REVIEW OF ADVOCACY NEEDS

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INTRODUCTION

METHODOLOGY

SUMMARY fiNDINGS

1.1 Aims

This review of advocacy and assessment Report on advocacy needs and capacity of service delivery partners to effectively undertake grassroots advocacy is prepared to serve as a base for creating the strategy for strengthening the capacities of these SDPs in lobbying and advocacy actions in family planning at the grassroots level and supporting them where necessary.

The Report comprises:

- Review of the responsibility of service delivery partners to the community and to civil society organizations in terms of advocacy;
- Assessment of SDPs' capacities in defining advocacy issues and implementation of advocacy activities at the grassroots level;
- Identification of key community stakeholders and gate keepers for implementation of successful advocacy campaign;
- Presentation of advocacy good practices and grassroots advocacy results so far;
- Assessment of challenges and specific needs of service delivery partners, YPPs and CHVs at the community and county level aimed at creating an enabling environment and increasing the demand of family planning services in the communities that they serve.

1.2 Methodology

The following methodology was used while preparing this report:

•Literature review on the policies that affect the SRHR situation in our country was done and forms part of chapter one of this report.

•Desk research on current policies and gap analysis on the same was done based on available sources. By this way, we collected relevant data on reproductive health policies in Kenya. We visited different websites of government ministries and public libraries in order to collect as much information on SRHR policies as possible. We also consulted reproductive health coordinators on SRHR situation in their counties.

•Specially designed interview guide for SDPs was used for one on one interviews for all the 7 SDPs and a focus group discussion guide was used for the YPPs and CHVs. A recording was done which was later transcribed and analysed using NVIVO. The members who were interviewed were:-

- Director/CEO
- Programme coordinator
- Advocacy focal point person
- Community member
- YPPs and CHVs

Which was considered a representative sample since advocacy is not the primary work of the SDPs.
The respondents above were asked about their grassroots advocacy practise and experiences, levels of engagement, challenges, good practices, support required and organisational challenges.

Key results

This assessment was aimed at reviewing advocacy needs and assessment of grassroots advocacy capacities of SDPs based on the number of employees, trainings/updates held and networks/coalitions with other organisations.

Key results of the activity confirmed this premise:

• The SDPs cover at least a county but their sub counties of interest are insufficiently defined especially because their areas of interest are skewed towards the location of their facilities;

•SDPs often do not understand the concept of grassroots advocacy, although they self-rated their advocacy capacity highly. From the interviews with advocacy focal persons we can conclude that term advocacy is not clear to them and most of the time concept of advocacy is partly understood. Those that understand what the advocacy activities imply are rare;

•It is particularly evident that advocacy activities are rarely based on need or analyses of the policies prepared by partner organizations, and they rarely monitor the progress of their agendas and advocacy strategies;

•Advocacy activities of SDPs are particularly limited due to the lack of clear financial plan and at times lack of funds;

•The Assessment also showed insufficient capacities of these organizations in terms of human resources. Many of these organizations do not have staff tied to advocacy and most of the activities are implemented on availability basis;

•The SDPs do not have enough capacity to clearly formulate their needs in terms of advocacy activities.

1.4 . Summary of Recommendations

Most of the problems identified in conclusions could be overcome by capacity building in following areas:

1.4.1 Public Policy Analysis

- Review of public policy basic concepts;
- Policy cycle phases and the specific role of actors;
- Policy problem analysis;
- Defining policy goals;
- Analysis of public policy actors;
- Public policy instruments and formulation of policy options;
- Public policy monitoring and evaluation;
- Basic characteristics and structure of the policy document

1.4.2 Effective Grassroots Advocacy

- Understanding of proactive grassroots advocacy strategy and different approaches to advocacy;
- Identifying the basic weaknesses of advocacy in the counties and good practice examples;
- Understanding the difference between grassroots advocacy goals and those of other programs and projects:
- The role of the main target groups in planning and implementing grassroots advocacy campaigns.

1.4.3Planning in the field of advocacy

- Problem analysis techniques, including the participative model of problem analysis;
- Selection and definition of clear and specific goals of grassroots advocacy;
- Grassroots Advocacy context analysis;
- Stakeholder analysis in grassroots advocacy process;
- Target groups selection;
- Effective communication techniques;
- Action planning;
- Monitoring and evaluation in the process of grassroots advocacy.
- Sexuality education;
- Respect for bodily integrity
- Choose their partner;
- Decide to be sexually active or not
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others”

Source: UN, 1995. ‘Report of the International Conference on Population and Development, Cairo,5-13 September 1994’, UN, New York. Signed by 179 countries

Literature Review On Sexual Reproductive Health And Rights, Family Planning and CAC

1.1 DEFINITIONS

Sexual and Reproductive Health Rights (SRHR)
Reproductive health and rights

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." (Programme of Action, Paragraph 7.2)

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."
(Programme of Action Paragraph 7.3)

Sexual rights

Although there is no standard definition of sexual rights, WHO has come up with the following working definition: "Sexual rights embrace human rights that are already recognized in national laws, international human rights document and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;

1.2 INTRODUCTION

What are sexual and reproductive health rights?

Simply defined, sexual and reproductive health rights are the right for all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote sexual and reproductive health (SRH).

SRH rights are a relatively new concept. Reproductive rights were first officially recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994. Prior to this, reproductive health programming had focused on family planning, fertility control and safe motherhood, having emerged from concern about population control. The definition of SRH agreed in Cairo moved beyond this, and was notable for being broad and comprehensive, and for placing reproductive health in the context of human rights and the right to health. This included rights to sexual health, and focusing not only on problems and diseases, but on what should be positive experiences around pregnancy & parenthood, sexuality & relationships. The key outcome of the conference was a programme of action for universal access to SRH by 2015, which was agreed by 179 countries. This commitment was later reaffirmed in various other international meetings, such as the 1995 World Conference on Women in Beijing.

However, despite this international commitment, there has been slow progress towards the ICPD programme of action; there have been varying interpretations of SRH rights at ground level, and lack of resources (Resource Flows, 2006),[3] with the result that some countries have seen modest advances, while others have seen none (UNFPA 2004)[4] . There was huge disappointment in 2000 when the UN general assembly rejected inclusion of SRH in the Millennium Development Goals (MDGs) – four of the goals are related to SRH, but none explicitly address it, leaving key omissions such as violence, unsafe abortions and family planning. In addition, although the ICPD definition of reproductive rights is now generally accepted, the definition of sexual rights remains much less developed, mainly because it is a more sensitive area.

However, recently there have been signs of increasing recognition that the MDGs cannot be achieved without achieving the ICPD goal. In September 2005, world leaders at the World Summit reaffirmed

commitment to SRHR, and specifically to universal access to services And in September 2006, the UN General Assembly finally adopted the ICPD goal of universal access to SRH as a target of the MDGs as a result of advocacy by international & national NGOs. In Kenya, the focus has been on the risks of HIV and AIDS for our youth as was evident in 1999 when Kenya declared HIV/AIDS a national disaster and almost all resources were channelled towards responding to the disaster. A decade later, after a lot of successful awareness-raising on HIV/AIDS, development of sex education curriculum, and other actions the focus is swinging to a broader approach to youth development, including the pivotal issues related to sexual and reproductive health Rights (SRHR). Donors, government agencies, programs and service providers are increasingly moving towards such a holistic approach to addressing youth issues hence the need for a better coordination of the multiple SRHR youth programs being implemented by partners.

Kenya is faced with a rapidly growing population with an annual growth rate of 3% per annum[5] (2009 National Census). According to the recent Kenya Demographic and Health Survey – KDHS (2008-09) and the 2009 Census, Kenya has a broad based (pyramid shaped) population structure with 63% of the population below 25 years. Similarly, 32% of the population is aged between 10-24 years; also 41% of women and 43% of men of reproductive age (15-49) are below 25 years of age. The rapid population growth coupled with large proportion of young people in the country puts great demands on health care, education, housing, water and sanitation and employment. With inadequate attention to the SRHR needs of this age group of the population, Kenya is unlikely to achieve the Millennium Development Goals (MDG) or Vision 2030.

Youth are at a stage in their lives when they are exploring and establishing their identity in society. They need to develop life skills that prepare them to be responsible adults and socially fit in society. Due to their large population, poverty and inadequate access to health care some youth do not get an opportunity to acquire life skills and consequently involve themselves in risky behaviours that expose them to social, economic and adverse health events such as substance abuse, school dropout, crime, social unrest, unemployment, unintended pregnancy and life threatening sexually transmitted diseases and infections. A recent assessment conducted by the HIV Free Generation project in Kenya found that the top three fears of young people were unemployment, unintended pregnancy and HIV and AIDS[6]

Adolescents and youth have been perceived to have few health needs and little income to access to health services. As young people pass through puberty and adolescence, health needs related to sexual and reproductive health arise. In general the health system seems to neglect the group though all need information on reproductive health and some need specialized or targeted services. The health system should provide information on sexuality, pregnancy prevention, and prevention of HIV/AIDS and other sexually transmitted infections by providing information and skill-based approaches such as life planning that can lead to favourable reproductive health outcomes.

The negative outcomes such as unintended pregnancy, early childbirth, abortion, early marriage, sexually transmitted infections including HIV/AIDS and risky behaviours such as early sexual debut, substance abuse, sexual and gender violence, multiple sexual partners, and inadequate access to and use of contraceptives, curtail young people's ability to achieve their economic and social goals, which in turn affect the country's long-term development

[2]Source: WHO 2004, Working Definitions, www.who.int/reproductive-health/gender/sexual_health.html
[3]Resource flows project, 2006. 'Financial resources flows for population activities in 2004', UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute. This draft report is available at www.resourceflows.org,
[4]UNFPA, 2004. 'Investing in people: National progress in implementing the ICPD programme of action, 1994-2004. UNFPA, New York. Available online at www.unfpa.org/icpd
[5]Kenya National Bureau of Statistics (2009). National Population Census
[6]npublished HIV Free Generation presentation (2011). Creating partnership for a HIV-Free Generation in Kenya

1.3 What is universal access to SRH services?

WHO has come up with a working definition, which includes prevention, diagnosis, counselling, treatment and care services relating to:

- Antenatal, perinatal, postpartum & new-born care
- Family planning services including infertility and contraception
- Elimination of unsafe abortions,
- Prevention & treatment of STIs, HIV/AIDS, RTIs, cervical cancer etc.
- Promotion of healthy sexuality

1.4 Rights-based approach to SRH services mean?

Rights-based approaches to SRH represent a shift from policy-making based on population level rationales such as population growth, economic and environmental factors, to recognition of the needs and rights of individuals. This came about largely as a result of the women's rights movement, culminating in the Beijing conference, and consolidated by the work of other RSH-related pressure groups such as LGBT (lesbian, gay, bisexual and transgender) and treatment access groups. A rights-based approach means as well as providing to SRH services & information, paying attention to sexuality & sexual rights of different groups.

A rights-based approach also implies responsibilities: There is a requirement for the individual to behave responsibly – but this assumes they have the relevant knowledge, skills and resources to do so, which depends on responsibilities of others: researchers, health professionals, religious leaders, national governments, donor governments etc. (Shaw, 2006).[7]

1.5 Why SRHR

Although cheap, effective interventions are available for many SRH problems, according to WHO unsafe sex is the second most important risk factor leading to disability, disease or death in developing countries and the ninth most important in developed countries (Glasier, 2006).[8]

Key SRH problems include:

Maternal mortality is the leading cause of death for women of reproductive age in many developing countries, and is largely preventable. This indicator shows the widest disparity in human development between north & south. Maternal mortality is declining in some Asian countries but not in Africa (Horton, 2006).[9]

There are now almost 40 million people infected with HIV across the world, 24.7 million in sub-Saharan Africa and 7.8 in South & South-East Asia (UNAIDS, 2006).[10]

Other STIs are often the second most important cause of healthy life years lost in women in developing countries (after maternal mortality).

1.6 Overview of broad context of sexual & reproductive health & rights

SRH policy and access to services are heavily influenced, often negatively, by sociocultural and political factors in the local and national context.

1.7 Sociocultural factors

Sociocultural factors are crucial in determining the nature of sexual relationships, sexuality and sexual behaviour, and vary hugely across and within countries. Issues around sex and sexuality are taboo in most cultures, which leads to a reluctance to discuss and address sexual health issues. It also leads to stigma of those who do not conform to socially accepted norms of behaviour, for example adolescents who have sex before marriage, and men who have sex with men. This in turn reduces access to SRH services by these groups.

1.8 Gender Norms

Gender norms in most societies tend to make men

[7]Shaw D, 2006. 'Sexual and reproductive health: rights and responsibilities', Lancet, published online Nov 1. DOI:10.1016/S0140-6737(06)69487-7
[8]Glasier A, Gulmezoglu AM, Schmid GP, Moreno CG & Van Look PFA, 2006. 'Sexual and reproductive health: a matter of life and death', Lancet, published online Nov 1, DOI: 10.1016/S0140-6736(06)69478-6.

macho, women passive, making them vulnerable in different ways to SRH problems and inhibiting access to services. For example, men may take risks in their sexual relations that expose them to HIV and STIs, and may be reluctant to seek services (which are often focused on women). Women are often economically dependent on men, and have limited power to claim their SRH rights, for example through condom use. It is also often culturally unacceptable for women to express sexuality, which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV, as well as indirect such as fear of accessing services, requesting use of condoms (Amnesty International, 2005).[11]

Religion has had a major influence in the field of SRHR, most notably the Catholic Church. The church has led what is being described as a "backlash against human rights" and in particular sexual & reproductive rights. The Vatican's stance against contraception has compromised the promotion of condoms for STI/AIDS prevention and with significant financial power, has wielded political power and influence. And there conservative attitudes towards sexuality have led to skewed funding for sex education programmes for young people focusing on abstinence as opposed to more comprehensive approaches, particularly in Africa. Pro-life movements linked to both have hampered efforts to reduce unsafe abortions. These religious groups have used concepts of "culture" and "tradition" to oppose sexual and reproductive rights (Long, 2005).[12]

1.9 Political factors

Political factors are themselves often influenced strongly by the socio-cultural context at national & international levels. As previously mentioned, the international policy context is clear on issues of reproductive health (ICPD programme of action) (less so on sexual health). However, there is a general lack of national & international political will to act to implement international policy, especially on sensitive issues such as abortion, and services for marginalized groups and adolescents (Langer, 2006).[13] The local legal framework is also important – repressive laws can prevent people's access to services, but others can enable access when enforced (Cook 2006).[14]

In many countries systems are not in place for the population to demand accountability of the government to provide quality services, and there are limited opportunities for civil society groups to participate in policy debates. However, there are examples of where social mobilization has been successful in pushing issues onto the political agenda, and helped to achieve increased access to services, for example on issues such as HIV/AIDS, FGM.

1.10 Economic & structural factors

Lack of political will has led to a corresponding absence of financial commitment for SRH (outside of HIV) by both international donors and national governments, and a lack of funding for improved access to services leads to national governments facing competing priorities for resources.. In most developing countries, resources will be insufficient and universal access will not be achieved, leading to rationing of resources (Rosen 2005).

[9]Horton T, 2006. 'Healthy motherhood: an urgent call to action', Lancet,published online Sept 28. DOI: 10.1016/S0140-6736(06)69389-6.
[10]UNAIDS, 2006. 'AIDS epidemic update: December 2006', UNAIDS, Geneva. Available at http://www.unaids.org/en/HIV_data/epi2006/default.asp
[11]Amnesty International, 2005. 'Women, violence and health'. London. Available online at www.amnesty.org/actforwomen.
[12]Long S, 2005 'Anatomy of a backlash: Sexuality and the "cultural" war on human rights'. Human Rights Watch.
[13]Langer, 2006. 'Cairo after 12 years: successes, setbacks, and challenges'. Lancet, published online Nov 1, DOI: 10.1016/S0140-6736(06)69486-5.
[14]Cook RJ & Ngwena CG, 2006. 'Women's access to health care: the legal framework', International Journal of Gynecology & Obstetrics, 94, 216-225.

A key strategy for expanding coverage of SRH services is their integration into existing health services. Integrated services are believed to promote more efficient use of resources, and be better from the service user's perspective. For example, a recent study analysing data from 18 African countries has shown that condom use by single people is mainly motivated by contraceptive desire not as protection for HIV, highlighting the need to promoting condoms as dual protection which will require integrated FP and HIV services (Cleland, 2006).

The most important barriers to integrating services now lie in international policy, institutional & financial arrangements. This is particularly notable in the case of HIV/AIDS, and has led to an increasing divide between HIV-related services and other health services including SRH. Politically, HIV/AIDS has become the key SRH international priority, which is reflected in policy and financing: since 1994, the proportion of donor SRH funding has increased substantially for HIV/AIDS and dropped for other areas, in particular family planning (Resource Flows, 2006).

A central principle of a rights-based approach to access is that of equity. A huge challenge in attaining universal access is overcoming the existing inequity in access to services. Currently there is much evidence to suggest that although access may be increasing at a national level in some countries, access is not equal across different social groups. Poverty is a key factor excluding many from accessing services. For example, studies have found that access to a skilled birth attendant at delivery is over 3 times higher for women in the richest quintile than those in the poorest in sub-Saharan Africa, and 8 times higher in South Asia (Greene 2005).

People who in some way do not conform to societal norms, face stigma, discrimination and violence, often backed up by repressive laws. This can limit their access to services, for example for fear of persecution or abuse, or by pushing groups underground so that it is hard to access them with programmes (Berger, 2005). This is compounded by the fact that it is often hard for marginalized groups to lobby for increased access, for example in Kenya currently gay rights organization finding it difficult to operate. Adolescents on the other hand face many barriers accessing services. These include: legal barriers, for example requirements for parental consent, or age limits for providing contraception; refusal of health workers to provide services to adolescents, or judgemental attitudes which prevent adolescents from seeking services in the first place (eg Kenya & Zambia, Wareniu 2006).

People living with HIV/AIDS face problems in accessing appropriate services which meet their specific sexual health needs, which are rarely understood or addressed by health service providers (Guttmacher Institute). Women in particular may have to deal with pressure from their families to have or not have children, challenges in negotiating safer sex and issues around disclosure. They can also be confronted with fear and judgemental attitudes of health workers, who may pressure them to abort, be sterilized, or use contraception because they think that people with HIV should not have children due to the possibility of vertical transmission (ICS SRHR factsheet). A study in Zambia found that people with disabilities, specifically women, faces various social, attitudinal and physical barriers to accessing reproductive health services. For example, health workers may assume that people with disabilities are not sexually active and so not offer them services (Smith, 2004).

A huge challenge in supporting expanded access is finding the necessary increased resources. In addition, the resource supply must be sustainable. The private sector has often stepped in to fill the gap where government services are failing to meet demand. Private health services are sometimes preferred for SRH by clients because they are perceived to afford greater privacy, or they provide services not provided by the state (such as abortion). The private sector is also increasingly being actively engaged by governments; in what are collectively known as public-private initiatives (PPIs). Apart from meeting the unmet demand for services, it has been argued that engagement of the private sector can improve access for the poor, since wealthier people will seek private services, freeing up public resources for free services (Sharma 2005). In Ghana, for example the government provides logistical and technical support to private providers in areas with no government services, and has in this way increased access to family planning (Dmytraczenko 2003). However, there is some evidence that the opposite can happen, increasing inequity between the wealthy and the poor, both in terms of access to services and quality of treatment (Rights & Reforms,

2005).

Social marketing involves using marketing principles and techniques to "sell" products and behaviors to the target population, and has been used in many countries to expand access to products such as condoms, and services such as voluntary counselling & testing (VCT).

A key debate within SRH has been that of SRH rights vs family planning. Family planning programmes emerged from concerns about population growth, and were based on ideas about state control for future social good. By contrast, reproductive health rights are based on concepts of individual control for current quality of life. However, more recently efforts have been made to bring the two together as complementary approaches, fulfilling individual rights to fulfil greater social aims (Cleland, 2006).

With the debate now ranging of whether the state should advocate for smaller families, raises questions over whether individual rights should sometimes be sacrificed for greater good. Another example is male circumcision, which has recently been shown to be effective in reducing HIV transmission but can easily be challenged by some as compromising men's rights.
The concept of SRHR emerged from the women's movement, and has focused on women's control of their bodies and women's rights. It has unfortunately tended to place blame on men, which has alienated them rather than engaging them, and resulted in the SRH needs of men often not being addressed. The women's rights movement is still a strong player in SRHR, but there is increasingly a call for men's rights. In the middle is a gender equity approach, which aims to achieve equitable access to SRH rather focus on either women's or men's rights alone. Examples of such groups include the "Maendeleo ya Wanaume" in Kenya a rights group in Kenya advocating for male rights and the Khululeka Men's Support Group in South Africa is a group of HIV positive men working to support each other to adopt responsible lifestyles. Several issues have been described above, including unsafe abortion and violence, that are present in current debate but absent in policy and programming for various reasons. Another example is family planning, which in recent years has been largely neglected. This is partly for historical reasons – it is seen by some as irrelevant (since fertility rates have dropped in many areas), and coercive (for example China's one-child policy); and partly because HIV has taken over as the key international SRH issue (Glasier 2006, Cleland 2006).

However there is evidence of ongoing and increasing need for family planning efforts – there is a large unmet need, especially in Africa; population continues to rise (in sub-Saharan Africa the population is predicted to more than double by 2050, and even in Asia will increase by 34%; Cleland 2006); it is missing from the MDGs but would make achieving them much more feasible, for example by contributing to decreasing poverty in many countries, as well as health benefits (less safe abortion & maternal, neonatal & child mortality), and supporting environmental sustainability (Cleland 2006).

Reproductive rights, embracing certain basic human rights that are already recognized in Kenyan law and in international human rights conventions. These include the right of the youth to appropriate and relevant information and services. Denial of reproductive rights to young people negatively affects their general wellbeing.

Unsafe abortion contributes significantly to maternal morbidity and mortality. The majority of women seeking care for unsafe abortion complications are below 25 years of age. Effective advocacy and service provision to reduce the need for unsafe abortion are not adequate. The promotion of knowledge and adoption of appropriate attitudes towards abortion related issues is what has been sighted in the policy as the way to reduce discrimination and stigma. This includes correct and adequate information where adolescents are found, as well as improved access to contraceptive and post-abortion care services.

Safe motherhood aims at assisting all women to go through pregnancy and childbirth with the desired outcome of a live and healthy baby and mother. Current safe motherhood programmes include preventive and health promoting activities encompassing family planning, antenatal care, safe delivery, postpartum care and maternal nutrition. However, these services are not equitably accessible to female adolescent users in all parts of the country. At the current estimate of 590/100,000 live births; Kenya's maternal mortality rate is unacceptably high. Adolescents are more likely to suffer pregnancy related complications than older women owing to their relative immaturity as well as preventable

causes such as malnutrition, infectious diseases and haemorrhage, malaria, and inadequate health care and supportive services, particularly in rural areas.

The Family Planning Programme, started in 1967 by the Ministry of Health, has contributed considerably to the decline in fertility rates in Kenya. The TFR estimated at 8.1 in 1977/78 declined to 4.7 in 1998, but increased to 4.9 in 2003. The contraceptive prevalence rates (CPR) for all methods and modern methods were estimated in 2003 at 39 per cent and 32 per cent, respectively. Although the 2003 CPR estimate for modern methods indicates a two-fold increase since 1989, the 1998-2003 trend data reflect stagnation at 32 per cent. The Kenya Service Provision Assessment (KSPA) survey indicates that only 73 per cent of all health facilities are offering temporary methods of family planning services.

Unmet need for family planning among married women in Kenya has remained high, at about 24 per cent since 1998. On the other hand, the population projections show that the number of couples of reproductive age together with sexually active unmarried individuals in need of family planning information and services will grow by about 200,000 per annum in the 2005-2015 periods. [15]

Key challenges sighted include: wide regional and socio-economic disparities in CPR; lack of security for contraceptive commodities; lack of sustained demand creation for family planning services; relatively low community and private sector participation in family planning service provision and low involvement of males; method mix that does not permit wide method choice and cost-effectiveness; inadequate family planning training for service providers; and low level of integration of family planning with HIV/AIDS services.

The age-specific fertility rate among young women aged 15-19 and 20-24 years is 103 and 238 per 1000 women (KDHS, 2008/9)[16] respectively. Age-specific fertility in Kenya peaks at ages 20-24 years and then starts declining from age group 25-29 onwards. The median age at first birth is 19.9 years. Pregnancies and births to adolescent girls are high risk since girls are not yet fully developed physiologically to carry a pregnancy. Young girls are more likely to develop complications of pregnancy and childbirth leading to higher rates of maternal morbidity and mortality. Limited access to youth and young mother friendly MCH/FP and SRH services29[17] exacerbates the problem. Under-five mortality rate (the probability of dying between birth and the fifth birthday) is notably higher among children born to mothers below 20 years (100 deaths per 1000 live births) compared to mortality among children born to mothers 20 years and above (77 deaths per 1000 live births).

Even though contraceptive prevalence rate (CPR) has been on the rise among sexually active young women, unmet need for contraception remains high. According to the KDHS 2008-09, CPR for any modern method is 25% for sexually active women aged 15-19 years and 37% for those aged 20-24 years. Among unmarried sexually active women of the same age groups (15-19 and 20-24 years) CPR for any modern method is 23% and 59% respectively. Condoms are the most commonly used method among young people. The unmet need for family planning among currently married 15-19 and 20-24 years is 30% for both age groups, which is higher than the unmet need of 26% among all currently married women. A study conducted by Nzioka (2004)30[18]in Makueni District found that contraceptive use among adolescent girls was hampered by inaccessibility to services, fear of side effects and religious beliefs. Most girls used untested traditional methods of contraception, and they did not have skills to resist sexual advances or negotiate condom use.

A study conducted recently in Kenya Service Provision Assessment explored the general provision of services for child health, family planning, maternal and new-born care, and HIV/AIDS but did not specifically examine the provision of services to young people in spite of the increased interest in providing information and services to this age group

[15]CBS (2002). Analytical Report on Population Projections, Volume VII, Nairobi: Government Press

[16]Kenya National Bureau of Statistics and Macro International (2009). Kenya Demographic and Health Survey 2008/9

[17]Makona et al. (2008). 2008 National youth shadow report: Progress made on the 2001 UNGASS Declaration of commitment on HIV/AIDS, Kenya New York Global Action Network, Global Youth Coalition on HIV/AIDS

[18]Nzioka, C. (2004). Unwanted pregnancy and sexually transmitted infection among young women in rural Kenya. Culture and Health 6(1): 31-44

Policy Gap Analysis

2.1 INTRODUCTION

The 2003 Kenya Adolescent Reproductive Health and Development (ARHD) Policy was a milestone for addressing the health and development concerns of Kenya's adolescents and youth. Prior to 2003, no policy document at the national level explicitly addressed adolescent sexual and reproductive health (ASRH). The progressive International Conference on Population and Development (ICPD) held in Cairo in 1994 had earlier stressed on the needs for governments to put human rights at the center of development. As part of the domestication of the ICPD Program of Action (PoA) and in response to the major reproductive and health development policy, the Government of Kenya developed and launched the ARHD Policy in 2003 and its plan of Action 2005-2015 through a national multi-sectoral approach.

The goal of the ARHD Policy was to contribute to improvement of the well-being and quality of life of Kenya's adolescents and youth; The ARHD Policy also sought to integrate the health and development concerns of adolescents and youth into the national development process, and to enhance their participation in that process. According to the ARHD Policy, adolescents are defined as persons ages 10 to 19, and youth are ages 10 to 24.

With the expiry of the Plan of Action in 2015, it became necessary to develop a new policy document that would provide policy directions for realizing the right to the highest standard of healthcare including reproductive healthcare. This was also necessitated by change in the local and international policy and legal environment. The most visible changes to this environment was the progressive constitution of Kenya, 2010, the devolution of healthcare and most recently transition from the Millennium Development Goals to the more ambitious seventeen Sustainable Development Goals.

As compared to the expired policy, the new Adolescent Sexual and Reproductive Policy focused on sexual and reproductive health as opposed to development and was developed by the Ministry of Health whereas the defunct one was developed by the National Council of Population and Development. There policy also laid more emphasis on evidence based intervention, Responsiveness to varying Sexual and Reproductive Health needs of adolescents in provision of care, insistence on multi-pronged and multi-sectoral approaches, Respect for human rights and fundamental freedoms and the meaningful involvement of adolescents in policy processes.

The constitution of Kenya in the The Bill of Rights Article 26 and Article 43 explicitly confer the right to health in general and to reproductive health in particular. Article 26 of the constitution provides that every person has the right to life and that life begins at conception. The Article 43 further provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43(2) states that a person shall not be denied emergency medical treatment while Article 43(3) says that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.

The Constitution defines the role of the Ministry of Health Headquarters as providing national leadership and stewardship on health matters. The central level will be responsible and accountable for quality and quantity of health care to ensure physical access, affordability, acceptability and equity to all people. The County government provides county level leadership and stewardship on health matters. It is responsible and accountable for implementation of national policies, strategies and guidelines. (MOH 2011).

This would later be affirmed by the overarching National Health Policy 2014-2030 that has a goal of attaining the highest possible standard of health in a responsive manner. The policy further clarifies health in the devolved system and emphasizes on Public participation, multi-sectoral coordination, and efficiency in application of health technologies and most importantly mutual consultation and cooperation between the national and county governments and among county governments as key ingredients in realizing Constitutional rights.

Key gains with decentralization of health care services in the devolved system of government include:

- Increased local ownership and accountability;
- Improved community participation and responsiveness to local needs;
- Strengthened integration of services at the local level;
- Enhanced the streamlining of services; and
- Promoted innovation and experimentation.

On the other hand, devolved system has had a share of challenges including being accused of exacerbating inequities, weakening local commitment to some public health issues and decreasing the efficiency and effectiveness of service delivery by disrupting the referral chain. The most affected being reproductive health services since some (e.g. family planning) are controversial and thus susceptible to local pressures, and others (e.g. emergency obstetric care) are dependent on a functioning, integrated, health system.

To comprehend the impact of the reproductive health services in Kenya, the following key aspects need to be put in context:

- The implications of the constitution and devolved system of government in relation to RH;
- Health and specifically RH policy framework;
- Impact and distribution of Development Partners (DPs) support to the area of RH;

To help conceptualize the policy gaps the following parameters will be utilized:

- Health financing,
- Service delivery,
- Human resources for health (HRH),
- RH commodities,
- Policy Environment

2.2 POLICY GAP ANALYSIS

The right to health and RH as stipulated in the new Constitution creates an avenue for structural and systemic adjustment of the health system. With devolution a reality the impact and implications of health financing both by the government and development partners faces a new dynamism all together. Glaring gap in the National RH Strategy and the 2011 Acceleration Plan for the Attainment of Maternal and New-born Health (High Impact Interventions - HII) in particular has been lack of priority setting and costing, which makes it difficult to use them as a basis for planning strategic interventions and support.

Family planning and maternal & child health in general have some degree of coverage in the country– especially in the provision of free maternity services and RH commodities – such as family planning contraceptives. Adolescent sexual health and gender – both rights and more specifically, gender violence issues – are well articulated but the major gap so far lies with ASRH and GBV/HR both from the government and DPs.

The constraints in service delivery concerning ANC, MNC and FP show that a number of shortfalls in general service provision are causing poor outcomes. To reduce the morbidity and mortality as a result of complications during the antenatal period, labour and post-delivery, sustainable high impact interventions (HII) for both mothers and new-borns in particular should be emphasized. High Impact Interventions (HII) acceleration plan developed in Nakuru 2011 is a key milestone towards the attainment of improved RH services. But this alone is not sufficient there is need to invest in developing critical health systems components and to ensure solid linkages between the packages to deliver an effective continuum of care.

Key deliverables for High Impact Interventions (HII) includes capacity development for skilled birth attendance and emergency obstetric care; and making family planning accessible to all. While poor women of reproductive age are the general target group for improved RH services, special attention should be given to adolescents and young people. Trainings should be planned and carried out in close consultation with district / county health management in order to avoid vacancies and to

ensure that personnel with appropriate skills are posted to rural areas.

Reproductive Health commodities constant stock-outs hinder service provision. There is need to integrate RH commodities (including contraceptives) into the general supply chain management and the relevant policy document should be broadened to encompass an RH commodity security strategy hence the need to involve respective ICCs for RH and for Procurement. The other key concern is wastage and/or artificial shortages RH commodities.

The Health Policy Framework, 1994-2010 and successive 5-year National Health Sector Strategic Plans (NHSSP I /1999-2004 and NHSSP II / 2005-2010) set the targets and processes driving the health sector development as well as the healthcare service delivery. The aim of the policy was to introduce reforms specifically in the way the healthcare services are organized, financed, delivered and evaluated.

The goals of the health policy were:

- Ensure equitable allocation of Government of Kenya resources to reduce disparities in health status;
- Increase cost-effectiveness and efficiency of resource allocation and use;
- Manage population growth;
- Enhance the regulatory role of the government in health care provision;
- Create an enabling environment for increased private sector and community involvement in service provision and financing; and
- Increase and diversify per capita financial flows to the health sector.

These goals are still valid and have informed to a large extent both Vision 2030 and its Medium Term Plan (2008-2012).

Important approaches and innovations of the health policy and more so of NHSSP II were: the concept of the Kenya Essential Package for Health (KEPH), the Community Strategy, the Joint Framework of Work and Financing (JPWF) - an essential element for entrenching the Kenya Health Sector-Wide Approaches (KHSWAp) and finally the Annual Operational Planning (AOP) process. These approaches are increasingly becoming a feature of the health sector.

National Health Sector Strategic Plan II 2005-2010 (NHSSP II) objective was to reverse the downward trends in the health indicators to achieve the MDGs. RH is well reflected in the NHSSP II under cohort 1 (Pregnancy, delivery, new-born child), cohort 4 (Adolescence) and cohort 5(Adulthood). The system is struggling to adequately respond to the health needs of the population in general and to that of mothers and new-borns in particular. This contributes to the high morbidity and mortality due to complications during the antenatal period, during labour and in the post delivery period.

The Vision 2030 health sector flagship projects for 2012 are to:

- Revitalize Community Health Centers to promote preventive health care (as opposed to curative intervention) and by promoting health of individual lifestyles;
- Delink the Ministry of Health from service delivery in order to improve management of the country's health institutions;
- Create a National Health Insurance Scheme in order to promote equity in Kenya's health care financing;
- Channel funds directly to hospitals and Community Health Centers (as opposed to district headquarters),
- Scale up the output-based approach system to enable disadvantaged groups (e.g. the poor, orphans) to access health care from preferred institutions.

The key document summarizing the principles, policies and timetable for the specific measures around health financing is "Social Protection in Health: Policy and Financing Strategy, March 2009". The Strategy's genesis has been slow and difficult. A National Task Force for Health Financing was established in late 2006 to re-define a national strategy but was interrupted by the post-election crisis of 2007/8. A new strategy was finally agreed with major stakeholders in 2009 and endorsed by the National Social and Economic Council (NESC) in early 2010.
The aim of the Strategy is to achieve equity of access to, equity of finance for and financial risk protection as defined by the World Health Assembly (WHA) 2005 - "Resolution on Sustainable Health Financing" through:

- Expanding coverage of the National Health Insurance Fund (NHIF)
- Improving private health and other social health insurance systems
- Protecting the poor
- Increasing PPPs
- Improving health regulation and standards
- Improving capacity and quality in the public health system.

In Kenya, the area of reproductive health (RH) is regulated by a number of framework documents issued by the Ministry of Health. The National Reproductive Health Strategy 2009-2015 is based on the National Reproductive Health Policy 2007. The RH Strategy is a very broad document covering all areas of RH with over 65 strategies, 31 outputs and 10 thematic areas including cancers and the elderly but there is virtually no reference to commodity security.

RH Strategy envisaged the following areas as priorities:

- Safe motherhood;
- Maternal and neonatal health;
- Family planning;
- Adolescent/youth sexual and reproductive health;
- Gender issues, including sexual and reproductive rights.

However, the RH Strategy does not give advice or direction on what, and how, these areas could be supported. Whilst a strategy can be broad, it is important that some clear direction is given about focus.

The Road Map for Attainment of Maternal and New-born Health (MNH) was developed to try and agree on where to focus support for MNH. However, the Road Map does not represent a cost-effective evidence based package of care. There are also some technical gaps such as exclusive breastfeeding, maternal nutrition and it is not focused on evidence based cost–effective interventions. It remains too general and too unfocused. Although the MNH Road Map is costed, these are referred to as additional funding requirements and it is therefore very difficult to use this to assess resources required and any gaps there may be.

To achieve significant progress on morbidity and mortality in RH, there will have to be improvements in coverage of High Impact Interventions (HII) such as Focused Antenatal Care (FANC), Emergency Obstetric Care (EMOC), Post-partum Care (PPC) and Family Planning (FP).The plan was a fresh impetus to re-focus on HII and prioritizes the activities within HII, assigning specific tasks to national, provincial, district and community levels and commits all actors to timeliness.

The HII Acceleration Plan was the first step in developing an evidence-based cost effective package to guide the districts/counties towards achieving MDG 4 and 5. A particularly important point is that it recommended that maternal and perinatal audits take place routinely after a death, but it remains unclear how this information would be collated nationally to help inform policy and practice.

Another gap in the plan is where the plan identifies several key activities that would help to harmonize support for MNH at district/county level such as partner mapping to identify and target resources and coordinate supervision; many of these health systems activities should lead to better essential services, particularly for women and children but the plan failed to provide any indicative budget. Therefore, there is no understanding of the financial, personnel and logistic resources required to deliver the HII package, or what resources are available or the additional resources required for priority activities to achieve a reduction in MNM. It will require additional strategic planning in each district/county and together with IPs to identify what additional support is required.

In addition, if this HII plan is going to be an effective strategy to reduce MNM, there are other technical and strategic weaknesses: the current plan is limited in scope, particularly with regard to Adolescent RH with very specific needs that are often not dealt with through routine services.

It is acknowledged that maternal mortality is a health systems failure yet there is insufficient emphasis in the HII plan on improving critical health systems to help deliver the agreed interventions, particularly on how an effective continuum of care will be developed in each district/county. Successful implementation will require key aspects of the health system to work so that the health system provides a continuum of care from the community to the tertiary level when required which would also include: appropriately trained health workers to be in place; specific

equipment and sufficient supplies of essential medicines.

Youth Friendly Services (YFS) / Adolescent sexual and reproductive health (ASRH): Currently, there are four national policy documents that guide the provision of youth friendly SRH services in Kenya. Apart from the National Reproductive Health Policy 2007, the Adolescent Reproductive Health and Development Policy (NCAPD/DRH 2003), the Adolescent Reproductive Health and Development Policy-Plan of Action (2005-2010) (MOH/NCAPD 2005), and the National Guidelines for Provision of Youth-friendly Services (MOH/DRH 2005). Broadly, the ARH&D Policy addresses the following adolescent RH issues and challenges: adolescent sexual health and reproductive rights; harmful practices, including early marriage, female genital cutting, and gender-based violence; drug and substance abuse; socioeconomic factors; and the special needs of adolescents and young people with disabilities.

The National Guidelines for the Provision of YFS in Kenya identify two approaches to be used in the delivery of SRH to young people: the targeted and the integrated approaches. The targeted (or youth-only) approach is an arrangement where services are designed and planned for adolescents alone and are offered in youth-only settings. The services offered in such a set-up may be clinical, non-clinical or a combination of both. In the integrated approach, young people receive SRH services together with the general public but special arrangements are put in place to make the services more acceptable to young people such as the training of health care providers, youth corners, etc. The national guidelines recommend three models of youth friendly service provision each with an essential service package: youth centre based model, clinic based model and school based model.

In addition to these health sector related policy framework documents, there is a National School Health Policy and guidelines, which were jointly developed and published in 2009 by the MOPHS and the Ministry of Education (with assistance from GIZ). These documents cover a comprehensive range of health issues and life skills that are vital for supporting the health of young people. They are meant to guide school authorities in enhancing the quality of health in school communities by creating a healthy and child friendly environment for teaching and learning. The gap in the above well-articulated documents lies in the implementation and the impact elicited therein. Other challenges include lack of coordination among implementers; low stakeholder involvement, including low political will and youth involvement; limited leadership; lack of resources; poverty and unemployment among youth; and limited availability of high-quality ASRH services. Additionally, ASRH remains a contentious issue among some communities, and some cultural and religious practices are barriers for implementation. Adolescents and youth still face challenges, such as completing secondary school, finding employment, postponing marriage, and avoiding STIs and unintended pregnancies.

The MoH/DRH and its respective DPs have adopted a National Contraceptive Commodities Security Strategy 2007-2012. Forecasting and quantification exercise is led by the DRH/MOPHS and carried out annually with a semi-annual review in which the DPs are involved. The strategy does not cover the entire range of drugs and consumables needed for RH related services. The planning and procurement for other RH commodities other than contraceptives is included in the general drug supply system. Internationally, the priority focus is on providing comprehensive SRH and it has become standard that the whole range of commodities to ensure RH services is covered by one common RH Commodities Security Strategy. This corresponds with international initiatives like the RH Supplies Initiative and would support the comprehensive RH approach pursued by GOK.

2.3 Gaps

The Policy Gaps Assessment found out several gaps that hindered effective development and implementation of sexual and reproductive health and rights programs. Whereas different counties experience these gaps in different capacities, most of the gaps were cross cutting under the following major themes:

1. Limited Involvement of County Health Management Team in Policy Development.

With the promulgation of the constitution of Kenya, 2010 and the ensuing onset of devolution, health services become a key function of the county governments. The County Health Management Teams were tasked with the ominous onus of delivering the right to the highest attainable standard of healthcare including reproductive health care as enshrined in the constitution. However, for effective and efficient delivery of services, a strong anchoring policy and legal environment is equally important. This key function remained a task of the national government. Based in Nairobi, the Ministry of Health at the national level retained the core mandate of developing national policies, guidelines and implementation plans, and disseminating them to the counties for implementation. Whereas the spirit behind this was right and guided by a sense of commitment to realization of quality health for all, counties in South Western Kenya as other counties nationally have realized hiccups in implementation of policies and guidelines on sexual and reproductive health and rights because of limited involvement in development, trouble domesticating them into county realities and sometimes limited will by counties to adopt them.
This was a cross cutting gap for all the counties.

2. Insufficient Resources

Policy development requires resources throughout the cycle of conceptualization, designing, revision, development, dissemination, printing, monitoring and evaluation among others.

Kisii, Homa Bay, Migori, Siaya and Kisumu did not allocate sufficient resources for these crucial processes. In Homa Bay County, for example Policy was lumped together with Planning & Administrative Services and whereas the programme received the highest share of the health budget in the FY 2015/2016 at 64.2%, allocation to the sub programme Policy, Planning & Monitoring Services was less than 1% of the program budget.

But that's not unique to Homa Bay County. A quick analysis of the Migori, Kisii, Siaya and Kisumu budgets reveals that policy was allocated limited resources and mostly lumped together with other sub programs, making it difficult to deduce how much exactly was allocated, despite the obvious evidence based need to allocate resources to this sub program. Apart from Kisumu which has a county policy, research and strategy officer at the governor's office, these counties did not have specific functional county policy development units or dedicated policy staff within the county Health Management Team over and about, there was also insufficient budgetary allocation to health, with meagre or no budgetary allocation to reproductive health and key sub programs like family planning, youth friendly reproductive health services and staff capacity building.

3. Poor Dissemination.

A national assessment of the 2003 Adolescent Reproductive Health and Development Policy (ARHD) found out that one of the reasons the policy hadn't contributed significantly to the well-being of adolescents was poor dissemination of the policies. But this was not unique to the ARHD policy or even at the national level. Whereas Kenya is a country with a progressive policy and legal environment, this has not always translated into implementation, allocation of resources or even improved outcome for young people.

Most stakeholders, including health care workers were not aware of the existence of certain national policies on health including the Adolescent Sexual and Reproductive Health Policy. Other crucial documents like the Adolescent and Youth Friendly Services Guidelines, the Maternal, Neonatal and

Perinatal Surveillance Report Guidelines, the National Family Planning Guidelines, all launched at the national level, had not been disseminated already to the counties.

This gap proved a stumbling block to implementation of policies within the counties in South Western Kenya, especially because of the missed opportunity to allocate more resources to implementation and for implementing evidence based minimum resources maximum impact interventions.

But this was not restricted to the health department only. A huge proportion of County Education officials were not aware of the existence of the Education Sector Policy on HIV/AIDS as were most county officials of the public private partnership frameworks.

4. Amorphous policy and legal environment on provision of CAC Services

Whereas the constitution of Kenya provides for safe abortion under specific circumstances, this right is not translated into any policy guideline, policy or ACT. Instead, healthcare workers remain uncomfortable to provide this very important service due to fear of prosecution occasioned by an unclear environment. As if that was not enough, the government procedurally withdrew guidelines on reduction of maternal mortality through unsafe abortion and instead issued a circular stopping all abortion related trainings. After pressure from stakeholders, the government embarked on a process of developing policy standards on reduction of maternal mortality which provided for clinical guidelines on abortion. The said document has not been released despite the assurance of the government that it will. This has further created more confusion. Service providers at government and public facilities are thus afraid of providing safe and legal abortion as provided for in the constitution for fear of reprisals and harassments by state agencies.

This was a cross cutting challenge for all the counties where the policy gaps assessment was conducted.

5. Lack of Reproductive Health Care Bill

The Constitution of Kenya in the fourth schedule provided a period for parliament to enact acts of parliament that would help define and ensure the right of every Kenyan to the highest attainable standard of health including reproductive healthcare. The failure by the national legislature to pass a reproductive health act, or at the very least pass a health care act that has a strong component of reproductive healthcare, means that Kenyans are left without a legal framework on reproductive healthcare. Whereas the constitution does not bar county assemblies from enacting their own reproductive health acts, uniformity of service throughout the country is likely not to be standardized, and at the very best, only a few counties have the technical capacity to develop appropriate standards and acts that speak to the supremacy of the constitution.
This was a cross cutting challenge for all the counties where the policy gaps assessment was conducted.

6. Insufficient capacity of county to develop strategies, domesticate commitments and spearhead development of ACTS

As mentioned in the previous paragraph, the counties where the gaps assessment was done have limited technical experts to help them domesticate international and national commitments, develop ACTS and strategies to oversee the realization of sexual and reproductive health and rights. The national government needs to provide continuous technical assistance as per the devolution position paper on health, however, due to weak coordination mechanisms between national and county government, this has remained a mirage. As devolution continues to deepen its root, most counties are progressively able to develop appropriate strategies and road maps in line with their count integrated development plan and Kenya blue development print, the vision 2030. In this regard, Homa Bay County for example have developed HIV/AIDS plan to address the HIV/AIDS scourge in the county. Members of County Assembly, including MCA Champions, have also increasingly developed ACTS and motions on sexual and reproductive health and rights issues.

7. Weak coordination (between key departments e.g. Education, Youth and Health and between national and county governments)

Coordination is of central importance if the constitutional right to the highest attainable standard of healthcare including reproductive healthcare is to be realized. The coordination needs to be vertical (between the different tiers of government) and horizontal (among the different departments of a government). Key departments such as health, education, youth and technology must work together in sharing data, experiences, opportunities and best practices in order to realize high impact. However, multi-sectoral technical working groups targeting common reproductive health and adolescent and youth development issues remain non-existent in most counties, and at the very based just on paper without clear coordination mechanisms and resources.

Whereas Kisii, Migori, Homa Bay, Kisumu and Siaya all have Reproductive Maternal and Neonatal Technical Working Groups, these technical working groups mostly have officers from the ministry of health, thus excluding key people and departments like Gender and Youth, Education, Finance among others.

8. Expiry of Crucial National Policy Documents

Another cross cutting gap in the counties was elapse of crucial policies and guidelines. This was either due to ongoing revision or lapse in strategy time. The National Condom Policy and Strategy (2009-2014); The Contraceptive Policy and Strategy (2002-2006); The Contraceptive Commodities Procurement Plan (2003-2006); The Contraceptive Commodities Security Strategy (2007-2012) and the National Reproductive Health Strategy 2009-2015 are just but a few that were adversely mentioned by the respondents during the gaps assessment. The expiry of these crucial guidelines makes it difficult for organized service provision nationally, and specifically at the counties where provision of services takes place.

9. General opposition to SRHR

Sexual and Reproductive Health and Rights information and services remain one of the most misunderstood issues. The development and implementation of policies in south western Kenya have received lukewarm response at best and hostility at the very worst. Service providers in Siaya for example were forced to remove implants they had inserted into a school going children after a school organized an inspection and chased away the adolescent, her protests and desire for the services notwithstanding. Implementation of the Education Sector Policy on HIV/AIDS that provides for comprehensive sexuality education has also faced several challenges as stakeholders and implementers have misunderstood this for encouraging sexual debauchery.

Advocacy Needs

3.0 Introduction

The results of the assessment conducted in April and May 2016 are presented in this Report aimed at assessment of capacity of service delivery partners in the field of grassroots advocacy. The Report was prepared by NAYA for the program CTG and will serve as the basis for designing of specific training programs aimed at strengthening the grassroots advocacy capacities of service delivery partners under CTG.

Service Delivery Partners in CTG consists of 7 organisations working in Migori, Homabay, Kisii, Siaya and Kisumu. These organizations are all local organizations with limited technical and organizational advocacy capacities. Most of them offer family planning services as their primary role and have little or no funds at all to support grassroots advocacy. These are the assumptions we started from while doing the assessment with the aim of gaining insight into their perception of their different grassroots advocacy capacities.

$levels of advocacy Frequencies				
		Responses		Percent of Cases
		Number	Percent	
What levels do you engage in advocacy	Grassroots	7	28.0%	100.0%
	Sub county	6	24.0%	85.7%
	County	6	24.0%	85.7%
	National	4	16.0%	57.1%
	Regional	1	4.0%	14.3%
	International	1	4.0%	14.3%
Total			100.0%	

The SD partners confirmed that all of them undertake grassroots advocacy mainly through their YPPs and CHVs who they have trained to create demand for the commodities and services. The YPPs and CHVs mainly conduct community forums on sexual and reproductive health including family planning, male involvement in family planning and also target the Sub County and county levels through stakeholders in Sub County, local leaders including chief, pastors, schools and the ministry of health on post abortion care. Matibabu through department of public outreach has engaged community health volunteers In Migori County who sensitise communities on health issues.

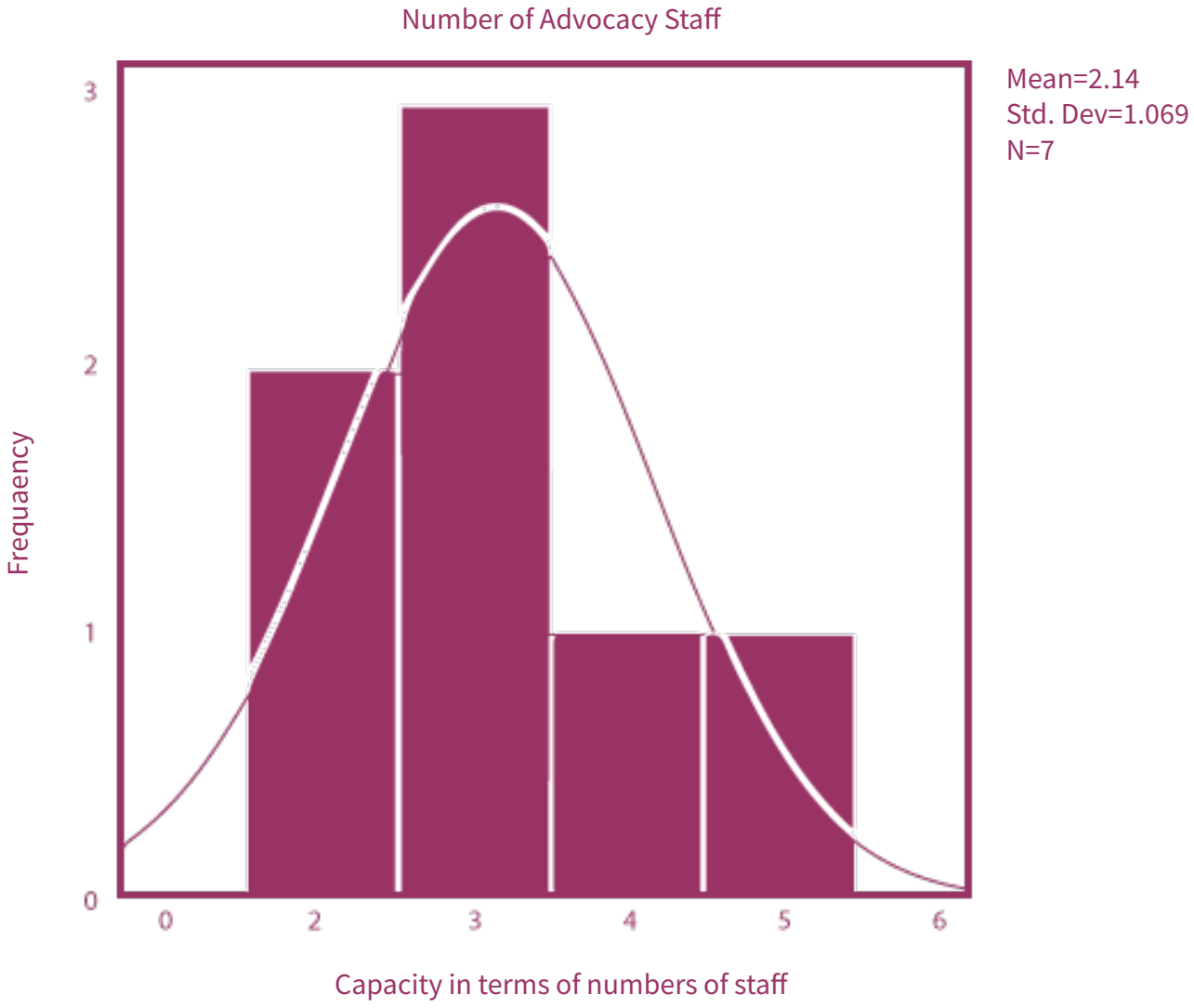
Whereas majority of the partners can engage the community on their own, most of them engage the county through the support of the advocacy partner. It is worth noting that KMET has engaged the county in developing a family planning strategy and a county commodity strategy in public private partnership in Kisumu County. The partner through this link, engaged the budget committee for budgeting of commodities.

At the national level, KMET has presented four papers on comprehensive abortion care since June last year and engaged bodies like the Kenya Organisation for Obstetrics and Gynaecologists. Internationally the have presented a paper on provision of Youth friendly services and a case study on Huduma Poa network integration.

3.2 Self-assessment Capacity
3.2.1 Staff

The results of self-assessment capacities made by respondents in this segment indicate that they are partially satisfied with their current capacities in terms of number of staff to carry out grassroots advocacy. The average number of staff tasked with grassroots advocacy per organisation were two i.e. the programmes coordinator and the advocacy focal persons who were recently appointed in the advocacy TWG. However some organisations had more than two and one even went further to have their CEO as an advocate.

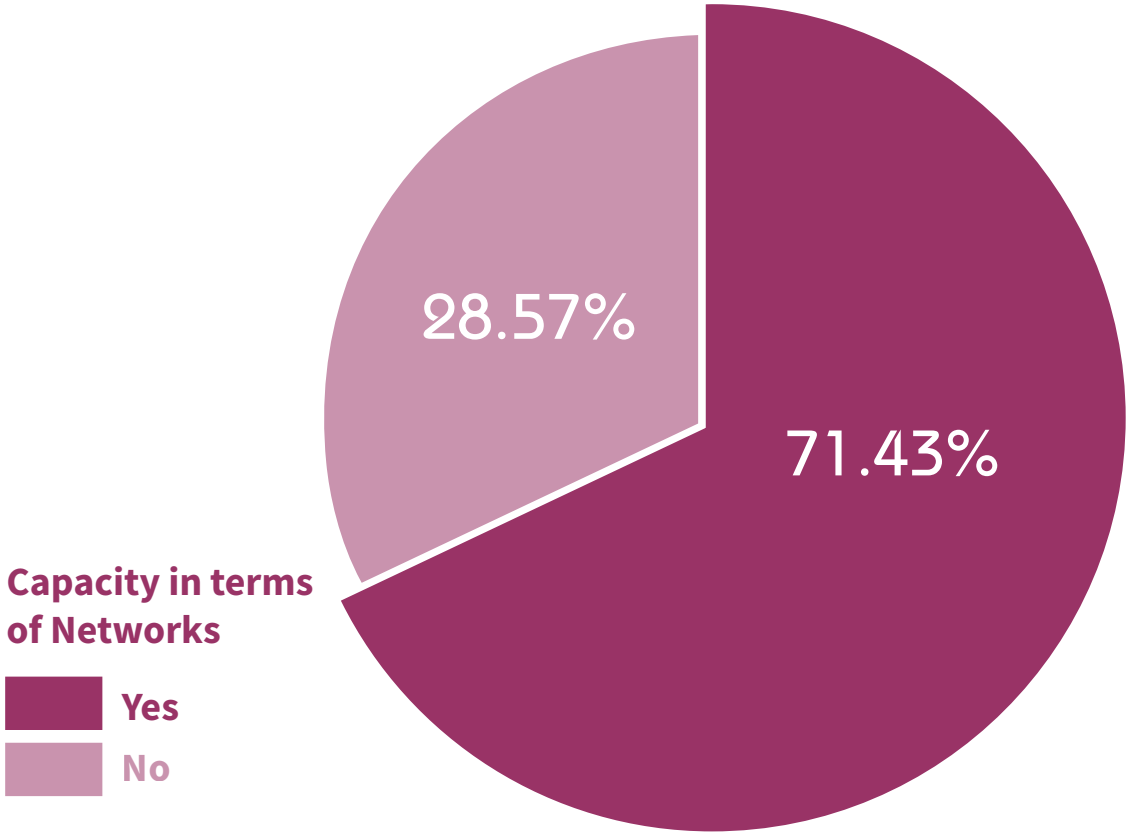
No of advocacy staff	Frequency	Percent
1	2	28.6
2	3	42.9
3	1	14.3
4	1	14.3



All the partners suggested that they need more capacity building for staff involved in advocacy work. Three partners had only one staff trained on advocacy. Omega Foundation went ahead and recruited a community person who is in charge of advocacy at the community level. Some partners had high staff turnover rates and had their advocacy needs changing from time to time since the advocacy roles and responsibilities were constantly shifting. But generally among all partners three quarters of them have been trained on LARC and CAC.

All the partners had a common challenge that they had inadequacies with the project staff and skills who are specifically attached to grassroots advocacy.

There was a general concern among the partners that the YPPs and CHVs trained in advocacy could not be relied on fully due to their high attrition rates and it would therefore be important to capacitate project staff on grassroots advocacy and prepare refresher courses for the already trained ones.



Dauwoye has Marie Stoppes, I choose life, Impact Kenya, Ministry of Health and YMCA as their advocacy partners. Viagenco network of partners in Mbita dealing in child rights, sexual offences and SRH while Nyarami has Ministry of Health as their partner. Matibabu has worked with KMET in Kisumu, Amurt in Samburu, NAYA Kenya and county government of Siaya.

It is worth noting that the SD partners mentioned that the advocacy partner is active in supporting them to champion the RH agenda and issues both at the grassroot through the youth advocates and at the county level through partnerships with the SD partners, MoH and other CSOs. The point persons at the Ministry of Health were mentioned as the Rh coordinators, the directors of health, CECs and the committees of health at the county assembly.

Generally, 71.43% of the respondents were satisfied with their participation in building networks and coalitions which help them push their advocacy agenda. But on further probing they are however unsatisfied with the perception of their organisation and mandate as seen by the government, county government and the ministry of health especially with regards to SA. They are particularly discontented with the fact that they cannot discuss this openly with some partners in the networks and coalitions that they subscribe to.

3.3 Have you participated in any policy/budget advocacy activity?

In collaboration with NAYA and other partners 5 representatives from Dawuoye attended a budget hearing in Marani and Mosocho. They advocated for increased resources for health biased family planning in April 2016. KMET has been represented in budget advocacy for Homabay (family planning) and Migori integrated budget hearing (invited by NAYA) but have also not participated in policy advocacy. Matibabu through its representatives have attended 4 budget and policy advocacy meetings organized by Naya. The last was in Alego and was both policy and budget advocacy where they discussed with the county health Committee on allocation towards maternal health.

Nyarami, Omega and Lwala have participated in one budget advocacy activity each but have not participated in any policy advocacy activity.

Viagenco has neither organized nor participated in any budget or policy advocacy activity.
The challenges as to why they did not actively participate in the advocacy activities were mainly competing tasks for the advocacy point person or the programmes coordinators-whichever case may apply-since they were also in charge of implementation of other programme activities. Insufficient information especially regarding the government calendar with regards to specific venues and dates of the engagement meetings was cited as a drawback.

*3.4 Are you aware of any SRHR policies that are relevant to your work? * Name some of the policies you know Crosstabulation*

	One	Two	More than two	None
% within Are you aware of any SRHR policies that are relevant to your work?	0.285714	0.285714	0.285714286	0.142857

The service delivery partners should be aware of policies that are relevant to reproductive health and specifically family planning and safe abortion. This will help provide updated information and access to full range of sexual and reproductive health services including FP in a safe and supportive environment free from abuse and exploitation since they are well aware of the policies surrounding their work. On asking if they knew the policies 28 percent of them knew only one policy while the rest knew more than one. The most popular policies were the sexual and reproductive health policy and the constitution of Kenya

3.5 Support given to YPPs and CHVs

Ypps and CHVs are charged with the responsibility of creating an enabling environment and increasing the demand of FP services offered by the facilities through educating the community and participating in activities that advocate for these services. The service delivery partners coordinate their activities and also support them with their work from time to time in the community.

At Dawuoye and lwala, the YPPs and CHVs have been integrated. The support given to them by the organisation includes lunch, transport and flipcharts. Other than incentives, the organisation does not have any stipend for them, resulting in complaints about too much workload. In addition, they do not have any long term plans with them.

At viagenco and matibabu they organise integrated events to ensure that mobilisation is successful since all the YPPs and CHVs participate. They have also enrolled YPPs and CHVs in other projects other than CTG which goes a long way in contributing to referrals. They have gone a step further and included their YPPs and CHVs in community lending schemes as they are also community members. Apart from the stipend, they have created recreational centres to generate income for them. For matibabu in collaboration with red cross have pushed for inclusion of their CHVs on the government payroll which is successful since most of them have been considered and they have plans of pushing for the inclusion of the remaining ones.

At omega and nyarami since all their facilities have YPPs and CHVs attached to them they decided to have them on the organisational payroll. All the YPPs and CHVs were trained on advocacy by NAYA and they have refresher trainings for them. Nyarami has sponsored nurseries for tree planting for the YPPs and CHVs as a long term investment plan.

For KMET they have supportive supervision, job aids that includes counselling bags and flip charts, they have a microfinance scheme where they can get soft loans from time to time. They also have the privilege to be capacity built on other courses offered to organisational staff and KMET also acts as a referee for those seeking jobs elsewhere.

3.6 Link service delivery to advocacy?

3.6 Link service delivery to advocacy?

The linkage between this two components is critical since advocacy work should ideally contribute by increasing demand for the services offered by the facilities. The service delivery partners do this mainly through community sensitization and grassroots advocacy. They start first by addressing gatekeepers who include chief's youth and women leaders, MCAs, religious leaders and teacher by giving them the right information and encouraging them to pass this on to the community members. All the organisations have some of these gatekeepers as their champions. They also identify these champions through free service camps and community forums which serves as a platform for them to engage with the community as part of it. As a good practice by Dauwoye and Lwala, when these champions from the community mobilise the forums are well attended.

Omega and Nyarami specifically targets women in adopting LARC and they conduct health talks in school on teenage pregnancy.

3.7 Advocacy issues at the community level

3.7.1 The respondents identified the following issues to be cross cutting at the grassroot and should be top of the advocacy agenda:-

- Access to services: Community want to know the causes of problems before they happen, e.g. why talk about unsafe abortion
- Resources: What are the resources available to prevent teenage pregnancy?
- Knowledge about policies: let the community know about the role of the policies

- Male partners still a stumbling block and their involvement is key.
- Need for more sensitization on LARC compared to short term methods
- Need for VCAT for service providers and opinion leaders and gatekeepers.
- Good will from political leaders to support family planning
- Religion, culture and family planning.
- Conflict of interest among different partners
- Language barriers and preference of certain expression of terms by community members (some terms in reproductive health are considered obsolete or disrespectful by community members)
- Teenage pregnancy and unsafe abortion
- Myths and misconceptions about Family planning methods and safe abortion
- Accessibility of commodities and services- In some situations we realise client has made a choice but no commodities

3.7.2 Advocacy Issues at the county level

- MCAs need capacity building on policies
- Budgetary allocation for reproductive health services
- Supply of family planning commodities from the government has been inconsistent
- Poor implementation of reproductive health policies currently in place
- Family planning advocacy in low population settings. Leaders question our motives in such situations, e.g. why not dwell on HIV or drug abuse.
- Capacity of leaders on causes of maternal mortality, including knowledge
- Data quality and integrity issues at the county level which consequently makes decision making a challenge
- Low budget allocation to SRH in terms of commodity supplies and campaigns to access services

3.8 Support from the board

The partners need support from the board to successfully deliver their mandate and with reference to Closing the Gap the partners generally felt that the various boards were supportive mainly through being champions in the community and fundraising.
Four of the partners have CTG as their core project and the board was well aware of their activities. All the organizations did an induction meeting to their board members and the various CEOs who sit in the board as secretaries update them regularly on their progress and challenges. This strategy has proved to gain more support as evidenced by KMET, Nyarami and OMEGA Foundation and in some instances like that of Matibabu Foundation the board members are at times involved in various activities as part of the ownership and feel process.

YPP & CHV's FGD

4.1 What is your understanding of advocacy?

In this we asked the YPPs and CHVs to define advocacy and some of their responses are as listed:-

"Reaching the community to come up with solutions"
"Meeting with individuals who can influence other community members to bring change"
"A way you can organize community to come with goals"
"To speak on community behalf"
"Fighting for something e.g. reproductive health and rights for better health services"
"A policy undertaken to bring a change within a region or community"
"Process of championing for an issue or course"
It is clear from the responses that some of the participants knew what advocacy is while others clearly had a vague/shallow understanding of what exactly advocacy entails and they needed clarification on its meaning and content.

4.2 Advocacy activities engaged in

In this the YPPs and CHVs were asked the advocacy activities that they engage in and their responses were as listed:-

"Peer to peer sessions from with teens and youth aged 18-24 in and out of school"

"Parent to youth sessions involving issues affecting their relationships. We learnt that bringing them together promotes openness"

"General sexual reproductive health talks and challenges"

"Sourcing contraceptives and distribution to sexually active youth. I last mobilized 100, out of which 10 managed to seek services. The activity was at the sports ground Kisumu"

"Holding Male involvement forums at the grassroots level. We want them to understand FP well as some men don't allow women to use family planning"

"School program in both primary and secondary schools. Discussions with school girls on family planning and CAC, through their female teacher who is the school matron"

"Targeting women with family planning education. We make women understand SRH is Part of life and way of preventing early and unplanned pregnancies. Outreaches take one and half hours including 20 minutes for asking questions"

"Chief Barazas. Meetings with the chief of Kiakumi location"

4.3 Challenges

- Religious beliefs and culture: Catholic don't want you to speak about condoms. Others say God created woman to give birth and fill the earth. There is time I tried passing information to the church but they were against it.
- Some people at the end of trainings say they are not satisfied therefore need for IEC in vernacular language and frequent activities
- Affordability of services e.g. removal of implant that require around 400-500 for insertion that was made elsewhere
- Not all YPPs and CHVs have been trained and some need refresher trainings
- Men who are against family planning
- Unprofessional service providers
- Distance and transport costs for outreaches
- Attitudes, myths and misconceptions. Attitudes and myths that IUCD disappears in the stomach. We ask them what they know about IUCD and Let them touch and feel it
- Stipend for YPPs and CHVs
- Incentives. Some community members want to be paid for attending forums
- Inadequate IEC materials. We lack IECs materials

4.4 Support required

- Capacity building: Only few people were trained
- We should support documentation of stories and experiences e.g. unsafe abortion
- Increase public private partnership in supporting CHVs and YPPs
- Sensitize community to support YPPS and CHVs in outreaches
- Help in sensitization and awareness creation through media
- Inform the community during outreaches and forums on the programs in place and the organizations undertaking FP
- Supplement CTG programs and other related programs e.g. HIV
- Identification e.g. badges and those we have need to be improved
- IEC materials including handouts for community members
- More community forums
- Exchange visits with Other YPPs
- Review stipend for YPPs and CHVs
- Full time employment for YPPs rather than part time
- Need for NHIF for YPPs and CHVs
- Communication stipend for YPPs and CHVs

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