Strengthening 'Voice' and Accountability

STRATEGIC PLAN
2022 - 2026

HERAF
Health Rights Advocacy Forum

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LIST OF ABBREVIATIONS

ADP	Annual Development Plan
CBOs	Community Based Organizations
CFSP	County Fiscal and Strategy Paper
CIDP	County Integrated Development Plan
CRC	Community Report Cards
CSC	Community Score Cards
CSEM	Civil Society Engagement Mechanism
CSOs	Civil Society Organizations
FBOs	Faith-Based Organizations
GDP	Gross Domestic Product
HCF	Health Care Facilities
HCWs	Health Care Workers
HERAF	Health Rights Advocacy Forum
ICT	Information and Communication Technology
MERL	Monitoring, Evaluation, Research and Learning
MNCH	Maternal, Newborn and Child Health
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
OCA	Organizational Capacity Assessment
OVCs	Orphaned and Vulnerable Children
PETS	Public Expenditure Tracking Surveys
PWD	Persons with Disability
PWSDs	Persons with Severe Disabilities
RBA	Rights Based Approach
SDG	Sustainable Development Goals
TOC	Theory of Change
UHC	Universal Health Coverage
UN	United Nations
WASH	Water Sanitation and Hygiene

FOREWORD

I am pleased to present our next five-year strategic plan for the period 2022 – 2026; this plan is preceded by the strategic plan 2017/18 – 2021. This Strategic Plan defines what we intend to achieve and how we will accomplish this in the next 5 years. It defines our collective vision, mission, and goals, reinstates our values, and brings forth our theory of change.

All the strategies are rooted in human rights principles and the obligation of governments to respect, protect and fulfill the rights of all people as stipulated in the Kenyan Constitution and other Human Rights Treaties. While promoting health as a human right, HERAF will endeavor to support citizens in holding elected officials accountable and upholding the rights of citizens to participate at all levels of government.

The strategic plan responds to the changing environment under which we work. Upon review of the gains made in the past: we seek to build from the gains made and lessons learned in the new strategic direction, we will strive to transform access to health services through strengthened voice and accountability as we look forward to 'A Kenya where health is equitably enjoyed'. The review of the last strategic period revealed that the organization was able to grow both internally and externally by building internal capacity to execute its mandate. We have also strengthened our networks and partnerships with different stakeholders over the years something that gives us the pride and urges to continue doing what we do.

Enhanced democracy, human rights and governance for health and quality of life, equity and inclusivity in the provision of quality health care services at both national and county governments, stakeholder engagement in health care governance and accountability processes and strengthened institutional systems for effective delivery of the organization's mandate will be the driving force through which HERAF will strive to realize a Kenya where health is enjoyed equitably.

It is our hope that with the new strategic plan, we will specifically enhance our overall effectiveness by ensuring that our vision and mission reflect on the changing world under which we work, further strengthen our networks and partnerships, develop innovative ideas to resource mobilize and ensure sustainability. Finally, it will enhance the oversight of the organization by strengthening the organizational governance and accountability to self, government, partners, and our beneficiaries.

As we embark on the five-year journey, we will rely on your support as we invite you to partner with us to take health rights a notch higher.

Dr. Andrew Juma Suleh,
Chairman, Board of Directors

ACKNOWLEDGMENTS

I am pleased to share our strategic plan 2022 – 2026, which seeks to steer HERAF towards the full enjoyment of health-related human rights for all in the next five years. I am grateful to all our partners who supported our strategic plan for 2017 - 2021. These are Centre for International Business Enterprises (CIPE), Open Society Foundation (OSF) through Open Society Foundation for East Africa (OSIEA), Christian aid, USAID Afya Pwani, Global Water 2020, IRC, URAIA Trust and Comic Relief. Through their support and the lessons learnt from its implementation have greatly informed the development of this strategy.

I am indebted by the support and guidance from the members of the Board, Dr. Andrew Suleh, Beatrice Kuria, Winfred Lichuma, Patrick Kamunyo and Lucy Simiyu. They diligently labored to provide strategic guidance that informed the policy direction for this strategic plan.

In a very special way, I appreciate the staff of HERAF. That is, Christine Ajulu, Bernice Kiragu, Heston Makamu, Jemima Muthoni, Edwin Kamau, Maureen Asembo, Peter Mutiso, Mary Kemunto, Patrick Nzomo, Elizabeth Semo and Janet Kaindi. Their time, determination, and valuable inputs during the visioning and validation workshops which were instrumental in putting into account the needs of our stakeholders.

I am also indebted to our partners including Dr. Margret Makumi, Paul Kuria, Margret Mbugua, Emma Njeri, Easter Nyawira, Esther Muhati, Mugambi Laibuta and Paul Gatitu who took part in the intense validation workshops that consolidated various elements of the strategy and produced the second and final draft of the document.

My special thanks go to Comic Relief and Uraia Trust for their financial support towards the development of this strategic plan. We look forward to opening new chapters of partnerships as we implement this strategic plan. I am grateful too, to our partners both at National and County government levels and communities that we serve for inspiring us to do our best.

Last but not least, I am overwhelmed by the support and facilitation skills from Mary Kuira, the Consultant who facilitated in putting this strategy together. She ably coordinating the team and put a lot of time, energy, and effort into making this strategic plan a reality.

Edward Miano Munene
Executive Director

1. INTRODUCTION

1.1 Overview

HERAF is a national non-governmental organization that promotes a health system that protects human rights, and is responsive, equitable, and accountable. It was established in 2006 and registered by the NGO Coordination Board in 2007 as Health Rights Advocacy Forum (HERAF).

1.2 Vision - A Kenya where health is equitably enjoyed by all citizens.

1.3 Mission Statement - Transforming health system through strengthened voice and accountability.

1.4 Target Groups and Beneficiaries

- Civil Society Organizations (CSOs) including Non-governmental organizations (NGOs), Community Based Organizations (CBOs) and Faith Based Organizations (FBOs).
- Organizations of People with medical conditions/ Patients' associations.
- Organizations of Persons with Disability (PWD).
- The health care workers and their professional associations.
- National Independent Commissions.
- The Private sector, Foundations, and Trusts.
- County governments (the Executive and County Assemblies).
- National government (Ministries, Departments, and Parliament).
- Development partners, donors, and UN Agencies.

The main beneficiaries are:

- Vulnerable and most at-risk populations (Women, youth, children, and the older members of society).
- Persons with Disabilities (PWD).
- Persons living with medical conditions.
- Health care workers.
- Community, religious and traditional leaders.
- County governments' officers and Members of County Assemblies (policymakers).
- National government officers and Members of Parliament (policymakers).

1.5 Values and Principles

- Equity and diversity
- Transparency and accountability
- Participation and Inclusion
- Teamwork
- Non-partisan
- Empowerment
- Integrity

2. LEARNING FROM PAST STRATEGIC PLANS

HERAF has implemented three (3) Strategic Plans since inception. The first strategic plan covered 2008 – 2012; it envisioned a Kenya where health is upheld and enjoyed as a human right. To achieve this vision, HERAF embarked on empowering Kenyan's to enjoy the right to health through increased human rights awareness, evidence-based policy advocacy, and strengthening citizens' participation in health sector governance, and budgeting processes. This plan focused on five (5) strategic Objectives; Creating and increasing awareness of the right to health in Kenya; Evidence-based advocacy for Health System Strengthening at National and County Levels; strengthening community participation in health sector management; Promotion of efficient and sustainable health care financing system; and Institutional Development. During the period, different strategies including Capacity Development; Partnerships, Networking and Collaboration; Human Resource Strengthening; Mentoring, and Technical Assistance were utilized to deliver the strategy. The core values that reflected the organization's work were upholding human dignity; equity and inclusivity; accountability and transparency and people-centeredness.

The second strategic plan, 2013/14 – 2017/18 was built on the lessons learnt from the previous one. Although the vision remained the same, the mission was revised to empower communities to enjoy quality health services by promoting informed participation in policy advocacy, planning, and governance processes. The focus was revised into four (4) strategic Objectives that included Empowering citizens to comprehend the human rights-based approach to health; Promotion of citizens' advocacy in the development and implementation of health sector policies at national and county levels; Increasing citizen's participation in County and National government's planning and budget-making processes; and Promotion of social accountability and transparency at national and county levels. The third strategic plan 2018 – 2021 maintained the 2013/14 – 2017/18 strategies.

During the 2017/18 – 2021 strategic period key projects implemented focused on leadership and governance, Mental Health, and Water Hygiene and Sanitation (WASH) in Health Facilities (HCF).

2.1 Leadership and Governance

HERAF promoted civil society organizations (CSOs) participation, engagement, and oversight in governance at the national and county level. Key interventions included public participation in policy dialogue forums, planning, budgeting, monitoring public services, and tracking utilization of public resources. This project was implemented in Nyeri, Kilifi, Makueni, and Elgeyo Marakwet Counties. Among the lessons learned included:

- An informed and organized civil society into County focused coalitions or networks was crucial in driving advocacy for County government planning and budgeting processes. Leveraging different CSOs' strengths and establishment of governance structures within the networks with clear roles and responsibilities streamlined access to county policy, planning and budgeting documents, timely analysis, development of popular versions, and ultimately better articulation of citizen feedback packaged into memoranda for submission to respective County Executive and County Assemblies. CSOs coalitions were also instrumental in monitoring how the approved budgets were implemented through Public Expenditure

Tracking Surveys (PETS), Community Report Cards (CRC), and Community Score Cards (CSC). This was a great shift from the disjointed and reactive civic engagement in county and national government policy advocacy, planning and budgeting processes that barely generated the much-anticipated impact.

- During the strategic period, targeted County governments of Nyeri, Kilifi, Makueni, and Elgeyo Marakwet put in place communication plans to create awareness and disseminate information on public participation in the county government planning and budgeting process. However, most of the strategies such as social media, government websites, television, and newspapers only reached technologically sound citizens especially those in urban Objectives. County governments failed to upload budget information on their websites in time or the websites were down and gave short notices for public hearings forums denying citizens effective participation. Therefore, people-centered channels that broadly disseminate information in usable formats are necessary for facilitating active citizen participation. Such channels include vernacular radio stations, public notice boards, and announcements in public gatherings supported by public participation forums that are devolved to ward and village levels.

- Civil society organizations were instrumental in citizens' capacity training on the budget, budgeting process, and opportunities for citizen engagements, representing citizens' views and exerting pressure on the County governments to prioritize community issues. Several, budgetary issues would not have found their way into the approved budget if there was no sufficient pressure from civil society coalitions. Hence, to successfully institutionalize budgeting processes, sustained support (financial and technical) to civil society should be provided.

2.2 Mental Health

Building the capacity of persons with lived mental health experiences was vital in enabling them to take charge of their own health and to engage with government officers and policymakers. HERAF worked with groups of persons with lived mental health experiences in sensitizing and training them on the policy process and the county budgeting process in Nyeri, Isiolo, Embu, Kilifi, and Nairobi Counties. This was instrumental in mobilizing and organizing community-based organizations into advocacy coalitions for championing human rights issues including mental health law and financial investments. As a result, there emerged more pro-active CSOs working with persons with mental health problems.

The emergence of COVID 19, increasingly made mental wellbeing a priority, including continued sensitization and awareness creation targeting the government to invest more, and develop policies and legal frameworks for mental health. There were advocacy efforts that called on the government to develop a national mental health framework, establishment, and operationalization of mental health Technical Working Groups (TWGs) at the county level, and train more health care workers including community health volunteers on community mental health service. HERAF was also involved in the rollout of the WHO Quality Rights training to increase the numbers of mental health champions in target counties of Nyeri, Isiolo, Machakos, Kilifi, and Nairobi.

During the period, the persons with lived mental health experiences were placed at the core of the implementation. Prior to the project, they were given less attention and were less productive. When HERAF trained these groups on the budget-making process, they were able to advocate for priorities to be included in the county planning process. This was a clear indication that persons with lived mental health experiences can articulate their needs within the planning process if accorded a safe platform.

Paucity of correct information was one of the hindrances towards development and implementation of mental health policies and increased investments. As more correct and factual information was made available, change of attitudes and perceptions towards mental health policy environment and investments were witnessed and should be sustained. The engagement with policy makers was essential in ensuring improvement of the legal and financial investments for mental health. HERAF mobilized and empowered persons with lived mental health experience, civil society organizations and stakeholders to effectively participate in public dialogue forums on the amendment of the Mental Health Act 1989 both at county and national government levels. Prior to these, stakeholders admitted that they were not aware of the process of the reviewing laws.

Implementation of the Rights Based Approach (RBA) to mental health was the best approach as it helped in demystifying the social cultural wrongs that were meted against persons living with mental illnesses and disabilities. The RBA puts the people first thereby capitalizing on the protection of these individuals as well as the allocation of resources in tackling the concerns raised.

2.3 Water, Sanitation, and Hygiene (WASH) in Health Care Facilities (HCF)

In order to increase access and quality of health services, HERAF advocated for improved development and implementation of laws, policies and financial investments for Water, Sanitation and Hygiene (WASH) in Health Care Facilities (HCF) in Nyeri, Isiolo, and Machakos Counties. The emergence of COVID – 19 exposed the serious gaps in the management of WASH in HCF with the majority of facilities unable to maintain a portable hand washing facility for patients, ensuring a steady supply of clean and safe water, and most financial realignments were done to the detriment of WASH.

Lack of proper latrines, good quality water, lack of proper hand-washing mechanism, or lack of proper hygiene in HCF emerged as one of the barriers hindering women from seeking maternity services in some of the health facilities. They shunned level 2 and 3 facilities that offered maternity services due to WASH conditions. On their part, persons with disability were affected as most health facilities had WASH facilities that did not meet their needs. Hence, advocacy should be stepped up to ensure the development of WASH infrastructural development for people with disabilities in HCF such as ramps for accessing toilets, handrails to support people while washing hands, wide walkways for people with wheelchairs or crutches, as well as mounting of washing basins at an acceptable height.

In all the facilities drawn from Nyeri, Isiolo, and Machakos counties that HERAF engaged with, none had a dedicated budget line for WASH. Discussions with the county and facility head established that WASH money was provided as a lump sum under the facility management fund. The challenge with this was that, if there were more pressing needs such as payment of labor then resources would be appropriated to such needs. HERAF commenced discussions around WASH among the County health department and the department for Economic Planning and Budgeting in order to ensure WASH in HCF was planned and budgeted for.

Empowered community members including facility clients, caregivers, Facility Management Committee Members and HCWs on WASH in HCF requirements was instrumental in enabling them to pile pressure on the county government during planning and budget public hearing forums to establish a budget line for WASH in HCF. It, however, remained an uphill task to convince the County government budget team of the importance of WASH in the HCF budget line. The economic value – returns in investments often dominated the discussions and prioritization among other county development needs and balancing for political interests.

2.4 Climate change

Climate change is threatening many health achievements in serious ways, including by leading to death and illness from increasingly frequent extreme weather events, such as storms and floods, the disruption of food systems, increases in food-, water- and vector-borne diseases, and mental health issues[1]. Further, climate change is undermining many of the social determinants for good health, such as livelihoods, equality and access to health care and social support structures. These climate-sensitive health risks are disproportionately felt by the most vulnerable and disadvantaged, including women, children, the elderly, persons with disability, the poor, and those with underlying health conditions[2].

The public, healthcare workers, decision and policy makers knowledge of how climate change affects health is low. The disease burden related to climate change pose added obstacles to achieving UHC by increasing overall use and cost of healthcare. As a consequence, climate change is pushing many people into poverty due to increased health burden, out of pocket expenditure and property loss among others thereby “trapping people into poverty”. Worsening poverty contribute to higher burdens of disease, placing more stress on healthcare system, putting greater stains on government budgets in the attempt to provide affordable, accessible and quality healthcare. This is compounded further by lack of coherent policy response which addresses the interface between climate change and health. Policies and strategies need to be sharpened, focused and coordinated to deal with the range of impacts climate change has on health system. Hence, there is urgent need for the government to build climate – resilient health systems, which guarantees access by all to protect health and avoid widening health inequalities.

[1] WHO Climate Change and Health. https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
[2] Ebi, K.L and Jeremy J. Hess, 2020, Health Risks Due To Climate Change: Inequity In Causes And Consequences. Health Affairs Vol. 39 No. 12. Climate Change. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01125

3. OVERALL CONTEXT

3.1 Internal Environment

HERAF is a National Human Rights organization registered as a Non-Governmental Organization (NGO) in Kenya by the NGO Coordination Board in 2007. HERAF is renowned for its practical experience and strategies that span over 6 years in policy and budget advocacy, as well as social accountability. During this period, the organization has established functional connections, networks, and linkages with national and county governments. This has resulted in the development of enviable and unmatched prerequisite professional and technical capacities that have been instrumental in the success of the organization.

In 2021, HERAF began the process of re-strategizing itself and positioning the organization to design and deliver more innovative products and services in current fast-changing political, social- economic, and technological environments. The organization has an institutional culture of very strong values where the leadership takes full accountability for the delivery of the organization's plans and goals. HERAFs brand is strong and connects well with the community. It has demonstrated leadership, especially in advocacy for people, a human rights-based approach to project design, and the implementation and community-led accountability processes. The organization has strong partnerships and collaboration with fellow civil society organizations, healthcare worker's professional organizations, the private sector, foundations, donors, and UN agencies.

Among the key programs run by the organization includes human resources for health, maternal, new-born, and child health (MNCH), HIV and AIDS, mental health, water and sanitation in healthcare facilities (WASH in HCF), and the health sector governance – policy, financing, and accountability.

HERAF conducted an organizational capacity assessment (OCA) on its internal systems that identified critical strengths and weaknesses to focus on during this strategic period. According to the capacity assessment, overreliance on traditional donors for support since inception was identified as the key weakness of the organization. This was noted as unreliable since fluctuations in the flow of donor funds reflect directly in the implementation of programs. Therefore, the organization has to establish a resource generation plan that will ensure efficiency in its productivity and performance. The plan should include a full-time staff responsible for resource mobilization. There is also the need to digitize HERAFs internal functions and procedures, which will greatly improve the organization's presence and visibility on social and mainstream platforms. It will also provide holistic data collection and analysis for purposes of decision-making. There is also a need to document and publicize success stories for the organization.

3.2 External Environment

3.2.1 The Global Context

Globally, there is an increased focus on the need to promote the health and well-being world's population, strengthen health systems, and tackle inequalities. Health is a precious global good, a basic human right, and a matter of social justice. Worldwide, health is considered an important global economic and security issue. Further, health is a prerequisite for human, economic, and social development. Hence, it has become a priority for political and social development agendas as demonstrated by its inclusion in global Sustainable Development Goals (SDGs)[3]. There is a global call that all members of a population should have access to high-quality essential health services without suffering financial hardship. This is globally possible if all States embrace and work towards achieving Universal Health Coverage by 2030 as reflected in the SDGs.

The progress toward achieving universal health coverage by all UN member counties by 2030 remains a challenge. Even before the emergence of COVID-19, there were no guarantees that all nations would achieve UHC in time. This is complicated by unequal economic growth and unfair international trade that deny poor nations from benefiting from innovations such as access to modern medical equipment, technologies, and vaccines[4]. Our works and experiences in the last two decades have revealed that health inequalities are largely driven and sustained by structural factors that the political system in each country should be able to address. Indeed, promoting investment in health including achieving UHC is a political choice that each government must prioritize.

3.2.2 The Kenya Context

3.2.2.1 Kenya's Democracy

A country's political structure influences essentially every facet of society, including health. Kenya is a democratic country that provides opportunities for citizens to determine how they should be governed. Democratic principles, such as freedom of assembly, association and speech, inclusiveness and equality, the right to vote in a fair and free election, and the right to representation provides opportunities for citizens to debate and influence social, economic, and healthcare policies from political leaders. Political will, attitudes, and perceptions of political and community leaders determine the type and levels of policies, budget allocation, and expenditure on health; responsiveness to citizens' needs, transparency, and accountability in public services. Hence, citizens through this strategic plan shall be empowered to be proactive in participating in all democratic processes impacting their health and wellbeing at the community, county, and national levels. HERAF will support communities to hold the government accountable for resources allocated to the health sector and demand affirmative health actions and programs directed to the most vulnerable groups.

3.2.2.2 Kenya's Health System

[3] UNDP, 2022. The Sustainable Development Goals (SDGs) in Action. United Nations Development Programme

[4] https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses

The right to health is a fundamental human right guaranteed in the Constitution of Kenya 2010. Article 43 (1) (a) of the Constitution 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 services. The Kenya Health Policy 2014–2030, Vision 2030, and global commitments such as Sustainable Development Goals (SDGs) provides an overall direction on how the country can attain the highest possible standards of health as provided by the Constitution. However, health system demand and supply-side determinants curtail the enjoyment of this right. These factors compromise Kenya's health stem capacity to guarantee demand and supply for quality healthcare services. It is therefore important that both demand and supply factors are addressed concurrently in order to strengthen the health system.

3.2.2.3 Human Rights

Lack of attention to human rights is a powerful barrier to the delivery of health services as they expose most at-risk and vulnerable populations to human rights abuses including negative attitudes, stigma, and discrimination at household, community, and health facility levels. Continued perpetuation of negative social-cultural practices such as female genital mutilation, forced early marriages, and negative religious and traditional beliefs, contribute to health inequalities. Failure to uphold human rights is also linked to denial of the vulnerable and most at-risk populations' capacity and opportunity to contribute to decisions that affect their health, and demand transparency, and accountability by government officers and service providers. The underlying causes of these inequalities should be addressed at all levels in order to achieve health equity.

3.2.2.4 Barriers to Health Equity

Health inequities are measurable differences in health profiles, which are not only 'unnecessary and avoidable, but in addition, are considered unfair and unjust[5]. Factors contributing to health equity are limitless and are associated with social, cultural, economic, demographic, legal, and technological barriers. Inequities in health complicate prevention, promotion, treatment, and care for both communicable and non-communicable diseases in a community.

Health equity and diversity demands that all people in a community irrespective of their socioeconomic statuses must have the ability to achieve good health. However, good health can only be achieved when demand and supply barriers erected by artificially established social, cultural, economic, demographic, legal, technological, climatic, and environmental inequalities are demolished.

3.2.2.5 Universal Health Coverage (UHC)

[5] Whitehead M. The concepts and principles of equity and health. Int J Health Serv 1992; 22: 429–445 as cited by Leila Hojat https://orcid.org/0000-0003-4364-8141

UHC is defined by WHO as a commitment "to ensure that all people obtain the health services they need without suffering financial hardship when paying for them[6]." Our experience in the last four years indicates that there are different understandings of what UHC mean and how it is implemented across the country. This was so because UHC is pushed by a number of different players whose interests inform their position. There was consensus that UHC's sole purpose is to ensure equitable access to health services. However, it was not clear whether UHC is a single target and if it should be interpreted with focus on political and social determinants of health. Further, there were risks that if UHC is solely interpreted in terms of costs, this could open the floodgates of privatization of health goods thereby negating the whole concept of equity, principles of universality, non-discrimination and social protection. Therefore, lack of financial protection and social security emerged as most critical items that Kenya's National and County Governments must address in order to effectively role out and sustain UHC.

The need for advocacy to create political processes that can guarantee enactment of requisite policies and frameworks for UHC was prioritised. There were pleas to advocate for development and implementation of UHC as a public service driven model. It was agreed this would be a better basis for ensuring health for all and a base for a publicly funded financial protection scheme. This called for more advocacy efforts to ensure both national and international commitments to publicly finance health are fulfilled by Kenya government.

3.2.2.6 Health Financing

In the last decade, Kenya's health sector has not witnessed a real increase in the overall resource allocation and expenditure. Health expenditure as a proportion of GDP, and public expenditure as a proportion of general government expenditure, stagnated during the period. Out- of- pocket expenditure has continued to be the highest source of funds for health care financing thereby hindering the majority of the poor from accessing health services, widening inequality, and pushing many into poverty. High costs drive households into poverty and limit their ability to use the services[7]. In 2018, for example, 28 percent of the people who reported being sick did not seek care as they could not afford to pay. The problem is complicated further by low insurance coverage. Only about 20% of Kenya's population has some form of medical health insurance[8]. HERAF will continue to advocate for increased allocation of health funding to at least 15% of the annual budget.

3.2.2.7 Financial Protection for Health

[6] http://www.who.int/universal_health_coverage/en/

Social Health insurance has been recognized in the Kenya Vision 2030 as one of the pillars for Kenya to achieve Universal Health Coverage (UHC) and eliminate the burden of user fees. Numerous advocacy efforts by civil society organizations in the last two decades have seen the government soften its approach to social financial protection for health programs. The program includes health insurance implemented by the National Hospital Insurance Fund (NHIF) through the subsidy program for Orphaned and Vulnerable Children (OVCs), Persons with Severe Disabilities (PWSDs), and older persons (over 70 years of age) and secondary school-going children[9]. There is also the Linda Mama program that offers free maternal care to pregnant mothers.

Despite major investments in financial social protection for health schemes, most poor and vulnerable households do not benefit from these initiatives. There is inadequate awareness and mobilization of the beneficiaries to demand and access these services. The government has not been able to allocate enough funding and to spend the allocated budget[10]. Corruption, low coverage, and program fragmentation, which have resulted in duplication and inconsistency in the operation and implementation of social protection for health by both national and county government entities have further hampered the program[11]. As a result, most needy persons such as persons with disabilities and families in hard-to-reach places are often left behind plunging them further into poverty due out of pocket expenditure for health.

Also, the vehicle through which these health, and social financial protection programs are implemented, NHIF is in dire need of reforms to effectively deliver on its mandate. HERAF will therefore advocate for increased awareness and demand for UHC, investments, and financial social protection for health for the benefit of vulnerable and most-at-risk populations such as women, children, the elderly, PWD, and persons living with diseases. Also, the organization will advocate for Public Finance Management reforms including for National Health Insurance Fund (NHIF) to ensure there are adequate policies that can drive UHC and, assure transparency and accountability.

3.2.2.8 Governance and Accountability

[7] https://www.health.go.ke/wp-content/uploads/2020/11/Kenya-Health-Sector-Strategic-Plan-2018-231.pdf
[8] The World Bank, 2014. https://www.worldbank.org/en/news/feature/2014/10/28/improving-healthcare-for-kenyas-poor.
[9] UNICEF-Kenya, 2018. Social Protection Budget. https://www.unicef.org/esa/sites/unicef.org.esa/files/2019-03/UNICEF-Kenya-2018-Social-Protection-Budget-Brief.pdf
[10] IBP, 2021. Why Poor Kenyans Miss Out on Social Welfare. https://www.businessdailyafrica.com/bd/data-hub/why-poor-kenyans-elderly-miss-out-on-welfare-stipends--3499362
[11] Okoth, F. M. (2021). Factors undermining the effectiveness of social protection programmes as a poverty eradication mechanism in Kenya [Thesis, Strathmore University]. http://hdl.handle.net/11071/12644

Good governance occurs when systems and the stakeholders who operate in them strive to be "efficient, effective, open, transparent, accountable, responsive, and inclusive[12]". Citizens and civil society organizations have a role to play in promoting external accountability mechanisms. They should actively engage in monitoring government policies and decisions made through established platforms for public participation and social accountability. In order to improve government accountability, the ability of civil society organizations to hold the government accountable should be strengthened. They should be enabled to understand national and county government structures, that is, who is responsible for what. Further, their comprehension of laws and policies that illustrate citizens' legal rights, available public services, respective delivery norms, and standards should be enhanced. Feedback /complaints redress mechanisms, social accountability tools, support to technical working groups and public forums that facilitate dialogue between citizens and government are also important for improved governance and accountability.

Public Finance Management Act, 2012 and the County Governments Act, 2012 requires National and County Governments to integrate "citizen voices" into national and county plans and budgets. Civil society organizations should strengthen the capacity of government structures to effectively promote public participation. These include public officer's ability to effectively engage citizens through civic education, awareness creation, public forums and sharing requisite information and documents such as plans, budgets and Bills into easy to read and user-friendly formats. Citizens, including vulnerable and most at-risk populations need both awareness and capacity that determine policy and development choices. That is, provide citizens and civil society organizations with information to make informed choices about policy / development alternatives and organize with others, and inform policy and decision-making debates. Citizens and civil society organizations should advance citizens voices and promote transparency and accountability in public service delivery both at the national and county government levels.

[12] Brinkerhoff, D.W., and T. Bossert. 2008. "Health Governance: Concepts, Experience, and Programming Options." Policy Brief. Bethesda, MD: Abt Associates, Health Systems 20/20. Available at: http://www.healthsystems2020.org/content/resource/detail/1914/.

4. THE STRATEGIC FRAMEWORK 2022-2026

4.1 Overview
This section highlights the strategies that HERAF will apply in the next five years.

4.2 Vision
A Kenya where health is equitably enjoyed by all citizens.

4.3 Mission Statement
Transforming health system through strengthened 'voice' and accountability.

4.4 Overall Goal
Promote active citizenship towards a Kenyan health system that protects human rights, and is responsive, equitable, and accountable.

4.5 Strategic Objectives
Strategic objective 1: Enhanced constitutional processes (democracy, human rights, and governance) for health and quality of life.

Specific Objectives for Strategic objective 1
1.1 To strengthen government and citizen structures to effectively engage in health governance.
1.2 To enhance access to justice among the poor, Vulnerable and Most at Risk Populations.

Strategic objective 2: Enhanced equity and inclusivity in the provision of quality health care services at both National and County governments.

Specific Objectives for Strategic objective 2
2.1 To reduce access-related barriers to equitable healthcare services at the community and health facility levels[13].
2.2 To strengthen the policy and investment framework for Universal Health Coverage (UHC).

[13] Barriers hindering health service delivery include: (human rights violations, social, cultural, economic, infrastructural, HRH, legal and technological, information barriers). Equity refers to fairness across board. Inclusivity refers to bringing on board all those who have previously been excluded in health care services especially poor, vulnerable and most at-risk populations.

Strategic objective 3: Enhanced stakeholder's engagement in healthcare governance and accountability processes.

Specific Objectives for Strategic objective 3

3.1 To enhance transparency and accountability in policy, planning and budgeting processes.
3.2 To improve inclusivity, responsiveness and accountability in allocation and utilization of public resources.

Strategic objective 4: Strengthened institutional systems for effective delivery of the organization's mandate.

Specific Objective for Strategic objective 4:

4.1 To enhance institutional governance and management policies and procedures.
4.2 To strengthen the monitoring, evaluation, reporting and learning (MERL) system.
4.3 To enhance partnership for resource mobilization, networking, learning, and experience sharing.

5. THEORY OF CHANGE

OVERALL GOAL

A Kenyan health system that upholds human rights, is responsive, equitable and accountable.

EXPECTED OUTCOMES

- Enhanced constitutional processes (democracy, human rights and governance) for health and quality of life.
- Enhanced equity and inclusivity in provision of quality health care services at both national & county governments.
- Enhanced stakeholder's engagement in health governance and accountability processes.
- Strengthened institutional systems for effective delivery of the organization's mandate.

BARRIERS

- Ignorance.
- Poverty.
- Negative social and cultural beliefs, norms and traditions.
- Human rights abuses.
- Unequal global economic growth.
- Unfair international trade.
- Environment and climate change
- Low political will.
- Poor accountability.
- Inadequate CSOs, HCWs, public servants and policy makers capacity.
- Low organizational capacity.

TARGETS/BENEFICIARIES

Targets

CSOs/NGOs/FBOs, PWDs, HCWs, CHVs, HFMCs
National and County governments staff and agencies, National and County Assemblies
Private sector, Foundations and Trusts
Development partners, Donors and UN Agencies.

Beneficiaries

- Vulnerable and most at risk- populations, the poor, PWDs
- HCWs, Policy makers
- Community, religious and traditional leaders.

ACTIVITIES/INTERVENTIONS

- Research.
- Policy review and analysis.
- Civic education.
- Human rights awareness campaigns.
- Capacity strengthening.
- Technical assistance.
- Advocacy.
- Access to information and dissemination.
- Media engagement.
- Partnerships, networking and collaboration.
- Organisational strengthening.

OUTPUTS

- Improved capacity of citizens, CSOs, public servants and policy makers on roles /responsibilities.
- Strengthened linkages and referrals for legal aid support.
- Reduced access-related barriers to health.
- Increased advocacy for health investments.
- Strengthened health policy, planning, budgeting and infrastructure.
- Improved responsiveness, efficiency, accountability and transparency.
- Enhanced engagements in demanding fulfilment of health commitments.
- Enhanced organisational governance and management systems.
- Strengthened monitoring, evaluation, and knowledge management systems
- Enhanced partnerships, networking, learnings and experience sharing.

6. MANAGEMENT AND IMPLEMENTATION OF THE STRATEGY

6.1 Organizational Structure

The organizational structure for HERAF shall be reviewed to improve the outline of how decisions are directed in order to effectively achieve the mission. These include the board member's structure, policies, staffing levels, qualifications, experiences, roles, and responsibilities. It will also focus on how information flows from the Board, Executive Director, Management Team, Members of staff, target audiences, and stakeholders.

6.2 The Board of Directors

HERAF is governed by the Board of Directors. The Board provides policy, oversight, and strategic direction to the organization. Specifically, the board shall ensure:

a) Approval of the strategic plan, policies, and guidelines.
b) Review and approve the annual work plan and budgets.
c) Provision of fiscal oversight and ensuring there is adequate accountability and compliance.
d) Provide policy guidance on resource mobilization and approve funding sources.

6.3 The Secretariat

The day-to-day running of the organization shall be vested in the hands of the Executive Director with the support of the management team. The Executive Director shall be responsible for:

a) Implementing the Strategic Plan, providing the leadership in the implementation of the decisions made by the board of directors.
b) Leading the day-to-day operations of the organization
c) Resource mobilization
d) Building and sustaining collaborative partnerships and networks.
e) Promoting organization's visibility.

6.4 Partnerships, Networking and Collaboration

HERAF will mobilize and build strategic partnerships and alliances with National and County Governments, development partners, civil society organizations, the private for- profit sector and other stakeholders in order to build synergy in realizing the strategic objectives.

6.5 Monitoring, Evaluation, Research and Learning (MERL) Framework

To ensure that this Strategic Plan is effectively implemented, monitored and evaluated, a detailed MERL framework will be developed. This will be linked to all projects being implemented by HERAF. The MERL framework will help in tracking progress, document results and provide tools for evaluating and forums for reflecting on the outcomes. The learning agenda will be integrated into the framework to ensure continuous learning based on the intended/unintended, positive/ negative outcomes. Gathering evidence on a regular basis will be critical in informing decision making either on the current strategies or on the implementation of the activities while also documenting lessons to inform future interventions/strategies.

Monitoring and evaluation of the strategy's implementation will involve tracking performance of the various indicators under the different pathways of change in the Theory of Change (TOC). Targeting will be informed by the current status of different indicators, active projects as well as the financial resources available. Monitoring of the strategic plan will be done annually through review and reflection forums where outcomes will be analyzed under each strategic pillar. Each year HERAF will have a learning agenda informed by the assumptions from the TOC and learning questions. HERAF will adopt Outcome Harvesting for monitoring qualitative indicators. Other methodologies to be adopted include Most Significance Change Technique, case studies and success stories.

7. LOGICAL FRAMEWORK

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
Strategic Objective 1: Enhanced constitutional processes (democracy, human rights, and governance) for health and quality of life.				
Specific objective 1.1 To strengthen government and citizen structures to effectively engage in health governance.	**Outcome 1.1.1:** Improved government inclusivity and responsiveness in decision making processes in health governance	No. of policies/ decisions/ governance processes informed by citizens opinions Level of adherence to public participation protocols by government	**Output 1.1.1.1:** Increased accessibility to information on governance among citizens and other stakeholders	No. of policy documents publicly available
				Extent to which citizens are able to access the information in a user-friendly format and timely manner
			Output 1.1.1.2: Increased citizens' awareness on health governance	No. of citizens sensitized on health governance
				Quality of engagements by citizens on health governance issues
			Output 1.1.1.3: Improved knowledge among poor, vulnerable and MARPs on their roles and responsibilities in health governance	No. of people showing improved knowledge (pre and post evaluation forms)
			Output 1.1.1.4: Public participation platforms established and institutionalized	No. of public participation platforms institutionalized (active, representative, operating as per law)
				No. of people participating in public participation platforms (by groups)
			Output 1.1.1.5: Enhanced accountability by policy makers	Responsiveness of accountability structures

	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
	Outcome 1.1.2: Enhanced CSO engagement with National and County Governments and other relevant stakeholders on health governance	Quality of engagement between the CSO networks, government and other stakeholders	**Output 1.1.2.1:** Established and strengthened partnerships among CSOs	No. of CSO partnerships sustained (frequency of meetings, allocation of budgets by participating CSOs)
			Output 1.1.2.2: Established /strengthened linkages between CSOs, Governments and other stakeholders	No. of engagements between CSOs, government, private sector and other stakeholders as a result of the linkages
			Output 1.1.2.3: Increased utilization of public participation platforms for engagement with policy makers	Frequency of utilization of the public participation platforms by civil society for engagement with policy makers
Specific objective 1.2 To enhance access to justice among the most at-risk individuals	**Outcome 1.2.1:** Increased access to justice for the most at-risk individuals	No. of most at-risk individuals who have accessed justice through legal aid support	**Output 1.2.1.1:** Increased citizens' awareness on access to justice	No. of citizens participating in awareness sessions on access to justice
				Level of knowledge on access to justice among citizens (pre/post assessment)
			Output 1.2.1.2: Strengthened linkages and referrals for legal aid support	No. of linkages strengthened for legal aid support
				No. of cases referred to relevant institutions for legal aid services
		Status of cases referred for legal aid services	**Output 1.2.1.3:** Integration of legal aid services into health and community outreaches	No. of health and community outreaches conducted incorporating legal aid services
				No. of most at-risk individuals accessing legal aid services during community health outreaches
			Output 1.2.1.4: Empowered citizens and other stakeholders utilizing justice and other alternative dispute resolution mechanisms.	Extent to which the empowered citizens and stakeholders are utilizing justice and other alternative dispute resolution mechanisms

Strategic Objective 2: Enhanced equity and inclusivity in the provision of quality health care services at both National and County governments.				
Specific objective 2.1 To reduce access-related barriers to equitable healthcare services at the community and health facility levels[14].	**Outcome 2.1.1:** Increased access to quality and equitable health services at the community and facility levels	Level of satisfaction with services provided at the community and facility level among community No. of clients accessing services at community and primary health levels	**Output 2.1.1.1:** Increased awareness on the rights-based approach to health amongst citizens, service providers, decision and policy makers	No. of sensitization sessions on awareness on the rights-based approach to health amongst citizens, service providers, decision and policy makers conducted
				Level of knowledge among citizens, service providers, decision and policy makers on the rights-based approach
			Output 2.1.1.2: Increased capacity of service providers on standards, guidelines, norms and protocols for service delivery	No. of service providers who participate in capacity building sessions on standards, guidelines, norms and protocols for service delivery
				Level of knowledge among service providers on standards, guidelines, norms and protocols for service delivery
			Output 2.1.1.3: Improved positive attitudes and perception towards citizens among public service providers and policy makers	No. of citizens seeking health services at targeted public health facilities and other referral facilities
				No. of citizens, vulnerable and MARPs seeking health services at the facility
				No. of clients reporting satisfaction with the quality of services provided at facility and community level

[14] Barriers hindering health service delivery include: (human rights violations, social, cultural, economic, infrastructural, HRH, legal and technological, information barriers). Equity refers to fairness across board. Inclusivity refers to bringing on board all those who have previously been excluded in health care services especially poor, vulnerable and most at-risk populations.

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
			Output 2.1.1.4: Increased availability of essential drugs, commodities and technologies at targeted public facility levels	No. of facilities reporting stock outs of essential drugs, commodities and technologies
				No. of tracer commodities in drugs and commodity ordering tools in primary health care facility
				No. of essential commodities available in the facilities
			Output 2.1.1.5: Improved provision of human resources for health and infrastructural development[15] by government and other stakeholders in health facilities	No. of facilities meeting the facility level guidelines, norms and standards (including MoH KEPH standards)
				No. of health care workers deployed at the health care facilities
				No. of people reached via e-health platform
				No. of health facilities that are PWD accessible

[15] WASH in health facilities, ICT and E-health

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
	Outcome 2.1.2: Improved health services for citizens	No. of health services / facilities improved as a result of social accountability processes % of citizens reporting satisfaction with health services	**Output 2.1.2.1:** Increased awareness among citizens on service entitlements by level of care (as stipulated in the Kenya Essential Package for Health)	No. of awareness sessions/ forums conducted among citizens on their health services entitlements
				Levels of knowledge among citizens on their service entitlements by level of care
			Output 2.1.2.2: Increased demand for and utilization of health services at community and facility levels	No. of citizens seeking services in community and public health facilities
				No. of facilities and community health units reporting increased client visits
			Output 2.1.2.3: Strengthened utilization of feedback and complaints redress mechanisms by health facilities	No. of complaints and redress mechanisms strengthened
				No. of complaints received and addressed by health facilities
			Output 2.1.2.4: Increased utilization of social accountability mechanisms (CSC, community dialogues, community report cards)	No. of citizens empowered on implementation of social accountability mechanisms
				No. of social accountability mechanisms rolled out by citizens (tools, committees etc.)
				No. of accountability reports developed and implemented (actions identified in the reports)
				No. of recommendations from the social accountability reports adopted and implemented by the government

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
Specific objective 2.2 To strengthen the policy and investment framework for Universal Health Coverage (UHC) in Kenya	**Outcome 2.2.1:** Improved development and implementation of policies and investment framework for Universal Health Coverage in Kenya	No. of UHC-related policies implemented No. of most at-risk individuals accessing comprehensive health services Levels of satisfaction among MARPs on UHC and social protection services	**Output 2.2.2.1:** Improved awareness on UHC and social health protection services among most at-risk individuals.	No. of awareness forums conducted to increase demand and uptake of UHC and social health protection services among vulnerable and most at-risk populations
				Level of knowledge by the poor, vulnerable and MARPS on the available social protection services
				No. of MARPs benefitting from UHC and social protection programs
			Output 2.2.2.2: Strengthened policy framework for implementation of UHC	Extent to which UHC-related policies reflect citizens' input
				No. of citizens demands included in the UHC benefit package
				Extent to which policies reflect citizens' input
			Output 2.2.2.3: Improved high-level political support for UHC policy investments and implementation	No. of high-level political meetings conducted on UHC
				No. of high-level political champions for UHC engaged.
				No. of national, regional and global commitments implemented by the government to meet UHC
				No. of national, regional and global commitments implemented by the government to meet UHC
				No. of UHC investment plans resourced

[16] HRH, ICT, Commodities, Infrastructure and Funding

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
			Output 2.2.2.4: Sustained CSO engagements on UHC at national, regional and global levels	No. of CSOs national, regional and global level engagements on UHC
				No. of CSO recommendations on UHC adopted and implemented
Strategic Objective 3: Enhanced stakeholder's engagement in health system care governance and accountability processes.				
Specific objective 3.1 To enhance transparency and accountability in policy, planning and budgeting processes	**Outcome 3.1.1:** Improved development and implementation of health policies in Kenya	No. of policies developed and implemented informed by citizens' inputs	**Output 3.1.1.1:** Increased knowledge amongst citizens, service providers, decision and policy makers on health policy frameworks	No. of capacity building sessions conducted on health policy frameworks among citizens, service providers, decision and policy makers
				Level of knowledge amongst citizens, service providers, decision and policy makers on health policy frameworks
			Output 3.1.1.2: Increased awareness of the impact of climate change and emerging pandemics on health policy and programming	No. of awareness forums conducted on the impacts of climate change and emerging pandemics on health policy and programming
				Level of adaptation and integration of climate change mitigation in health policy and programming
				No. of policies/ development plans that incorporate health sector considerations in risk mitigation
			Output 3.1.1.3: Increased citizen participation in development and implementation of health-related policy frameworks and programmes	No. of memos submitted on policies
				Level of participation in policy development and implementation by citizens

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
			Output 3.1.1.4: Increased monitoring of government compliance to national, regional and global commitments on health and related determinants including climate change	No. of citizens empowered on monitoring government compliance to national, regional and global commitments on health and related determinants (including climate change using social accountability tools)
				No. of social accountability tools developed and used
				No. of social accountability recommendations used to inform policy and program decisions
Specific objective 3.2 To improve inclusivity, responsiveness and accountability in allocation and utilization of public resources	**Outcome 3.2.1** Improved inclusivity, responsiveness and accountability in allocation and utilization of public resources	No. of budget decisions informed by citizens recommendations Level of adherence to public participation protocols by government	**Output 3.2.1.1:** Increased awareness on planning and budgeting cycles, avenues for engagement and budget engagement tools	No. of awareness sessions conducted on planning and budgeting
				Level of knowledge of stakeholders on planning and budgeting cycles, avenues for engagement and budget engagement tools
			Output 3.2.1.2: Increased demand and access to government planning and budgeting information.	No. of publicly available documents informing policy planning and budgeting processes
				No. of citizens expressing satisfaction with the planning and budgeting information disseminated by the government

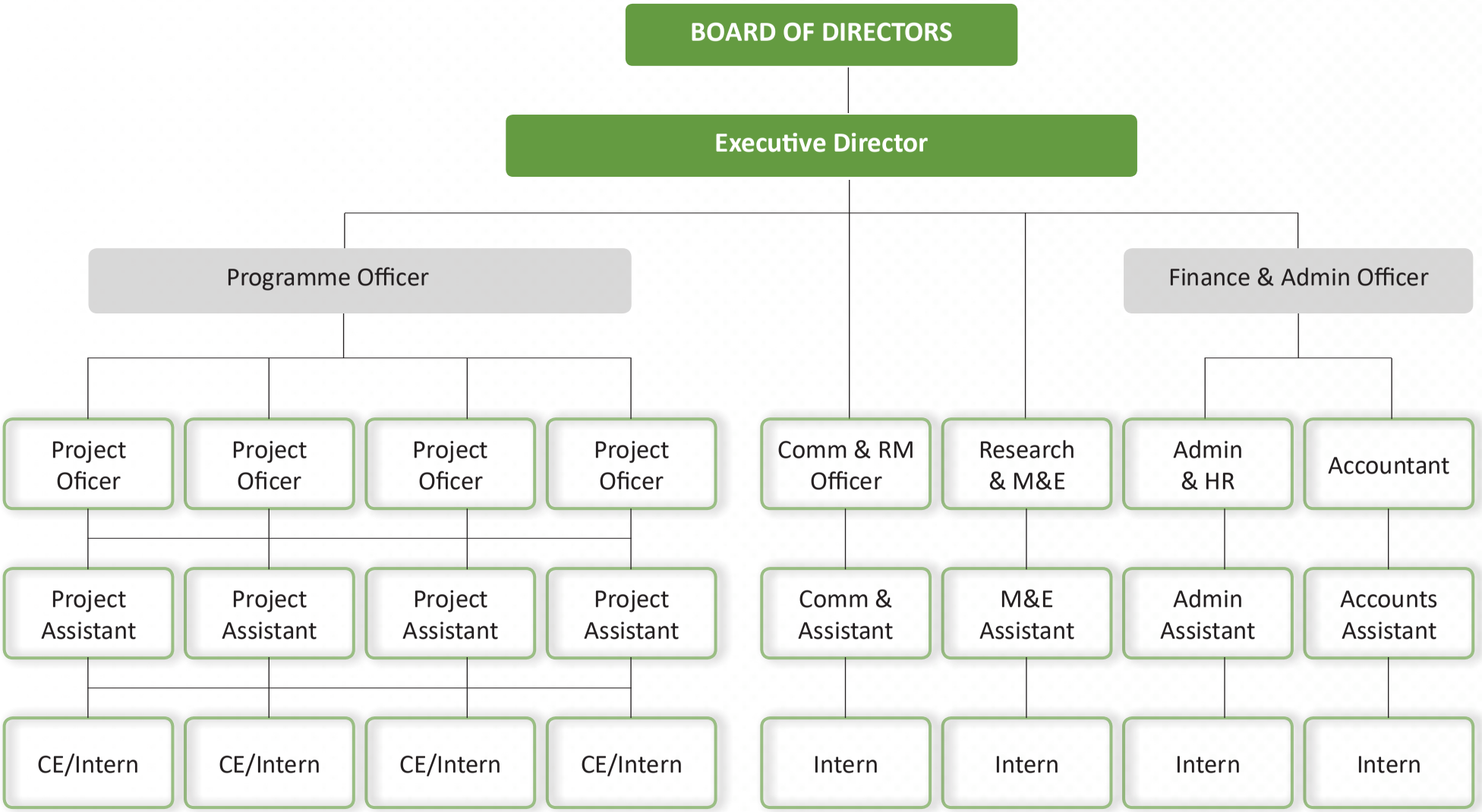
SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
			Output 3.2.1.3: Improved citizen participation in planning and budgeting processes at county and national level	No. of stakeholders participating in public participation forums (by type of stakeholder e.g. citizens, government, NSAs etc.)
				No. of citizens engaging in budget making and planning processes
				Quality of citizen submissions in planning and budgeting processes
			Output 3.2.1.4: Increased demand for accountability on duty bearers in budget allocation, utilization, reporting and feedback	No. of citizens empowered with practical skills on monitoring and tracking public expenditure
				No. of Public Expenditure Tracking Committees operationalized
				No. of feedbacks to accountability committee recommendations from the government
				No. of follow ups made by citizens on budget recommendations

Strategic Objective 4: Strengthened institutional systems for effective delivery of the organization's mandate				
Specific objective 4.1 To enhance institutional governance and management policies and procedures	**Outcome 4.1.1:** Improved organizational capacity to deliver her mandate	Change in HERAF capacity (based on baseline and end line organizational capacity assessment scores) Level of satisfaction among stakeholders with HERAF's organizational performance	**Output 4.1.1.1:** Institutional capacity development plan developed and implemented	% of capacity development priorities implemented (based on capacity assessment)
				Extent of staff, board members and key partners' engagement in the institutional capacity assessment
			Output 4.1.1.2: Institutional policies and procedures reviewed, adopted and implemented	No. of institutional policies reviewed, updated and operational
				Extent of harmonization of policies and guidelines to inform practice
				Extent of adherence to organizational policies (by staff and board)
			Output 4.1.1.3: Board engagement with management strengthened	Level of engagement of board members in targeted sub-committees
				Extent of support from board in delivery of capacity development priorities
				No. of AGM resolutions that are implemented
			Output 4.1.1.4: Increased capacity of HERAF staff to deliver their mandate (recruitment, training and development of members of staff)	No. of staffing gaps addressed annually
				No. of staff who have benefitted from staff capacity development initiatives (by type of initiative etc.)
				No. of staff wellness initiatives implemented
				Ability of the staff to execute their mandate

SPECIFIC OBJECTIVE	OUTCOMES	OUTCOME INDICATORS	OUTPUTS	OUTPUT INDICATORS
Specific objective 4.2 To strengthen the monitoring, evaluation, reporting and learning (MERL) system	**Outcome 4.2.1:** Strengthened MERL system supporting evidence-based decisions	No. of decisions informed by MERL data	**Output 4.2.1.1:** Organization's Monitoring, Evaluation, Reporting and Learning (MERL) plan reviewed and implemented	% of organization's total budget resources allocated to MERL
				Extent to which organizational MERL plan is being implemented
			Output 4.2.1.2: Capacity for staff to integrate MERL into routine programme activities enhanced	Level of utilization of M&E data in programming
				Comprehensiveness of learning products developed.
			Output 4.2.1.3: Strengthened data management processes / systems (collection, analysis, reporting, storage, use)	No. of data management tools operationalized
				No. of MERL platforms established for aggregation and dissemination of MERL information
				Range of learning products disseminated (by type)
Specific objective 4.3 To enhance partnership for resource mobilization, networking, learning, and experience sharing	**Outcome 4.3.1:** Increased resources basket	No. of funding partnerships sustained for at least 3 years	**Output 4.3.1.1:** Resource mobilization plan institutionalized	Frequency of donor mapping
				% of resources mobilized to implement the strategic plan
				No. of new / non-traditional donors supporting HERAF
	Outcome 4.3.2: Strengthened programme design and implementation	No. of programmatic changes informed by lessons learned in collaborative platforms	**Output 4.3.2.1:** Networking and collaborative platforms strengthened at county, national, regional and global levels	No. of collaborative platforms sustained (by type and level – county, national, regional and global; internal vs external)
				No. of collaborative platforms sustained (by type and level – county, national, regional and global; internal vs external)

8. ANNEXES

8.1 Organogram



8.2 Projected Budget 2022 – 2026

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
Strategic Objective 1: Enhanced constitutional processes (democracy, human rights, and governance) for health and quality of life.	1.1.1.1. Increased accessibility to information on governance among citizens and other stakeholders	500,000	750,000	825,000	907,500	998,250	**3,980,750**
	1.1.1.2. Increased citizens' awareness on health governance	750,000	825,000	907,500	998,250	1,098,075	**4,578,825**
	1.1.1.3. Improved knowledge among poor, vulnerable and MARPs on their roles and responsibilities in health governance	1,000,000	1,100,000	1,210,000	1,331,000	1,464,100	**6,105,100**
	1.1.1.4. Public participation platforms established and institutionalized	800,000	880,000	968,000	1,064,800	1,171,280	**4,884,080**
	1.1.1.5. Enhanced accountability by policy makers	1,200,000	1,320,000	1,452,000	1,597,200	1,756,920	**7,326,120**
Overall Est. Cost: Specific Objective 1.1.1		**4,250,000**	**4,875,000**	**5,362,500**	**5,898,750**	**6,488,625**	**26,874,875**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
	1.1.2.1 Established and strengthened partnerships among CSOs	400,000	440,000	484,000	532,400	585,640	**2,442,040**
	1.1.2.2 Established /strengthened linkages between CSOs, Governments and other stakeholders	100,000	110,000	121,000	133,100	146,410	**610,510**
	1.1.2.3 Increased utilization of public participation platforms for engagement with policy makers	1,500,000	1,650,000	1,815,000	1,996,500	2,196,150	**9,157,650**
Overall Est. Cost: Specific Objective 1.1.2		**2,000,000**	**2,200,000**	**2,420,000**	**2,662,000**	**2,928,200**	**12,210,200**
	1.2.1.1. Increased citizens' awareness on access to justice	500,000	700,000	980,000	1,372,000	1,920,800	**5,472,800**
	1.2.1.2 Strengthened linkages and referrals for legal aid support	100,000	140,000	196,000	274,400	384,160	**1,094,560**
	1.2.1.3 Integration of legal aid services into health and community outreaches	700,000	980,000	1,078,000	1,185,800	1,304,380	**5,248,180**
	1.2.1.4 Empowered citizens and other stakeholders utilizing justice and other alternative dispute resolution mechanisms.	1,500,000	1,800,000	1,980,000	2,178,000	2,395,800	**9,853,800**
Overall Est. Cost: Specific Objective 1.2.1		**2,800,000**	**3,620,000**	**4,234,000**	**5,010,200**	**6,005,140**	**21,669,340**

Overall Est. Cost: Strategic Objective 1		9,050,000	10,695,000	12,016,500	13,570,950	15,421,965	60,754,415
Key Strategic Objectives	**KEY ACTIVITIES**	**ESTIMATED COSTS PER YEAR (KES MILLIONS)**					
		2022	**2023**	**2024**	**2025**	**2026**	**TOTAL**
Strategic Objective 2: Enhanced equity and inclusivity in the provision of quality health care services at both National and County governments.	2.1.1.1. Increased awareness on the rights-based approach to health amongst citizens, service providers, decision and policy makers	1,500,000	1,650,000	1,815,000	1,996,500	2,196,150	**9,157,650**
	2.1.1.2. Increased capacity of service providers on standards, guidelines, norms and protocols for service delivery	1,000,000	1,100,000	1,210,000	1,331,000	1,464,100	**6,105,100**
	2.1.1.3. Improved positive attitudes and perception towards citizens, vulnerable and most at-risk populations among public service providers and policy makers	1,500,000	1,650,000	1,815,000	1,996,500	2,196,150	**9,157,650**
	2.1.1.4. Increased availability of essential drugs, commodities and technologies at public facility levels	1,000,000	1,200,000	1,440,000	1,728,000	2,073,600	**7,441,600**
	2.1.1.5. Improved provision of human resources for health and infrastructural development by government and other stakeholders in health facilities	1,200,000	1,440,000	1,728,000	2,073,600	2,488,320	**8,929,920**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
Overall Est. Cost: Specific Objective 2.1.1		**6,200,000**	**7,040,000**	**8,008,000**	**9,125,600**	**10,418,320**	**40,791,920**
	2.1.2.1 Increased awareness among citizens on service entitlements by level of care (as stipulated in the Kenya Essential Package for Health)	1,500,000	1,650,000	1,815,000	1,996,500	2,196,150	**9,157,650**
	2.1.2.2. Increased demand for and utilization of health services at community and facility levels	1,700,000	1,870,000	2,057,000	2,262,700	2,488,970	**10,378,670**
	2.1.2.3. Strengthened utilization of feedback and complaints redress mechanisms by health facilities	1,900,000	2,090,000	2,299,000	2,528,900	2,781,790	**11,599,690**
	2.1.2.4. Increased utilization of social accountability mechanisms (CSC, community dialogues, community report cards)	2,300,000	2,530,000	2,783,000	3,061,300	3,367,430	**14,041,730**
Overall Est. Cost: Specific Objective 2.1.2		**7,400,000**	**8,140,000**	**8,954,000**	**9,849,400**	**10,834,340**	**45,177,740**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
	2.2.2.1. Improved awareness on UHC and social health protection services among most at-risk individuals	700,000	770,000	847,000	931,700	1,024,870	**4,273,570**
	2.2.2.2. Strengthened policy framework for implementation of UHC	1,300,000	1,430,000	1,573,000	1,730,300	1,903,330	**7,936,630**
	2.2.2.3. Improved high-level political support for UHC policy investments and implementation	2,100,000	2,310,000	2,541,000	2,795,100	3,074,610	**12,820,710**
	2.2.2.4. Sustained CSO engagements on UHC at national, regional and global levels	2,100,000	2,310,000	2,541,000	2,795,100	3,074,610	**12,820,710**
Overall Est. Cost: Specific Objective 2.2.1		**6,200,000**	**6,820,000**	**7,502,000**	**8,252,200**	**9,077,420**	**37,851,620**
Overall Est. Cost: Strategic Objective 2		**19,800,000**	**22,000,000**	**24,464,000**	**27,227,200**	**30,330,080**	**123,821,280**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
	3.1.1.1: Increased knowledge amongst citizens, service providers, decision and policy makers on health policy frameworks	1,600,000	1,760,000	1,936,000	2,129,600	2,342,560	**9,768,160**
	3.1.1.2: Increased awareness of the impact of climate change and emerging pandemics on health policy and programming	2,400,000	2,640,000	2,904,000	3,194,400	3,513,840	**14,652,240**
	3.1.1.3: Increased citizen participation in development and implementation of health-related policy frameworks and programmes	2,500,000	2,750,000	3,025,000	3,327,500	3,660,250	**15,262,750**
	3.1.1.4: Increased monitoring of government compliance to national, regional and global commitments on health and related determinants including climate change	2,800,000	3,080,000	3,388,000	3,726,800	4,099,480	**17,094,280**
Overall Est. Cost: Strategic Outcome 3.1.1		**9,300,000**	**10,230,000**	**11,253,000**	**12,378,300**	**13,616,130**	**56,777,430**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
	3.1.2.1: Increased awareness on planning and budgeting cycles, avenues for engagement and budget engagement tools	1,700,000	1,870,000	2,057,000	2,262,700	2,488,970	**10,378,670**
	3.1.2.2: Increased demand and access to government planning and budgeting information	850,000	935,000	1,028,500	1,131,350	1,244,485	**5,189,335**
	3.1.2.3: Improved citizen participation in planning and budgeting processes at county and national level	650,000	715,000	786,500	865,150	951,665	**3,968,315**
	3.1.2.4: Increased demand for accountability on duty bearers in budget allocation, utilization, reporting and feedback	1,800,000	1,980,000	2,178,000	2,395,800	2,635,380	**10,989,180**
Overall Est. Cost: Strategic Outcome 3.2.1		**5,000,000**	**5,500,000**	**6,050,000**	**6,655,000**	**7,320,500**	**30,525,500**
Overall Est. Cost: Strategic Objective 3		**14,300,000**	**15,730,000**	**17,303,000**	**19,033,300**	**20,936,630**	**87,302,930**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
Strategic Objective 4: Strengthened institutional systems for effective delivery of the organization's mandate	4.1.1.1: Institutional capacity development plan developed and implemented		1,650,000	1,815,000	1,996,500	2,196,150	**9,157,650**
	4.1.1.2: Institutional policies and procedures reviewed, adopted and implemented	1,100,000	1,210,000	1,331,000	1,464,100	1,610,510	**6,715,610**
	4.1.1.3: Board engagement with management strengthened	1,100,000	1,210,000	1,331,000	1,464,100	1,610,510	**6,715,610**
Overall Est. Cost: Specific Objective 4.1.1		**3,700,000**	**4,070,000**	**4,477,000**	**4,924,700**	**5,417,170**	**22,588,870**
	4.2.1.1: Organization's Monitoring, Evaluation, Reporting and Learning (MERL) plan reviewed and implemented	700,000	770,000	847,000	931,700	1,024,870	**4,273,570**
Overall Est. Cost: Specific Objective 4.2.1		**700,000**	**770,000**	**847,000**	**931,700**	**1,024,870**	**4,273,570**
	4.3.2.1: Networking and collaborative platforms strengthened at county, national, regional and global levels	400,000	500,000	625,000	781,250	976,563	**3,282,813**
Overall Est. Cost: Specific Objective 4.3.2		**400,000**	**500,000**	**625,000**	**781,250**	**976,563**	**3,282,813**
Overall Est. Cost: Strategic Objective 4		**5,500,000**	**6,110,000**	**6,796,000**	**7,569,350**	**8,443,473**	**34,418,823**

Key Strategic Objectives	KEY ACTIVITIES	ESTIMATED COSTS PER YEAR (KES MILLIONS)					
		2022	2023	2024	2025	2026	TOTAL
Sub Total- Programme Costs		48,650,000	54,535,000	60,579,500	67,400,800	75,132,148	**306,297,448**
Administration and Operational Costs -7% of Total Costs		5,405,556	6,059,444	6,731,056	7,488,978	8,348,016	**34,033,050**
Personnel Costs - 30% of Total Costs		23,166,667	25,969,048	28,847,381	32,095,619	35,777,213	**145,855,927**
Sub-Total- Administration, Operational and Personnel Costs		28,572,222	32,028,492	35,578,437	39,584,597	44,125,229	**179,888,977**
Overall Est Total		**77,222,222**	**86,563,492**	**96,157,937**	**106,985,397**	**119,257,377**	**486,186,425**

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