

**KENYA CIVIL SOCIETY CAPACITY DEVELOPMENT TRAINING: POLICY ADVOCACY,
EVIDENCE BASED ADVOCACY (USE OF RESEARCH) AND EFFECTIVE COMMUNICATION**

26-28 June, 2018; Mash Park Hotel, NAIROBI

TRAINING REPORT



*Prepared by: MeTA Kenya
Health Action International (HAI)
Health Systems Advocacy Partnership (HSAP)
P O Box 66054-00800
Nairobi-Kenya*

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1. INTRODUCTION

1.1 Background

MeTA Kenya which is implementing the Health Systems Advocacy Partnership (HSAP) organized its first capacity building training on policy advocacy, evidence based advocacy (the use of evidence) and how to effectively communicate using evidence. This training brought together 25 local Civil Society Organizations (CSOs) working in 11 counties in Kenya, these are: Nairobi, Meru, Homabay, Siaya, Kisumu, Busia, Bungoma, Kakamega, Narok, Elgeyo Marakwet and Nandi counties. Kenya has a devolved system of government and thereby has 47 county governments; one of the devolved functions is health. These CSOs represented organizations working on Sexual Reproductive Health, anti Female Genital Mutilation (FGM), LBGTIQ rights, HIV & AIDS and women empowerment programs for incoming generation.

The three-day Advocacy training focused on Sexual and Reproductive Health Commodities, and how local Civil Society Organizations (CSOs) capacity can be increased to effectively advocate for increased affordability and availability of SRH commodities in the counties within which they work. The training also aimed to capacitate the CSO's to be able to design, conduct, and evaluate advocacy campaigns that would support implementation of both new and existing SRHR policies. Community-based advocacy is a crucial intervention, needed to equip grassroots groups, networks, and organizations with the requisite skills to also empower communities to demand for the rights and specifically the highest attainable sexual reproductive health rights. The three-day training took participants through the essential steps in undertaking an effective advocacy campaign.

The training was facilitated by Multi-track consultants who are experts in the field of policy advocacy and who have facilitated various training workshops for many none profit organizations. Ms Eve Odette who is a member of the Access to Medicines Platform Executive Committee and an advocacy guru presented perspectives on Policy Advocacy and use of evidence in effective advocacy.



Other presenters were: Dorothy Okemo the MeTA Kenya Coordinator who gave opening remarks by making two presentations. One on the work of MeTA Kenya and the thinking behind engagement with local CSOs whose capacity is sufficiently built to effectively advocate as MeTA Kenya partners in various counties. Robert Athewa was also present during the opening and gave remarks on the HSAP project in Kenya. He gave opening remarks on behalf of the other partners indicating the work that Amref was doing with community health workers and issues of HRH specifically looking at implementation of the Collective Bargaining Agreement (CBA) with doctors to ensure retention of health Human Resources for Health.

On day one there was one other presentation by Mary Magubo a member of MeTA Kenya Council and Advocacy Coordinator at the Reproductive Maternal Health Services Unit (RMHSU) of the Ministry of Health (MoH). Mary chaired a highly interactive session where she presented the findings of a national study undertaken by the Ministry of Health on “the Confidential Enquiry into Maternal Deaths”.

The second day saw an equally interactive presentation made by Angela Nguku, Executive Director of The White Ribbon Alliance on SRHR perspectives and specifically on “Engaging with the youth and adolescents in SRHC-Addressing the ever increasing teenage pregnancy”.

On day three there was a case study presentation by Kevin Mwangi of The Kenya Legal and Research Network (KELIN). He presented a legal perspective of the motion and opportunities for advocacy.

The motion was tabled at the Kisumu County Assembly with the aim of shutting down organizations working on LGBTI,

1.2 Training Objectives

- To equip participants with skills and knowledge and each of the steps necessary for an effective policy advocacy campaign and integrate Advocacy into SRH advocacy partners’ work.
- To provide basic skills and practical tools in advocacy to SRH partners.
- To build capacity of participants on how to use evidence to advocate to various target audiences e.g. policy makers, communities and the media.
- To give the participants an introduction in measuring success (of an effective advocacy campaigns
- To clarify for the participants the difference between Advocacy, Lobbying Behavioural Communication Change and Activism and when each is effective.

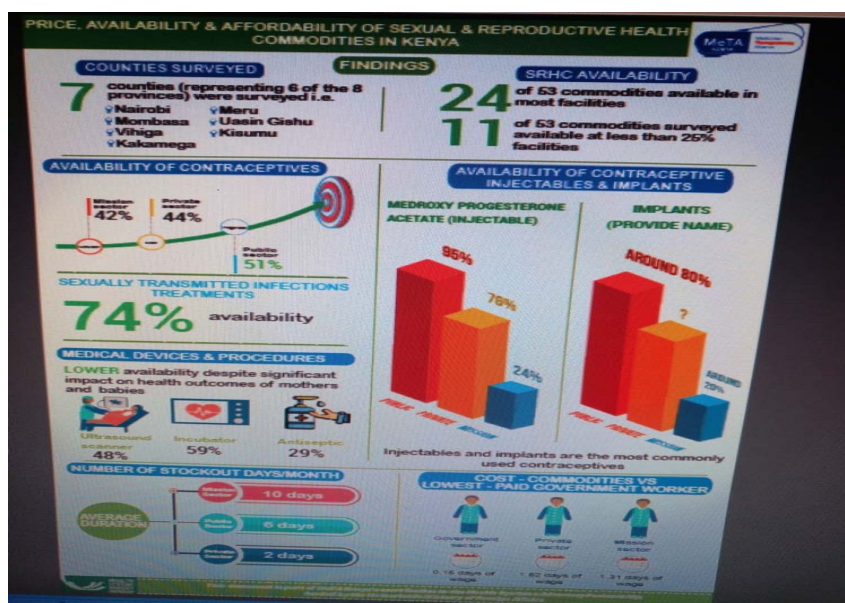
2. Training overview and opening remarks

2.1 Remarks and presentation by the MeTA Kenya Coordinator

Ms. Okemo welcomed the participants and appreciated the fact that each and every single one of the participants who were selected came for the training and checked in the previous day as per plan. She added that she had received an overwhelming number of applications for the training and only the 25 CSOs in the room had been successfully shortlisted.

She wished the participants good deliberations and hoped that the three day training will increase their knowledge and capacity to engage with the various groups of people with whom they advocate with. She then went into making her presentations. The first was a power point presentation on both MeTA and an overview of the SRHC research that was conducted in 2017, this gave the participant perspectives on what MeTA Kenya was and the work they did in Kenya as well as a synopsis of the research and key findings. On MeTA Kenya she noted that this was HAI's implementing partner in Kenya of the Health Systems Advocacy Partnership (HSAP). HSAP is strategic Partnership comprises of five organizations namely (AMREF Health Africa, The African Centre for Global Health and Social Transformation (ACHEST), Health Action International (HAI), WEMOS Foundation and is funded by the Dutch Ministry for Foreign Trade and Development Cooperation. Together the HSA Partnership contributes to ensure equitable access to high quality SRHR services by strengthening health systems so that improved maternal and child health outcomes are achieved despite social and political challenges.

The second presentation was the full report of the SRHC study including the findings and recommendations and the areas of advocacy for local CSOs from the respective counties, this was in an effort to set the stage and provide perspectives that would be explored during the group sessions especially on the sessions on use of evidence for advocacy and communication. She noted that the study was supported by HAI through MeTA Kenya to measure the availability, affordability of sexual and reproductive health commodities in Kenya. Data was collected from 44 public health facilities, 42 private health facilities and 34 mission based health facilities all totalling to 120 health facilities.



The report focused on issues affecting access to SRHC (contraceptives, maternal and child commodities, SRH antibiotics and devices which represented the list of 53 commodities that were surveyed. This list she noted was arrived at by looking at various WHO, UN lists and it therefore was a very inclusive and essential list for SRH commodities. This research showed that availability of SRHC is low in Kenya, as only 46% of the commodities were available in the facilities. Availability across the sectors was similar, with highest availability in the public sector (51%).

Moreover, 20% of the commodities researched were available at only a quarter of the facilities, while an average of only 45% of commodities were available at more than half of the facilities.

Some of the key recommendations included:

- Improving the supply chain.
 - Efficient and accurate delivery.
 - Move to a 'pull system' of SRHC stock ordering.
- Providing (continued) training for staff.
- Providing client and community education on SRH and services. Staff sensitisation and continued education is needed to ensure clients feel comfortable in accessing SRH services at facilities.
- Improving access to SRH services is the pharmacy chain. A sub-optimal pharmacy chain leads to problems with availability and stock-outs of the commodities. To improve the pharmacy chain, SRHC should be accurately ordered, the delivery should be efficient, accurate and timely. The pull systems should be encouraged to support this.

3. Training Sessions

3.1 Participant expectations

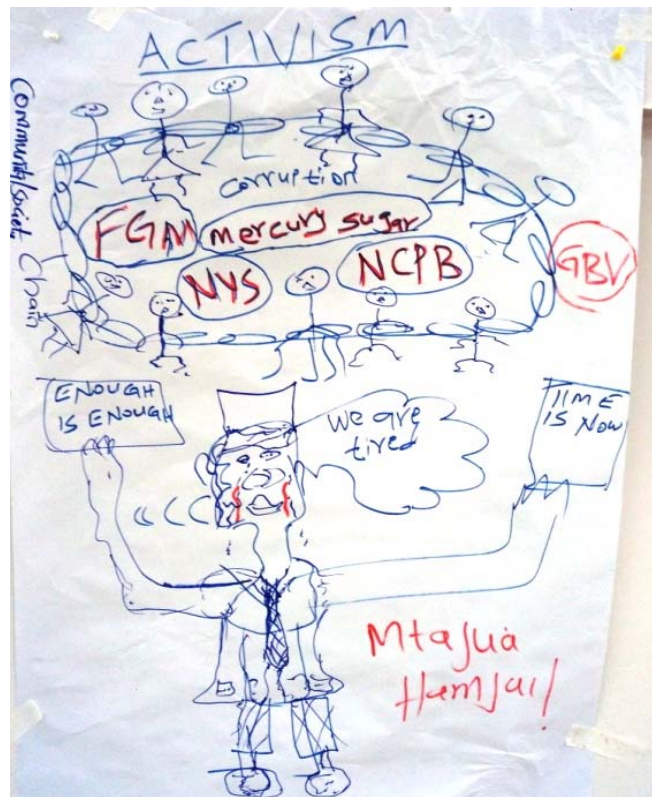
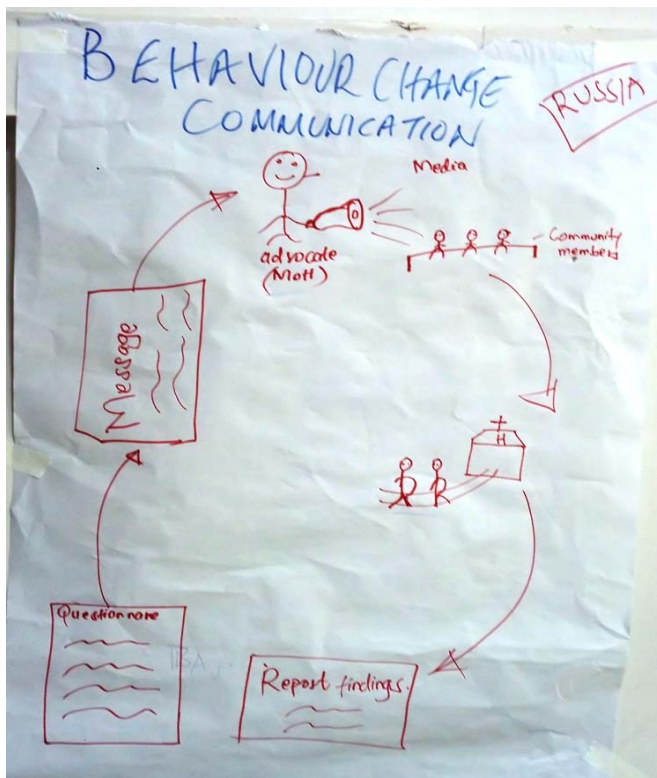
The participants shared their expectations of what they expected to learn from the training which were quite ambitious and outlined below:

1. Advocacy and use technology against FGM
2. Knowledge on skills based advocacy
3. Rights of girl child with respect to SRHR and at what age they should be involved
4. How to write a policy brief
5. Resource mobilization for advocacy
6. How to be an effective advocacy agent
7. How to rally stakeholders for advocacy
8. Family Planning is a taboo in some communities- approaches managing this at community level
9. How to influence the public and government on SRH
10. How Collaborative partners can work together under the platform
11. How to effectively communicate and engage different stakeholders
12. Effective advocacy strategies at grassroot level
13. How policies influence advocacy and impact of the same
14. How to do advocacy in a more effective and efficient way
15. Communication tools to effectively advocate for effective change
16. Develop an effective advocacy message
17. How to use advocacy to ensure proper implementation of legislation
18. How to develop an advocacy plan

19. How knowledge, attitude and practice inform advocacy

3.2 Setting the agenda: Access to Medicines Platform Executive Committee Member (Eve Odette)

As a guru in advocacy, Ms Odette was best placed to set the agenda for the 3 day training for CSOs. She pointed out that it was important for CSOs to be cognisant of the fact the differences between Advocacy, Lobbying, Behaviour Change and Activism. She divided the participants into four groups representing the different football teams at the world cup and mandated them to make a poster presentation of each of the four methods of interaction, after which each group presented to the whole team and she reinforced the differences between these four.

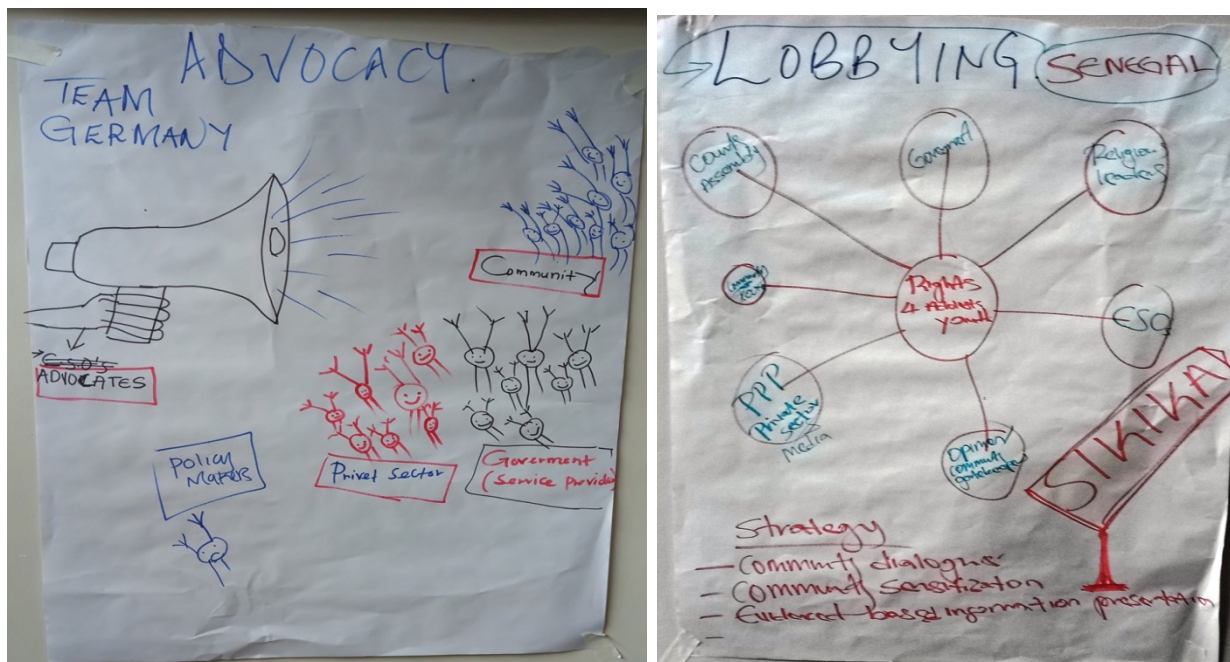


Participant poster presentations

She added that:

1. Behaviour change required the use of champions or role models
2. Lobbying could be done one on one, within a group of select people, based on an issue of interest or around a cause to influence change. This is used mainly when there is an exchange or use of undue influence
3. The difference between Lobbying and advocacy was that advocacy is about rights /public interest while lobbying is mainly driven by personal or private interest
4. Advocacy usually targets decision maker to effective policy change or policy implementation

5. Advocacy addresses policy: target policy makers: enactment, review, implementation, change (laws/legislation/guidelines and /budgets and requires political will).



Poster presentation by participants

Presentation by Mary Magubo- Advocacy and Communication Coordinator Reproductive Maternal Health Services Unit of the Ministry of Health: “Confidential Enquiry into Maternal Deaths survey”

Ms Magubo commenced her presentation sharing the national guideline for Maternal and Perinatal Deaths (MPDSR) which is a continuous surveillance that links the health information system and quality improvement processes from local to national levels. It includes the routine identification, notification, quantification and determination of causes and avoidance of all maternal deaths. It works by utilising this information to respond with actions what will prevent future deaths and taking actions to eliminate preventable maternal deaths while Implementing the Global Strategy for Women’s and Children’s Health.

The study was commissioned to collect data and prepare a report that would recommend actions to take to eliminate preventable maternal deaths especially while looking at the statistics that indicate that approximately 8000 women die due to pregnancy related complications in Kenya every year The report further interrogated the quality of care provided at every level of care and the underlying causes of death in health care facilities.

The other objectives of the study was to document the burden of maternal and perinatal deaths, to gain understanding of the health system failures that lead to maternal and perinatal deaths, to raise awareness among health professionals, administrators, programme managers, policy makers, community members

avoidable factors in the facilities and communities and last but not least stimulate action to address avoidable factors thereby preventing future maternal and perinatal deaths.

The statistics she presented were astonishing indicating that previously only 19% of maternal deaths had been reported in the DHIS system. 8.9% of the deaths were of girls below the age of 20 years; 23.1% was death of women between the ages of 20-24 years, 27.5% of deaths were of women between the ages of 25-29 years, 21.5% of deaths for women between the ages of 30-34 years; 12.6% of deaths for women between the ages of 35-39 years, 4.3% deaths for women between ages 40-44; 0.4% deaths for women above 45 years of age and no records for 1.7% of the deaths.

In terms of parity, 20.9% of the deaths were for first time mothers, 21.5% of deaths were women who have given birth once before; 15.3% for women with 2 children; 14.5% for women with 3 children; 7.2% for women with 4 children; 14% for women with 5 plus children and 6% no records were available for these percentage.

She added that in terms of period of death, 43.4% of the deaths occurred during week day out of office hours; 29.5% during weekends and 26.7% during weekdays during working hours. The participants inquired to find out what the reason for this could be, Ms Magubo indicated that there might be a need to do a follow up study to establish the reasons but speculatively the reason could be related to issues of lack of accessibility to health facilities during weekday out of office hours. Furthermore the report indicated that there was limited proportion of ANC tests performed an indicator of the high maternal deaths with percentage of blood sugar tests conducted being a paltry 3.1% stool test at 4.4.%, malaria at 9.2% and 22.3% for Urinalysis. With gestational diabetes and pre-eclampsia being one of the highest causes of death, the low testing during anti-natal clinics meant no diagnosis of preventable and manageable conditions.

The highest deaths were also recorded among those women who were attended to by Medical Officers, followed by those attended to by midwives, followed by those attended to by Gynaecologists, unskilled attendant and finally clinical officers. Speculative reasons for this also pointed to issues of accessibility as by the time the women were referred to the level 3-5 that has medical officers and doctors, it was too late to save the mother's life. This ties in to the statistic indicating that 42.6% of the deaths occurred in level 4 facilities; 19.8% in level 3 facilities; 18.2% in private/FBO run facilities; 9.9% in level 5 facilities, 8.3% in level 2 facilities and just 1.2% in level 1 facilities.

While delving further into her report she indicated that in terms of statistics for the timing of the deaths; 37.4% of deaths occurred during the postpartum period; 21% not specific; 18.4% during intra-partum period; 14% after 28 weeks and undelivered while 8.3% before 28 weeks gestation

The report indicated the causes of maternal death as 39.7% obstetric haemorrhage; 19.8% non obstetric complications; 15.3% hypertensive disorders in pregnancy; 9.7% for pregnancy related infections; 8.3% for pregnancies with abortive outcome; 2.7% for other obstetric complications; 2.5% for unknown and undetermined causes; 1.9% for unanticipated complications of management and 0.2% as a result of direct

deaths without an obstetric code. One of the shocking statistics was that of an adolescent mother who was having her 4th pregnancy.

In conclusion the report indicated that the identified gaps in care included incorrect management with correct diagnosis, infrequent monitoring, prolonged abnormal observation without action, incorrect diagnosis and delay in referral especially level 3. Some of the recommendations included capacity building, retention and mentorship of healthcare workers, proper data capture and documentation, provision of a minimum ANC/PNC package, strengthening of community units, using up-to-date treatment protocols, expansion of diagnostic services and enacting policy and legislation for CEMD. The study was made possible through UKaid, UNFPA and LSTM Centre for Maternal and Newborn Health.

The participants while discussing noted how the indicators also tied in to the earlier presentation made on SRH Commodities and the recommendations thereof. After a very stimulating discussion and setting the pace of the SRH landscape the facilitator continued with the session on issues identification and setting.

3.3 What is Advocacy and Issue setting

The facilitator gave the participants the simplest meaning of advocacy which she noted was a set of targeted actions that seek to bring about change in the attitudes, practices, policies and laws of influential individuals, groups, and institutions. It is directed towards informing and persuading decision-makers to take action on a specific issue. She further noted that the basis of advocacy was that it was:

- Rights based.
- Goal oriented- there is a desired end result.
- Evidence-based
- Relevant to the context- should fit the social, cultural, political, and legal context of the society.
- Timely.
- Should involve others- constituents and allies.

Understanding the issue:

Understanding the issue requires one to research history and rationale for public policy and understand causes of the issue, gathering evidence of the impact of the issue if unresolved and considering possible solutions and research implications. Also required is to map out decision making processes for the specific issue and current opinions and attitudes of decision makers targeted for advocacy.



The first step in advocacy was issue identification and understanding the issue; this is the problem or situation that an advocacy group seeks to address. The participants in their groups identified the issues that they were dealing with in their respective county blocks as outlined below

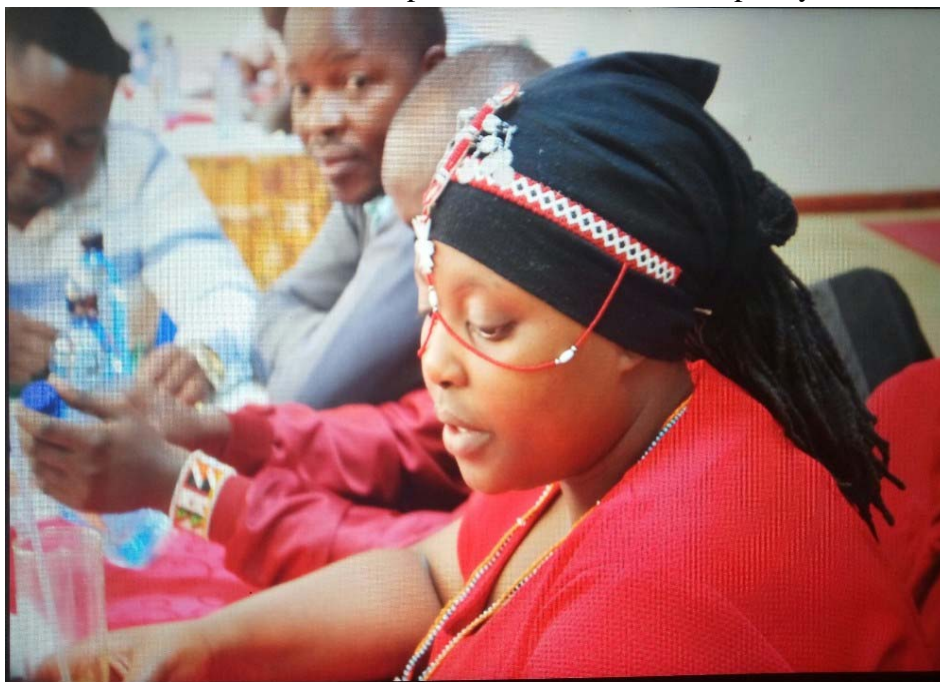
GROUP 1: MERU

- defilement (sexual act with a minor)
- enabling environment for youths to access contraceptives
- lack of legal/policy structures for age appropriate CSE
- Male chauvinism-decision makers
- Lack of youth friendly contraceptives

GROUP 2: NAROK

- Increased allocations for SRH commodities/ sector- to address the issue of teenage pregnancies
- Advocacy messages on social accountability- public to hold office bearers to account (community engagement)
- Awareness creation on maternal deaths- all stakeholders/ public awareness-community (ignorance-action taken by governments to provide enough funds for awareness creation for demand creation-govt of Narok to raise and commit resources for awareness raising

- Advocate for the review and implementation of the SRH policy



GROUP 3: KISUMU, HOMABAY, SIAYA

- HIV/STIs (LGBTIQ)-discrimination and lack of commodities for key populations: lubricants, female condoms, PREP and PEP- parliament bill tabled to stop providing services to LGBTIQ- big hanging fruit emerging issue for advocacy- bill for case study
- Teenage pregnancies, lack of education on FP – reduced demand and access- youth friendly centres/ access to and use of condoms (quality)
- Neglect of maternal health cases affecting pregnant, unborn and new borns (STIs, drug users-affect unborn child,
- Increase availability of community education-change behaviour and improve indicator

GROUP 4: BUSIA, BUNGOMA, VIHIGA

- High rate of teenage pregnancies-lack of FP commodities/ where available they are inaccessible to the youth- stock-outs/personnel unfriendly
- High rate of new HIV infections among the youth due to lack of accessibility
- Teen pregnancies- parents do not talk or mentor the youth-lack of information/not aware/cant access

GROUP 5: KERICHO, ELGEYO MARAKWET

- Prevalent teenage pregnancy rates, high fertility rates/ lack of youth friendly services
- Lack of prioritization of FP commodities in budgetary allocations
- Lack of information of FP commodities for women or reproductive age- no knowledge of method mix

- Formulation and implementation of policies- exclusion of youth in leadership and governance (in agenda setting and not just public participation).
- Accessibility and availability of youth friendly family planning commodities: attitudes, no youth friendly services.

The day's session closed with the participants presenting the discussions they had had in their groups to identify and set the issues for advocacy as they related to their county needs taking in to consideration the two presentations that had been made so far.

3.4 Advocacy Goals and Objectives

The next session of the training focused on setting advocacy goals and objectives keeping in mind that: An advocacy goal is a long-term result and is the impact change that is desired.

- An advocacy objective is the short-term target (one to two years) that contributes towards the goal and is the outcome change that is desired.
- A policy objective would be looking at what policy actions, pronouncements, or government programs do we want to see and what specifically are we asking for? Whom do we want to take action?
- An advocacy objective can be achieved by the organization or network alone- own resources, energy and action and its success can be measured easily.
- The outcome objective must be SMART, clear about the policy actor or decision-maker; policy action or decision, and timeliness and degree of change that is desired.

In their groups the participants presented the objectives as shown below:

GROUP	OBJECTIVE PRESENTED
KERICHO & ELGEYO MARAKWET	<ul style="list-style-type: none"> • Chair of health committee approves guidelines on youth participation in agenda setting policy formulation and implementation in Kericho county's health sector by September 2018
WESTERN	<ul style="list-style-type: none"> • Chair of the health committee in Bungoma county to approve a proposal to increase budget allocations for HIV awareness creation prevention by September 2018
NAROK	<ul style="list-style-type: none"> • Reduce teenage pregnancy from 40% to 18% by the year 2020. • The county director of education to issue a circular to all heads teachers for girls to be retained in school and readmitted back after delivery by September 2018 • The county commissioner to enforce implementation of

	the circular through public administration
NYANZA	<ul style="list-style-type: none"> • The chair of the legal committee to withdraw the unconstitutional bill tabled in Kisumu county assembly by August 2018 • The county RH coordinator to influence sex education to adolescents and implementation of youth friendly centers in the counties by December 2018



The Team from Meru County brainstorming on their goals and objectives

3.5 Advocacy Message development

The facilitator while taking the participants through the message development session informed them that the process of designing messages should always take into account the objectives of planned advocacy campaign, the target audiences and also the availability of resources. If your objective is to obtain support from key policy makers and influential people, one may have to consider the following factors to run a successful campaign:-

- Define measure and deliver tangible results to show how your campaign will make progress
- Articulate clearly the impact that your advocacy message can have on the issue
- Show intricately what is being accomplished with the optimization of resources
- Be specific about possible outcomes when explaining your plan of action on the issue and emphasizing how these actions will tackle the issues menace directly
- Posses a crisp clear definition of the issues control that can be easily deciphered by the public as well as policy makers.

Once objectives have been defined and target audiences have been mapped out, the next step will be developing the specific message. The facilitator indicated that the message one makes will determine how your audiences is receptive to the message.

Identification of the decision maker: was a sub topic incorporated in the advocacy message development session. While developing a message one needs to know key decision makers at all levels. The session focused on mapping power and influence by determining who can make change happen, who can make the decision and who has influence are all useful to know to effectively package your message. The key steps in identifying the determining the message are; a) Identify the decision maker b) conducting a thorough backgrounder on him/her and check if he has made any statement for or against the issue you want to address.

The message should demonstrate the problem/issue and propose a solution based on facts or evidence. It also needs to be credible, clear, compelling, concise, consistent and convincing, simple, persuasive and incorporating a direct call to action. It is also important for one to emphasize the urgency and high priority of the recommended actions. For effective message delivery one should choose effective spokes people who are credible, eloquent and convincing communicators.

Presentation by Angela Nguku, Executive Director White Ribbon Alliance (WRA) on engaging with the youth and adolescents in SRHR-Addressing the ever increasing teenage pregnancy”

Ms Nguku commenced by defining who a youth was and by the United Nations definition a youth is person aged between 15-24 years, however the Kenyan constitution defines youth as a person between the ages of 18-35 years. Adolescent are persons between the ages of 10-19. Her presentation drew concern to adolescent and it highlighted that young people as defined by the Kenyan constitution accounted for 78% of the Kenyan population.

Youth aged 15-24 years accounted for an estimated 35% of new HIV infections among ages 15+ years; and that in 2015, there were an estimated 1.8 million adolescents aged 10-19 years living with HIV.

In relation to teenage pregnancy the presentation highlighted that complications in pregnancy and childbirth were the leading cause of death for 15-19 year-old girls globally in 2015.

This again tied in very well to the earlier presentations that had been made by the MeTA Kenya Coordinator and the Ministry of Health representative.

While presenting the Reproductive health outcomes she informed the participants that 16 million adolescent girls between the ages of 15 and 19 became mothers every year. Poor sexual and reproductive health outcomes are even worse in sub Saharan Africa where the prevalence of teenage pregnancies is high, health care systems are weak with inequities existing between the urban and rural communities. To bring it closer home she shared statistics that 1 out of every 4 girls in Kenya aged between 15-19 years is a mother or pregnant with her first child. Teenage pregnancy is highest in Narok County at 40%; Homabay 33%, west pokot 29%, Nyamira and Tana River at 28% and lowest in Nyeri at 7%. 13,000 adolescents drop out of school every year as a result of pregnancy

Some of the challenges, limitations and obstacles of addressing teenage pregnancy in Kenya include: poor and ineffective enforcement of existing legal frameworks to address harmful cultural practices such as early and forced child marriage, female genital mutilation (FGM) and gender-based violence (GBV), Low

prioritizations in Adolescent sexual reproductive health investments and minimal Translation of policies and commitments into implementation strategies to include adolescents are some of the obstacles the facilitator mentioned that challenged the curbing of the increasing high rate of teenage pregnancy. More to these obstacles is that the existing adolescent programmes are not effectively implemented or adequately evaluated to build evidence on efficacy as well as cost effectiveness

On the consequences of teenage pregnancies, the facilitator shared that Adolescent pregnancy is associated with higher rates of morbidity and mortality for both the mother and infant. An increase in maternal mortality and low birth weight are the major adverse outcomes of adolescent pregnancies. Teenage mothers are at greater risk of socioeconomic disadvantage throughout their lives than those who delay childbearing until they complete their education. Other consequences include:-unsafe abortion, sexually transmitted infections (STIs) including HIV and AIDS which may lead to deaths or long term disabilities. In concluding her presentation, she indicated that to curb the ever rising teenage pregnancy would a multi-sectoral approach effort. Actions are needed from each of the sector levels and adolescents too have a key role to play.

The participants who work in both Narok and Homabay counties agreed with these statistics and added that one of the biggest factors of high teenage pregnancies was the cultural factor.

3.6 Advocacy tools (media, policy brief)

The facilitator indicated that generally media exist to tell or sell a story that is news worthy to its consumers. To effectively undertake advocacy activities, one of the avenue may be the use of various media to communicate an issue especially for the reason that key decision makers pay attention to the media and this could easily influence them to support a cause.

The facilitated in a discussion with participants named the various forms of media including traditional media and new electronic media.

Traditional media comprises of print media magazines, journals, newsletters, newspapers, radio, television and new forms of media include social media platforms like, blogs, facebook, twitter and instagram. A discussion ensued as she asked participants on which social media platforms they are conversant with and which were best suited for highlighting issues. Facebook, twitter and instagram were noted to three of the most used online media platforms even by organizations promoting their services or

Amongst media tools that an advocacy campaign can use include holding a press conference, issuing a press release, writing media statements, media interviews and conducting editorial board meetings. It was emphasized that while all the presentations made presented good information that could be used for advocacy, one may still need to package the information in a manner that the media will pick on the key salient points to cover. Giving the media a full report of a study may lead to a misreporting or misrepresentation of the facts.

Day 3 starting with a case study presentation of a petition that had been filed at the county assembly of Kisumu which is passed threatened the existence and operations of organizations working on LGBTIQ issues.

Case Study presentation of the legal implication of a motion tabled in the Kisumu County assembly on withdrawal of licences of business permits for organizations promoting pornography by Kevin Mwangi of KELIN.

While the motion talked about organizations promoting pornography the content of the motion was specifically targeting LGBTIQ communities and organizations. In his legal assessment of the motion, Kevin reiterated that:

- The issue of homosexuality is explicitly outlined in the laws under section 162 of the penal code.
- Only the PBO Act of 2013 is mandated to register or deregister not for profit organizations in Kenya and in the interim this role is co-shared with the NGO Coordinating Board as the PBO act has not been operationalized yet.
- Under the fourth schedule of the constitution among the areas that have been devolved include...Control of drugs and pornography” which would explain why the motion was drafted in a manner to look like it was directed at pornography.
- There has been precedence set in judicial rulings that have protected the rights of LGBTIQ communities notably:
 - C O L & another v Resident Magistrate - Kwale Court & 4 others [2016] Eklr
 - Petition 150 of 2016; Eric Gitari v Attorney General & another [2016] eKLR
 - Petition 440 of 2013

In summary, Kevin noted that there were issues for advocacy in the motion and encouraged the participants from Kisumu county to use the knowledge from the training to come up with a good advocacy plan that will educate, inform and empower the members of the county assembly to better understand not only their mandate but also the issues affecting LGBTIQ communities.

3.7 Evidence for Advocacy: how to undertake a research

While introducing the role of evidence in advocacy, the facilitator indicated that research had various benefits including:

- Understanding why an issue is a problem to our constituents.
- Understanding the scale & impact of the issue
- Understanding the history & rationale for current public policy; understanding the position of decision-makers
- Understanding how changing laws and programs / lack of action undermines rights
- Frame issue in clear language
- Be able to communicate issue effectively

She further reiterated the factors to consider when identifying a research issue especially if the findings and recommendations will be used for advocacy.

These are:

- What is important to our constituents?
- Number of individuals affected (breadth)?
- How are they affected (depth)?
- Priority areas for Government?
- Chances of advocacy success?

The first step is to structure your research by defining the problem then identifying, who else is interested, summarizing what you already know and filling in the gaps. There are two main research techniques i.e. primary research and secondary research. Secondary research includes getting information from other CSO reports, studies done by International organizations, Media reports, research institutions and government sources. While primary research includes: surveys face to face/telephone interviews, different stakeholder groups and focus group discussion. When commissioning a research one needs to develop clear Terms of Reference (ToRs), provide clarity about experience & expertise required, provide clarity about evaluation criteria, have the skill of writing quality reports – basis to prepare a compelling case and be able to interpret the results and review of research reports (feedback to consultants).

Once a research is conducted then it is important to package into policy briefs, press release, policy statement, infographic or policy position paper depending on the audience and intended purpose.

3.8 Essentials of writing a policy position paper

The facilitator delved into the 101 of writing a position paper by giving a step by step format to make it easier for the participants to develop one after the training. She described a policy position paper as a written explanation of one's policy position, with the objective of:

- Communicate, clearly and concisely, the position taken by your organization
- Influence policy makers, ideally to act on an issue or a situation.

When writing a policy position paper, provide a summary: which is an opening paragraph which goes straight to the point, summarizing the issue and the recommendation(s). Indicate the issue by providing a statement of the issue and explaining the issue, using relevant data and statistics. Give a history: if there is a public policy already in place and explain the policy.

Identify the stakeholders who have an interest in the issue and describe the (potential) impact of current (or proposed) public policy. Provide policy options: List possible options, and make recommendations on the best options giving specifics on which is preferred and providing justification for the choice. Finally as much as possible, include citations as footnotes to demonstrate supporting evidence including citing your own, more detailed, research report.

She emphasized that it was important to have a follow up mechanism to celebrate and measure success, these include: publishing of press releases, monitoring progress of a policy intervention, thanking your allies and building on new areas of action.

3.9 Action Planning

The last exercise of the training was around action planning. The facilitator explained that action plans are simple lists of all of the tasks that one needs to undertake in order to meet an objective by focusing on achieving a single goal. Action Plans are useful, because they give you a framework for thinking about how a project can be effectively undertaken. The help to prioritize actions and make sure that implementing of the action plan is systematic and deliberate. The participants then went into their groups using the knowledge they had gained over the past 3 days to develop their county action plans for advocacy as summarized below:

NYANZA

- Dialogues with Reproductive Health (RH) Coordinators to prioritize youth friendly services and age appropriate Comprehensive Sexuality Education (CSE)
- Meetings with key decision makers to sensitize them on the county specific HAI SRHC study findings (County Director of Health (CDH); County Commissioner for Health (CEC); Reproductive Health Coordinator (RHC))
- Sensitive Members of the County Assembly (MCAs) on LBGTIQ (bill dismissed)

WESTERN

Chairman increase budget allocation for HIV awareness

- Develop budget proposal (monthly VCT visits, budget allocation and expenditure)
- Meet with committee on health



The teams from Kisumu, Western and Rift Valley developing their action plans

NAROK

The County Director of education to issue a circular to retain pregnant teenage girls in school until delivery and to readmit (skilled staff, knowledge of landscape). Increased performance and transition of girls from primary to secondary school through:

- Conduct baseline survey
- Inform / sensitize key stakeholder/ hold meetings (teachers etc
- Monitoring implementation of circular

Bottlenecks to achieving this include:

- Inadequate funds for mobilization
- Beurocracy within organizations
- Political conflicts/influence
- Organization structure
- SOP of the organizations

ELGEYO MARAKWET

County Governor issues public statement on the importance of women giving birth in hospital to speak at all forums on importance of mothers taking advantage of skilled delivery (more CHVs to go to the village to talk to mothers) improve uptake of skilled delivery

- Policy brief on stats on maternal health
- One on one meetings with the County Governor
- Organize forum with other CSOs in Elgeyo Marakwet county

Challenges: young organization, need capacity building on health, inadequate resources for advocacy funding and time/ accessing real time data on MH indicators

- Human resources working on MH, access to governor and deputy governor/ active CSOs, working CHVs

KERICHO

Chair issues guidelines on inclusion of youth in agenda setting, implementation etc

- Funding / capacity building youthful health workers/ real time data for advocacy/ how many youth attended to in health facilities
- Established structures with county governments/ newly acquired skills on advocacy/ good working relations with professional bodies- nurses, Kenya Medical Practitioners and Dentists Union (KMPDU)
- Conduct survey on youth in leadership position

- Develop guidelines on youth participation in health agenda setting
- Guidelines, survey report , meeting reports
- Number of youths in decision making levels

4. Closing Remarks

The participants gave a vote of thanks and were very impressed with the level of training, materials provided and the co-facilitator's who made the various presentations. They all agreed to stay engaged and use all the knowledge they had acquired as well as share any success stories arising from how they are able to use the training on policy advocacy. The participants then filled out the post training questionnaires which would help to assess the level of competence before and after the training.

In her closing remarks, the MeTA Kenya Coordinator thanked the participants for not only applying for this training but for remaining attentive and active throughout this 3 day session. She noted that this team was very engaged and great CSO allies when engaging on advocacy at the county level. She emphasized that the training was not a one off but was the first in a series of interactions that we will be focusing on as part of our objectives of increasing CSO capacity to effectively advocate for SRHC & SRHR. While concluding, she further informed the participants that:

- MeTA Kenya will continue to share all research findings, briefs, and infographics to facilitate the joint advocacy efforts
- Another training would be held next year and consideration will be made based on the proposals made in the post questionnaire to agree on relevant topics for capacity development.
- MeTA Kenya would share all presentations made at this training for follow up actions by the participants including the final training report
- As requested by the participants find a way to customize findings from individual counties where surveys were conducted to personalized advocacy interventions by the CSOs from different counties.



Group Photo at the end of the 3 day training

5. Workshop Evaluation

5.1 Pre and Post Training Evaluation

Participants took pre and post evaluations to gauge the increase in basic understanding of advocacy prior and after the training. Here is a summary of the results

At pre-training, majority of the 24 participants, nearly 80 % **defined advocacy** as to include:

- Making citizens aware of what is of benefit to them
- Informing people of what concerns them
- Engaging community members
- Safeguarding/defending the rights of communities/peoples
- Helping people to defend their rights
- Sharing information internally

The post training saw increased and accurate understanding of advocacy. Majority of the participants cited:

- Helps influence change/ a medium through which social change is achieved
- Creates awareness for community members/ address need for positive change
- Addresses systemic issues
- It is directed towards informing and persuading decision makers to take action on a specific issue
- Influences decision making on a cause pertaining policy for public interest
- Advocacy helps to influence implementation of policies and safe guard the rights of citizens
- Advocacy drives change on issues
- Advocacy brings stakeholders together

On whom to involve in advocacy, there was a 50/50 understanding among participants. The suggestions included the following at pre-training: CSO, Local authorities, community members, youth, adolescents, persons living with HIV, human rights groups, opinion leaders, stakeholders.

This categorization was more refined and consistent to stakeholder groups including some of the above mentioned, plus media.

The participant understanding of **the benefits of research** was generally well versed both pre and post evaluation. The suggestions included to inform programme approaches, generate new knowledge, create good understanding of an issue and identify new way of doing things.

Advocacy tactics were not clear to majority of the participants at the beginning. Suggestions tended to be varied and quite mixed up. In particular, suggested concepts included behaviour change activities, community dialogue, public relations, trainings, knowledge dissemination and investment conferences.

The post training evaluation revealed a better understanding of the concepts including- media engagement, influencing, policy meetings, writing policy briefs.

Prior to the training, participants tended to be mixed up on the difference between advocacy, lobbying, activism and Behaviour change activities. After the training, this seemed very clear, with an impressive 90% of the responses reporting accurately.

At the beginning, there seemed to be confusion among nearly 95% of the participants on the difference between **outcome and impact change**. This greatly improved at the end of the training with participants scoring accurately against the outcome and impact indicators that were provided in the questionnaire.

5.2 Feedback from participants

a) Proposals for topics for future trainings

- How to use technology for advocacy, media engagement
- Networking and collaboration
- Practically developing policy briefs
- Budget process: tracking and analysis and conducting social audits
- Proposal writing for SRH programmes
- Research
- Public speaking: engaging with policy makers
- M&E for social accountability
- Social accountability
- Gender inclusivity
- Rights based approaches
- M&E for SRH programs implementation

b) Feedback on course content and facilitators/presenters

- The presentations were well structured and well versed with knowledge on topics
- Spendid!
- The presentations given were very informative, clear and concise. A lot of knowledge gained
- High knowledge in advocacy
- The training should be done for more days

c) Rating of facilities and amenities

10	9	8	7	6	5	4	3	2	1
7 scores	4 scores	3 scores	2 score	2 scores	0	0	1	0	0

d) Training facilitators rating

10	9	8	7	6	5	4	3	2	1
9 scores	4 scores	6 scores	1	0	0	0	0	0	0

ANNEXES

1. Training Program
2. List of Participants

TRAINING PARTICIPANTS

	NAME OF PARTICIPANT	ORGANISATION & DESIGNATION	CONTACT DETAILS	COUNTY OF ORIGIN
1	SARUNI E SIMPAI	Program Coordinator Community Health Partners (CHP) Ewaso Ngiro-Narok Kenya Sanitation and Hygiene Improvement Program (k-ship)	MOBILE: +254726422758/+254780422758 email: saruni.simpai@chp.or.ke / sarunisimpai91@gmail.com	Narok
2	KIBET COLLINS	Socially Organized Educative Team (SOET)	collinskibet3@gmail.com www.soet.or.ke	BUNGOMA Kapsokwony
3	CHEPKIRUI HILDAH	The Centre for Community empowerment and Development (CECED)	chepkiruihildah@rocketmail.com cecedorg@gmail.com	KERICHO
4	ERIC OCHIENG OWINO	Family Life Program Busia	0722116778 Ochiow10@gmail.com	BUSIA
5	KEVIN MWANGI	Programme Associate Kenya Legal and Ethical Issues Network (KELIN)	kmwangi@kelinkenya.org	NAIROBI
6	NASERIAN KIRROKOR	The Nomad Child Foundation	nomadchild@mail.com naserian80@yahoo.com	NAROK, KAJIADO, LAIKIPIA, ISIOLO, SAMBURU
7	JACK MACHAKI	NACCSNET	Jack.machaki@gmail.com	
8	EVANSON SAITOTI	Partners in Action	evasaitoti@gmail.com 0710229302	NAROK
9	TIMOTHY KIPRONO	Elgeyo Marakwet	kipronotc@gmail.com	NANDI
10.	JANET MWANZA	Girl Redefine	0721643504 Janetmwende01@gmail.com	NAROK WEST
11	HENRY LIMEIN	Silan Foundation	silanfound@gmail.com	NAROK
12	CATHERINE KIMAREN MOOTIAN	AfyaAfrika	0727068747 catetito@yahoo.com	NAROK
13	KENNEDY SHONDO	Mental Health Integrated Program	shiherakennedy@gmail.com	VIHIGA
14	BREANIAH ANYANGO	Local Initiatives Development Agency	breaniahashley@gmail.com or lidakenyaorg@gmail.com 0714495554	KISUMU
15	DOUGLAS ONYANGO OTIENO	Tinada Youth Organization	0724018799 infotinadayouth@gmail.com or roydouglas88@gmail.com	KISUMU,
16	OMONDI OLIECH	Livero Consortium Community Based Organization	liveroconsortium@yahoo.com	KISUMU
17	JAPHETH ODONDI	Programs Coordinator National Youth Forum	aincyouthdept@gmail.com	VIHIGA

		of African Israel Nineveh Church (NYFA)		
18	PHLIX OMOLO	Community Advocacy Coordinator- Young Advocates Community Integrated Program YACOP	0720818748 youngadvocates@gmail.com	KISUMU
19	JAPHETH OUKO ODONGO	Director- Family Support for Sustainable Development	0723551971, oukojapheth1@gmail.com	KISUMU
20	BERYL MORAA	Days for Girls- Ugunja	moraaberyl@gmail.com	SIAYA
21	GEORGINA ADHIAMBO	voices of women in western kenya	Cell: +254 700 264 827,+254 736 970 904 Email: geoginaa@yahoo.com , vowwek@gmail.com	KISUMU
22	CAROLINE JEPCHUMBA	Action Africa Help- International	cjepchumba@actionafricahelp.org Tel: 0722207726 or 0713257709	NAROK WEST, KAGUMA, TURKANA COUNTIES
23	FREDERICK ODHIAMBO	CIFORD	cifordmeru@yahoo.com	MERU/ TIGANIA EAST, IGEMBE/IMENTI
24	AILEEN KANANA	RIPPLES INTERNATIONAL	advocacy@ripplesintl.or.ke P.O Box 1236- 60200 Meru Kenya Tel Cell: +254 724 098 986/254 734 948 077	MERU
25	WIRY ASIGE	NAROK INTERGRATED DEVELOPMENT PROGRAM	Wiry.asige@adssouthrift.org/ wiryasige@gmail.com	NAROK



PROGRAM

MeTA Kenya Civil Society (CSOs) Capacity Building Workshop

Venue: Mash Park Hotel, off Ngong' Road-Nairobi

Date: 26-28 JUNE 2018

Daily routine	Monday 25 June	Day 1 26 June	Day 2 27 June	Day 3 28 June
08.30-10.30 Knowledge Sharing	0200-1700 Registration and check in of participants	Welcome & Introductions Presentation on HSAP/MeTA Kenya Presentation of findings of the SRHC Study 2017 (MeTA Kenya Coordinator)	Recap day 2 (by Groups) Identification of the Decision Maker Group work: Mapping and knowing decision makers at every level	Recap day 3 (by Groups) Evidence for Advocacy: <ul style="list-style-type: none"> • Importance of Research • Importance of Landscape analysis
		TEA BREAK 10.30-11.00		

Daily routine	Monday 25	Day 1 Tuesday 26 June	Day 2 27 June	Day 3 28 June
11.00-13.00 Skills Development		<p>Introduction to Advocacy</p> <p>Presentation on the Confidential Enquiry into Maternal Deaths study (Advocacy Coordinator at RMHSU of MoH)</p> <p>Group Exercise Identification and Prioritization of advocacy issues for SRHC</p> <ul style="list-style-type: none"> Advocacy issues prioritized 	<p>The Advocacy Message Development</p> <p>Group work: Message development</p> <p>Presentation on SRHR Perspectives in Kenya: Engaging with the youth and adolescents in SRHC-Addressing the ever increasing teenage pregnancies by White</p>	<p>Case study presentation on advocacy opportunities for motion on LGBTIQs presented in Kisumu County Assembly- by KELIN</p> <p>Evidence for Advocacy:</p> <p>Writing a Policy Brief</p> <p>Group work: how to develop a policy brief from research/Landscape outcomes</p>
13.00-14.00		LUNCH BREAK		
14.00.-15.00		<p>Setting advocacy goal and objectives</p> <ul style="list-style-type: none"> advocacy goal set Advocacy objectives set <p>Group work/ Practice on setting advocacy objectives</p>	<p>Advocacy tools: Media</p> <ul style="list-style-type: none"> Types of Media <p>Media Communication tools:</p> <ul style="list-style-type: none"> Press statements Press releases 	<p>Action Planning -</p> <p>Group Exercise: developing 6 month to 1 year advocacy action plan</p> <p>Measuring Success</p>
15.00-16.20 Skills Development				
16.20-16.40	TEA BREAK			
16.40-17.20 Sharing & Planning		<p>Plenary presentation: Advocacy objectives</p>	<p>Media management</p>	<p>Dissemination of research booklets</p> <p>Next steps & Closing</p>