference to the situation it was designed to address. If it has not, then other measures will have to be considered. Useful lessons can be drawn from the outcome to inform future projects, including what approaches were effective and what could be improved upon. Finally, everyone involved in the project, including those who supported it financially and in prayer, must be informed of the outcome.

Planning the evaluation includes ensuring that the aims and outcomes are clearly stated. The SMART approach applies to both. That is, they should be Specific, Measurable, Achievable, Relevant, and Timely. Given this approach, it is then possible to define what the 'success' of the project will look like and set out what the evaluation will measure. The plan for the evaluation should identify the methods that are to be used and who will undertake them. Will it be only the team members, or should it include an external person to act as a 'critical friend'?

The evaluation will be carried out at the end of the project. On the other hand, monitoring should be carried out throughout the life of the project to ensure that it is running efficiently. This will require several questions. For example, are the planned actions being carried out? Are the agreed deadlines being met? Is the income and spending in line with the budget?

Early detection of drift from the project plan allows immediate corrective action to be taken. For a micro project of short duration, this may be all that is needed. For more major projects taking several years, it is good practice to carry out regular formal reviews in addition to the ongoing monitoring. These reviews will consider both process and progress to assess whether any immediate remedial action is needed.

The evaluation methodology is similar to that used for the initial assessment of need (see above). The focus of the analysis is on evidence of effectiveness and the lessons to be learnt. Four questions should be answered.

1. Were the aims achieved?
2. Were the outcomes achieved?
3. Were mistakes made?
4. What good practice was seen?

The objectives can be achieved without achieving the aims. For example, the aim of a project may be to improve child health in a rural area. The primary outcome may have been to place a community health worker in each village. The latter may have happened without any apparent improvement in child health. Further research will be needed to determine why this happened and whether the project plan was deficient. When a project has been successful, it is just as important to work out why this was so that lessons can be learnt for future projects.

The results of the evaluation should be shared with everyone involved in the project, particularly the frontline workers and the prayer supporters.

When advocacy is ineffective

Success is encouraging, but what do you do when the project seems to have made no difference to the people you are trying to help? This is the time for honest and prayerful reflection. It is important to turn to a trusted Christian friend to help with this process to ensure that our thinking is balanced, avoiding the extremes of self-blame and self-excuse. It is also important to remember that God's measures of success and failure are different from ours. In the end, the main question is, 'Was God glorified by our actions?'[1] and the second is, 'Did we show love to our neighbour?'[2]

The first area for reflection is our motives. Why did we become involved with the issue in the first place? Hopefully, it was out of compassion and a sense of justice, but could it have been out of a grudging sense of duty or an arrogant self-belief. Inappropriate motivation will affect our relationships with everyone concerned with the project and can derail it. If this is the case, then we need to repent.

The second area for reflection is our approach. Did we take a purely secular approach to our planning, or did we seek God's wisdom? [3] This goes beyond a token prayer at the beginning of every planning meeting and includes wide consultation with other knowledgeable Christians, especially local Christian leaders who are in touch with the problem. We may need to go back and re-examine the situation.

The third area for reflection is our methods. This is a technical issue, and it would be wise to discuss this with someone experienced in advocacy. Arguably, it might have been better to do this before the project was launched, but hindsight is always easy. It may be worth a new project with different methods.

The fourth area for reflection is the issue itself. The problem may be intractable and beyond the scope of our efforts. Nevertheless, the mere fact that we challenged it is a witness to others that God is concerned with the needs of the poor and disadvantaged and that he is a God of justice. Even if the problem is intractable, it may be possible to mitigate its effects on the people we serve by relief or development programmes. Of course, even intractable problems may finally be overcome by persistent efforts. William Wilberforce campaigned in Parliament for 20 years before the Slave Trade Act of 1807 ended the transatlantic slave trade. Pray for guidance about the next steps.

Finally, we need to remember Peter's exhortation, '*Each of you should use whatever gift you have received to serve others, as faithful stewards of God's grace in its various forms*'. (1 Peter 4:10)

We are to aim for faithfulness, not success.

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TACKLING BARRIERS TO ADVOCACY

Introduction

In the exploratory survey undertaken by CMF and expanded in the light of Global Advocacy Group discussions and experiences, respondents identified several obstacles to advocacy. The survey focused on advocacy work that an expatriate Christian healthcare professional currently resident in a low or middle-income country or repeatedly visiting one or more projects in such countries might undertake. The survey results may also benefit national Christian healthcare professionals who are in a cross-cultural ministry (such as professionals with a middle-class urban background working in a remote rural area or a slum situation, or healthcare professionals working with minority groups, such as refugees, tribal people, or people regarded as 'social outcasts'). The issues raised are directly health-related, healthcare-related, or social justice problems with a health impact.

One pre-condition for effective advocacy is that the aspiring advocate should be sufficiently self-aware of their own preconceived ideas and prejudices, and what this means for their sphere of influence. They need to be aware of how locals might perceive their position before God as a person of relative privilege required to humbly exercise stewardship of resources. This self-awareness will need prayerful meditation, consultation with wise Christian friends, a habit of being observant, and time for reflection.

Politics and law-abiding citizens

The root causes of injustice are often 'political' because they need a response from national or local government. However, when working on a specific issue of injustice, assistance from a broad spectrum of society can be advantageous.

It could be unwise to utilise someone actively engaged in party politics publicly as an influencer. Using other, widely respected, 'influential people' (like faith leaders, professionals, or business people) may be preferable –

particularly leaders known in the community for their integrity and social engagement. When new to an area, one needs to listen to locally knowledgeable informants to choose the prominent people to approach. Beware of over-hasty commitment to any alliance.

In a democratic country like the UK, writing to individual Members of Parliament is a standard technique. However, if it is a matter on which MPs will vote, one should only write to the MP of the constituency where you live (or they will ignore your letter). The same may apply in other countries.

One needs to be courteous:

> *There is a culture in many Western countries that regards it as legitimate to question the motives of all politicians and treat them with cynicism and suspicion. This is very unhelpful, and Christians should make sure that their letters instead reflect the values of the Kingdom of God.*[1]

Antagonising potential allies by rudeness is counter-productive, whether in a letter or an interview, so it is worth taking time (and advice) to compose the message with correct salutations and level of formality, considering the addressee's position.

It can be a good move to provide information to known Christians in positions of authority or influence. Often, however, the best approach is to offer the information to all those in authority in the area of concern to prepare the ground. They may prefer to speak out simply as politicians, administrators, or sympathetic citizens rather than overtly as Christians. Ignorance of existing laws can lead to wasted or misdirected effort. It may be difficult without expert informants to discover all the extant legal aspects of the cause. Making new laws is more likely to be a party-political issue, dependent on who is presently in power. Campaigning for a social justice issue during the time of any local or national election could be unwise. It risks confusing people about one's motives. Advocating for compliance with an existing law can hardly be considered subversive,

so it is safer and more likely to be effective over a shorter period. As far as possible, work for equitable implementation of existing good laws before seeking to change the law. For instance, there may already be disability rights laws that are being ignored. Advocate for their implementation before seeking new legislation.

When resident abroad, Christians are to pray for the welfare of the nation where they live and work; for the good of the people among whom they live. As expatriates living and working in another country, perhaps paying taxes, but without taking citizenship, we may feel we have no right to criticise or try to change the country's laws publicly. We certainly have no right to break the law (even if it is a bad one). But citizens, even in a non-democratic country, have a responsibility to do what is within their power to improve their country's laws and resist injustice.

Sometimes as a foreigner, you can 'see' things which local people appear to miss because you have a wider experience and know it can be different elsewhere. Hence, you might need to draw the attention of acquaintances to the problem tactfully. You might first ask, 'What do you think of this?' before suggesting it is wrong. It may be something they have previously fought for or cried over but had to learn to live with (while accepting that it was not ideal). You have to be humble before the received wisdom of the local community.

Expatriates might have only a short-term presence, and therefore might think in a short-term time scale to tackle problems that have persisted for generations. Take time to become familiar with the people and their problems before trying to change anything. We might try to start something and know we will not be there to see the end result (good or bad).
As Sandra Ng writes for Oxfam America:

> *In the context of international development work, an additional challenge is that most advocacy resources go to making a campaign happen, not to learning from it…we often give inadequate attention to monitoring policy implementation.*[2]

When starting a campaign, one must consider the possible consequences to the individuals engaged in it as well as the intended impact on beneficiaries. If *you* fight a cause publicly and antagonise authorities, you may be sent home, visa cancelled. Or you could choose to go home if things became too difficult. But your local collaborator has to stay and live with the consequences, which may be social opprobrium, loss of income, loss of status, unemployment, or worse. For good reason, you may choose to work through local collaborators, but be fair and warn them in advance that there could be recriminations. The best method might be for you as a foreigner to privately raise awareness of the issue with some sympathetic individuals, offering to support them on their terms if they choose to act.

Sandra Ng states about Oxfam America:

> *...our partners' strategies for advocacy work begin with changing and creating awareness in individual civil society actors. They believe that when these actors are empowered they will become change advocates who then form the movements to influence institutions.*[3]

In some situations, a foreigner or a health professional gets more respect and attention than an 'ordinary' local person, so accompanying a local to the outpatient clinic or a local authority office might help that person gain access to care and services. Using this route, however, could mean indirectly encouraging a discriminatory practice that favours articulate professionals.

Dealing with cultural barriers

This is mainly applicable to foreigners and, to some extent, if one belongs to a minority group in one's own country (which is true for Christians in many nations).

> *When I was working abroad, perhaps the biggest cultural difference between my perception of the social situation around us and that of the*

Christian friends with whom I worked & talked was that I thought of people in terms of individuals and they thought in terms of (extended) families.[4]

One issue with people thinking in community terms, not as individuals, is they may not feel able to make personal decisions or take personal responsibility. This can seem strange to Westerners. If the cultural norm is for the head of the family to determine what is acceptable, you should ensure their approval before a more 'junior' family member is involved in your advocacy. We should look for natural groups (eg relatives, neighbours, work colleagues, a congregation, etc.) rather than individuals to support our advocacy.

Group mentality means shared responsibility and confers a feeling of anonymity. If one person alone puts his head above the parapet, they may be a target. It is, therefore, better to try and work through groups rather than asking individuals to make personal statements. The one who acts as spokesperson (the group's public face) might need to be someone with more security (ie a resilient personality, professional status, secure financial means, or family connections). Do not let a vulnerable person become a target. A younger person or someone from an ethnic minority might be less respected if they were prominent in the advocacy work. Use an existing group if one is available (eg a local club). Failing that, create a 'platform group' rather than working alone. This will ensure you are in line with the cultural norms. A group containing people affected by the advocacy issue and those from unaffected communities is less easily stigmatised or marginalised. Involving majority communities alongside minorities can give the advocacy group greater credibility.

This is also a way to broaden people's experiences. For example, if the initial concern is for people disabled due to leprosy not receiving government benefits, create a group of variously disabled people who can share their differing experiences and jointly represent their own interests. However, watch out for other cultural factors such as appropriate age, ethnicity, and gender mix in the group.

In cultures that give greater importance to the community's welfare than that of the individual, one human life seems to count for little. This may be more pronounced in densely populated countries. In South Asian countries, individual workers are easily replaceable and can appear dispensable. Hence occupational health and factory safety may not be a priority. If one worker is injured, another will be available to come to do their job. People lost in ferry accidents or fires may not seem particularly important to the wider public. This is most likely a cultural and not a religious norm. So, it can be hard (but necessary) to advocate for industrial and public transport safety issues in such societies. In these instances, it could be helpful to investigate whether there is any representative body such as a trade union movement with which you can work.

Another type of cultural barrier can be communication habits. In some cultures, even in the 21st century, there has to be a verbal discussion, preferably face to face, rather than just reading. Drama (in the street, on radio, or TV) might convey messages more effectively than reasoned arguments laid out in pamphlets or newspaper articles. In some cultures, respect for historical authority figures is often greater than in the West, so quoting from the speeches or writings of a great religious leader or a famous poet might be well received. Thoughtful articles may influence some officials in newspapers or magazines, but one needs to know who and what the targeted audience reads in order to submit an appropriate item (in the correct language and style) to a local or national publication. Cross-cultural difficulties are significant but not insurmountable with the Holy Spirit to aid us. '*Pray about which issues to raise, what to say, and then pray that God will use your words*.' [5]

Overcoming/circumventing religious barriers

Religious barriers can occur not only in other faith contexts but also within Christian churches. Historically, this was the case in India, where barriers existed for people affected by leprosy who wanted to go to

church. Muslims could not attend mosque because their feet were bandaged for ulcers and so could not perform the ritual washing before entering. Hindus were forbidden to enter temples because they were Dalits (what used to be called 'untouchables'). In one recorded example, a Parsi patient was buried at a mission hospital, and the family denied permission for ritual exposure of the corpse, as customary in the Zoroastrian religion. Christian ministers sometimes forbade people affected by leprosy to participate in the sacraments. In Nepal, where people with leprosy started many remote village churches, congregations were historically more receptive to converts with the illness. The background of the people who are locally-honoured can influence attitudes.

Vishal Mangalwadi makes a compelling case for the biblical worldview shaping the belief that we can make choices and that our choices can change things. People of other faiths may take a more fatalistic attitude, believing 'this world is as God intended it to be, so I should accept it'. This has real consequences for how communities and individuals respond to crises and injustice. [6]

If you can overcome the hurdle of convincing people that it is worthwhile trying to change things, you can often find good allies in people of other faiths. They, too, want to see people live healthy lives. Islam teaches the equality of all believers (a kind of brotherhood) rather than a hierarchy as in Hinduism, so cooperative community effort is potentially more familiar. One aspect to stress is the shared welfare interest, which usually has no theological connotations. Challenging authority may be more difficult within a society with established caste structures, such as some Hindu communities. Win over the influential members of the community first. Work on the common ground between you and a person of another faith to advocate for issues affecting you both. There have been many examples of sympathetic Muslim preachers using Friday prayers to disseminate public health messages.

Lack of allies

It may often feel it is a lone battle, but even if no one is physically with you, you may gain 'moral support' from friends far away. Any Christian friend in any part of the world can pray for your work. Feed your friends at home with information as you study the problem which God has put on your heart. Be ready to align yourself with other organisations which have similar goals (other faith groups or secular), even if your organisation cannot do so because of its constitution or reputation, etc. Look widely for organisations with overlapping interests. If there are none in your area, consider linking up through individual visits or correspondence to organisations doing similar work elsewhere. National faith-based organisations such as a Christian hospitals' association, or networks of secular NGOs, may achieve far more than individual institutions or groups if they jointly approach a government department or the district administration.

Scatter seeds. Talk often in casual conversation about your cause, whenever you are with people who might conceivably be interested and ask them questions to increase your knowledge and challenge them to think about it. They may become allies or suggest others who will. Write to local newspapers with information – you never know who might read it. Leave a book about the matter at the public library or college. Accept invitations to speak anywhere, and if you are shy to give an address, suggest an interview (you can tell the interviewer in advance what they should ask you). You might take an affected person into the interview with you to express their opinion (anonymously if necessary). Be a catalyst, if not an agent of change.

Lack of resources

When working in resource-poor settings and working with or through poorly-resourced agencies and individuals, be aware of people being more susceptible to inducements because of poverty. People may appear to

respond eagerly to your enthusiasm, but later, you may discover they were anticipating your friendship would lead to employment in the campaign.

Poorer people (whether earning daily wages or living off subsistence agriculture) may not have much free time to spend on unpaid voluntary work (including travel to meetings) because of long hours, little or no holidays and ongoing household responsibilities. In addition, there may be no cultural tradition of 'volunteering', so people may not understand that you are actually promoting a cause only because you believe in it and not because you are paid to do so.

People willing to give time might not have the other material resources to support their voluntary work, such as access to stationery, a printer, car, smartphone, or phone credit, etc. Therefore, we need to be sensitive and offer support if possible. People may not have space in their homes for meetings, so hiring rooms might be necessary. Andrew Tomkins reminded his listeners at the CMF Rendle Short lecture in 2016 to '*Put more emphasis on planning for logistics, communications, and sustainability than you do in the UK*'.[7]

Utilise local knowledge and facts to illustrate topics. People may have a geographically-limited life experience and may not think or talk much about national and world affairs. Rather than saying 'did you know there are 3,000 cases of leprosy diagnosed per year in this country and 10 per cent are already disabled' consider 'in our own district, last year 80 people were found to have leprosy, and eight of them were already suffering permanent damage to their bodies'.

Opportunities to speak out publicly on matters of health and justice often arise in connection with various 'International Days'. The local government authorities may already be sponsoring a procession, rally or cultural event (such as a children's art competition) for World Health Day, International Women's Day or International Day of People with Disabilities. They will often be glad of a volunteer to speak or people to carry banners. The local radio station may be marking the day with invited speakers or a 'phone in'.

Accept any such invitation. This is a relatively inexpensive and highly visible way to publicise one's cause. However, be careful about translation. Use someone who shares your views as a translator or interpreter if you cannot speak the national or local language well. Go through the material in advance to decide on suitable vocabulary in the local language.

One of the cheapest and most sustainable ways to strengthen advocacy is by modelling the behaviour you want to encourage. One way to do this is by demonstrating in your words and actions the inclusiveness, generosity, respect, and solidarity you want to see shown towards people suffering social injustice. In one example, at a leprosy conference held in a fancy hotel, the management tried to refuse entry for people with leprosy. Some guests, already allocated rooms, refused to stay if the others were not admitted. Such action can be quite powerful.

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ADVOCACY STORIES

Illustrative examples of advocacy

Refugee Tales (registered charity in the UK)[1]

Outline of issue:
Campaigning to end indefinite detention in immigration removal centres, they amplify and disseminate the voices of people with lived experience of detention.

Good features of a model which might be copied:

- A public-facing campaign focusing on a single issue (eg end indefinite detention), but supporters are provided with information on wider aspects of the welfare of detainees. Detainees are mostly, but not all, asylum-seekers.
- Individuals (ex-detainees) who would like their stories to be heard may have poor English, do not have access to channels for publicising their stories, and may need to remain anonymous. So, they each tell it to a writer who reproduces it in effective prose or poetry, keeping factually and emotionally faithful to the original tale. Tales are collected in books to be sold, posted on websites, and read aloud in public meetings.

Nepal Leprosy Trust (registered as local NGO in Nepal)[2]

Outline of issue:
Community groups introducing change in Nepal

Good features of a model which might be copied:

- An agency of a mission hospital established several community groups. The agency simply introduced the members to each other and the group idea. They facilitated skills development (literacy, group management, networking etc.), then left the group to choose the issues and how to tackle them.

- Groups were originally composed of and for people disabled by leprosy. Once they had discovered their own ability to bring about change in their own lives, they began to notice the unmet needs of others in the local villages and campaigned for them too.
- Mixing people with similar disabilities from different causes within the groups works well (for instance, those with mobility impairments, whether from leprosy, trauma, spina bifida, tuberculosis of the spine etc.). This can also help the wider community to identify with those in the group.

Advocacy for Empowerment Project (AEP), a project within TLMI Bangladesh (part of an international Christian NGO)[3]

Outline of issue:
Changing public attitude towards people affected by leprosy.

Good features of a model which might be copied:
Using journalists to disseminate messages in their own words, the NGO ran a workshop for journalists and shared information about leprosy in Bangladesh. They included the stories of affected people. They then challenged the participants to write this up. A prize is given annually for the best published or broadcast article.

Open Doors World Watch List, working for persecuted Christians overseas[4]

Outline of issue:
Working to support persecuted Christians overseas.

Good features of a model which might be copied:
Open Doors publicly launch their annual report on the global persecution of Christians at Westminster each year. They invite many MPs, journalists

and the wider public to participate in the event. They give very specific and feasible suggestions for actions that MPs can take in response to the issues and needs raised.

Brother Andrew, representative of Open Doors[5]

Outline of issue:
Discrimination against Christians.

Good features of a model which might be copied:
Through a contact, a visiting Christian leader was able to go with a local pastor to meet a member of the government in an Arab country with a strongly Muslim culture. They were able to ask for him to use his influence to redress the unjust treatment of national Christians. This incident is described in *Secret Believers*, a book by Brother Andrew.

Saskawa Memorial Leprosy Foundation
(Japanese charitable foundation)[6]

Outline of issue:
Trying to reduce stigmatisation of people affected by leprosy worldwide.

Good features of a model which might be copied:
Each year, the foundation produces a manifesto based on the UN declaration of rights and gets signatures from influential people (including businesspeople, sociologists, Nobel prize winners, politicians etc.) who agree to support the cause The public launch is held on World Leprosy Day, with reporters present. The foundation then distributes copies widely (printed and digital) to key people in endemic countries, such as Ministers of Health or Prime Ministers.

POhWER, A British non-profit society providing trained Independent Mental Health Advocates [7]

(POhWER provides advice and advocacy services to people who suffers from mental health issues, learning and physical disabilities).

Outline of issue:
Some mentally ill people detained under the Mental Health Act cannot speak up for themselves or even access their rights under the law.

Good features of a model which might be copied:
The Independent Mental Health Advocates listen to the patient to understand and then relay their views and preferences. The advocates are not advancing any specific interest but presenting the patient opinion lucidly wherever needed (eg at a hospital managers' hearing to review their detention or in a multi-disciplinary meeting about future accommodation). This is strictly personal advocacy by lay people (they are not lawyers but might request on the patient's behalf to retain a lawyer, if appropriate).

Some examples of micro-advocacy taken from a Community Health Worker (CHW) programme in India [8]

EXAMPLE ONE

Outline of issue:
People are often powerless in the face of the healthcare system in India. There is a focus on hospital care. Long term follow-up and issues related to rehabilitation and return to function are often ignored - particularly for those who cannot pay.

Good features of a model which might be copied:
A Community Health Worker (CHW) is a 'health advocate'. In the example described below, the CHW focused on accessing a simple intervention that

would change a young boy's life. The barriers to access were knowledge and finance. The CHW made the family aware of the potential for a prosthetic limb and mobilised the community to raise the funding to provide it.

The story

A 17-year-old boy from a low-income family in a village in Maharashtra had his leg amputated following an accident. After his discharge from the hospital, he believed he would never walk again and that his life was, effectively, over. He became withdrawn and depressed. A Community Health Worker visited the home and realised that he needed a prosthetic limb. The family were not in a position to pay and felt powerless to help. However, the Community Health Worker spoke with the village leader, who mobilised the village community to support the family to have the artificial limb fitted. Within 25 days, he had the limb fitted and had begun to learn to walk again. He was able to resume his studies with renewed hope for his future.

EXAMPLE TWO

Outline of issue:
Equitable access to Covid vaccination is an issue of global importance. The poor and marginalised lack the literacy and technical skills to operate online booking systems. In addition, there are many false beliefs about the vaccine that deter people from taking the vaccine.

Good features of a model which might be copied:
The role of a Community Health Worker as a health advocate is vital during the global pandemic. Supporting individuals to overcome barriers to taking the vaccine is vital for national and global vaccination strategy.

The story

A Community Health Worker in Gujarat, North India, taught in a village about Coronavirus, how to prevent spread, and the importance of vaccination. A 45-year-old woman approached her to ask about the vaccine.

She was overweight and diabetic. The Community Health Worker recognised that she was at risk of becoming seriously ill if she contracted COVID-19 and advised her to request a vaccine at the local government vaccination centre. The lady returned the next day upset as she had been refused a free vaccination on the basis of being under the age of 50. She was unable to afford to pay for a vaccine in a private hospital. The Community Health Worker was aware that 'high risk' groups were also eligible for free vaccination, so she made further enquiries on behalf of the lady. She discovered from the Government Village Health Nurse (VHN) that 'at risk' individuals under the age of 50 needed to fill in a specific form to apply for a free vaccine. This would have been impossible for the lady to do on her own. However, the Community Health Worker and the VHN completed and submitted the form on her behalf, and she was thrilled to receive her first dose of the Covid vaccine free of charge at the vaccination centre.

EXAMPLE THREE

Outline of issue: Lack of access to clean water is a barrier to health in many poor and marginalised communities. Government schemes may not be implemented, and communities lack the knowledge and power to lobby for improved access to clean water and sanitation.

Good features of a model which might be copied:
Community Health Workers work as advocates for whole communities supporting initiatives that support health-promoting behaviours – for example, provision of clean water.

The story

The setting is a very small hamlet at Kotba in Chhattisgarh, North India, with a population of about 250. There are no basic amenities such as roads, clean water, a health centre, a school etc. Most of the village people are illiterate. Due to poverty, many of their children do not go to school.

Instead, their hunger pushes them to go for work in the fields. Since most of them are landless labourers, they end up working in other villager's fields. Their work depends upon the monsoon. During the monsoon season, as rain flows through the fields, it looks clean for them. Thus, these people use flowing water in the fields to drink and cook. The people of this village often suffer from vomiting and diarrhoea.

A Community Health Worker visited the hamlet and started to teach them how to find clean water resources and use them. While teaching the lesson, they listened carefully. They then interrupted angrily, saying that the village's entire population depends upon only one damaged hand pump (a borewell). They did not have enough money to repair it and do not know how to approach the government authorities or office for help. The villagers asked the Community Health Worker to help repair the hand pump.

The Community Health Worker went directly went to the boring department mechanic and explained the situation. The boring department mechanic immediately provided four hand pumps. However, the Community Health Worker felt that was insufficient, so he went to the Panchayat (local Government) secretary, who provided Rs.5,000 to repair the old hand pump. So, five hand pumps were provided in total.

The Community Health Worker gave further health teaching, including how to prepare Oral Rehydration Solution (ORS) if diarrhoea did occur. The work of the Community Health Worker as a health advocate improved the health and life chances of the whole community.

Doctors of the World (registered charity in the UK)[9]

Outline of issue:
Migrants' access to healthcare in the UK and particularly in England has been hindered since 2015 by several UK Government policies as part of a 'hostile environment' towards those with insecure immigration status.

Doctors of the World run a clinic in London for those who are having difficulty accessing primary care. They advocate for improved access to healthcare for all, particularly migrants.

Good features of a model which might be copied:
Use of research and their patients' experiences to produce:

1. Resources and training for healthcare staff so they can advocate on behalf of individual patients facing barriers to healthcare.

2. Evidence for meetings with government ministers, contributions to parliamentary committees and responses to public consultations by the government.

In addition, they collaborated with other charities or coalitions such as the Stop Sharing campaign and Hands Up for our Health. This included promoting petitions for the public to sign, using social media hashtags such as *#PatientsNotPassports* and obtaining supportive statements by healthcare organisations such as the British Medical Association and the Royal Colleges.

Ethical Procurement for Health – an example from the BMA

The British Medical Association (BMA) set up its Fair Medical Trade programme in 2007 to promote research and advocacy in ethical procurement of goods and services for the UK NHS.

The project can be summarised as follows:

> *The NHS spends in excess of £40 billion on the procurement of goods and services every year. The market for such commodities is global and is increasingly outsourced to minimise costs. Unfortunately, there is evidence that such outsourcing harms fundamental labour rights and consequently the health of populations elsewhere.*

Ethical procurement is about the overall sourcing practices of purchasing organisations - such as NHS Providers. It looks at the steps they take to ensure the maintenance of employment conditions and workers' rights in line with internationally recognised conventions and local laws in the supply chains of the products and services they procure.

This includes working with companies throughout the supply chain to help their workers to access fundamental rights such as:

- *The right to safe and decent working conditions*
- *To be paid at least the legal minimum wage*
- *To join and form unions so they can bargain collectively for their rights*
- *The elimination of child labour*

It is paradoxical to provide healthcare using goods and services that may harm health because they fail to protect fundamental labour rights. However, because the levels of spend are so high in healthcare, the medical community also has the capacity to change this and impact global trade and, consequently, global health significantly.

The above is taken from *Fair Medical Trade* (*bma.org.uk*)

Although the BMA is a large organisation, much of the impetus behind this project has come from ordinary members raising concerns over ethical procurement. It is a good example of how sustained advocacy from individuals working within larger organisations can bring about significant change.

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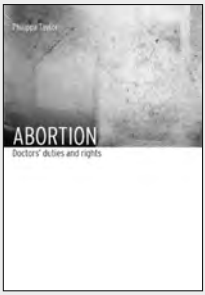

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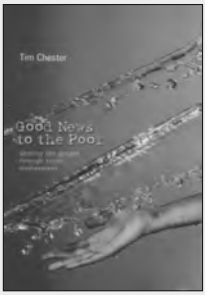

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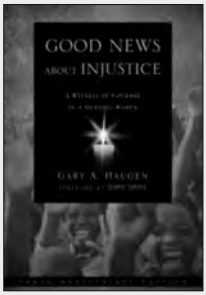

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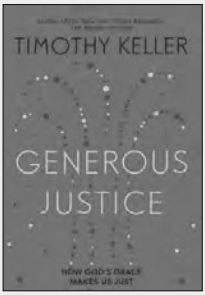

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THE ADVOCACY JOURNEY

ENGAGING IN ADVOCACY FOR GLOBAL HEALTH

Giving the best healthcare can also mean addressing the social, economic, cultural, and political factors that affect people's health and access to healthcare. Race, gender, language, politics, and religion can all limit access to the resources necessary for good health in different communities.

How do we address these barriers to health effectively? How can we best advocate for health in the UK and globally as Christian health professionals?

This practical guide to healthcare advocacy is written by CMF members working in different health and healthcare advocacy fields. It looks at the biblical imperative to speak up alongside the poor and marginalised, and at the practical realities of advocacy.

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