2015

HERAF ANNUAL REPORT AND FINANCIAL STATEMENTS

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List of Abbreviations & Acronyms

AFGH	Action For Global Health
CHWs	Community Health Workers
CIDP	County Integrated Development Plan
CIPE	Center for International Private Enterprise
CSO	Civil Society Organisation
FBO	Faith Based Organisations
GFF	Global Financing Facility
GIZ	German Development Cooperation
HENNET	Health NGOs Network
HERAF	Health Rights Advocacy Forum
HERAF	Health Rights Advocacy Forum
HIV/AIDS	human immunodeficiency virus/ acquired immunodeficiency syndrome
HPAF	Health Policy Action Fund
IEA	Institute of Economic Affairs
IEC	Information Education Communication
KCM	Kenya Coordination Mechanism
MNCH	Maternal New-born and Child Health
NACC	National AIDS Control Council
NGO	Non-Government Organisation
NHIF	National Hospital Insurance Fund
NIC	National Industrial Credit Bank
NSSF	National Social Security Fund
OSIEA	Open Society Initiative for East Africa
PLWHA	People Living With HIV/AIDS
RBA	Rights Based Approach
RMNCAH	Reproductive, Maternal, New-born, Child and Adolescent Health
UHC	Universal Health Coverage

Who we are

Health Rights Advocacy Forum (HERAF) is a non-governmental organization that works through strategic partners in the form of Health Professionals Bodies and Associations, Non-Governmental Organizations (NGOs), Patients' Organizations, Faith Based Organizations (FBOs), Research Institutions and Universities involved in health issues, Health, HIV&AIDS and Human Rights Networks to promote human rights based approach in health care delivery. It was established in 2006 and registered as a Non-Governmental Organization (NGO) in Kenya by the NGO Coordination Board in 2007.

Vision

Kenyan community where health is upheld and enjoyed as a human right

Mission

To empower Kenyans to enjoy the right to health through increased human rights awareness, evidence based policy advocacy, strengthening citizens participation in health sector governance, and budgeting processes.

Core Values

We strive to reflect these core values in all our work:

- Upholding human dignity
- Equity and inclusivity
- Accountability and transparency
- People-centered

Strategic Objectives

1. Create awareness, inform and educate health professionals, civil society and communities on health as a fundamental human right.
2. Influence Kenya's health policies to guarantee promotion, respect and protection of the right to health.
3. Provide leadership among health professionals, civil society and the local masses in identifying and addressing emerging health rights issues in Kenya.
4. Advocate for an efficient health financing system that ensures equity, accountability and sustainability of Kenya's health care system.
5. Institutional Development

Board of Directors

1. Dr. Andrew J. Suleh	Chairperson
2. Beatrice Gachambi	Secretary
3. Judy Ngugi	Treasurer
4. Edward Miano Munene	Member
5. James Kamau	Member
6. Commissioner Winfred Lichuma	Member
7. Beatrice Kuria	Member
8. Dr. Bactrin Killingo	Member
9. Lucy Simiyu	Member

Members of Staff

1. Beatrice Gachambi	Officer, Programmes
2. James Chege	Officer, Finance and Administration
3. Catriona Mumuli	Assistant, Projects
4. Teresia Kimani	Assistant, Finance, Administration and Accounts
5. Lumasia Emmanuel Karani	Assistant, Projects
6. Elizabeth Semo	Administration assistant
7. Christine Ajulu	Project Officer Programmes

Message from the Chairman

Article 174 of the Kenya Constitution 2010 articulates the rationale behind devolution as, among other reasons, self-governance, economic development and equitable sharing of national and local resources. Towards this end HERAF worked with other stakeholders to compliment the duty bearers (government's) efforts in ensuring swift transition of health devolution in the 47 counties. The one swoop devolution that Kenya undertook came with a ton of challenges considering the fact that implementation of the entire devolution process had to be a three year process. The list of challenges includes country-specific issues such as restructuring to accommodate devolution and universal aspects such as quality, cost and access as well as the high disease burden and the changing patterns of disease.

Health services devolution in Kenya means counties taking up responsibilities to deliver essential health services whilst the central government focuses on policies and regulations. The division of roles and responsibilities between central and county governments, and equitable resource allocation has the potential to improve health service delivery and enhance accountability. This potential can only be realized if due care is paid to successful management of the transition process (whose final year was 2015), equitable distribution of resources including use of targeted funding and conditional grants, redefining the role of the government and the National Health Insurance Fund (NHIF) as purchasers of healthcare, and strengthening the processes and transparency of the procurement system.

As the county governments continue to manage the human resource for health, among the top concerns in the sector is how the staff trainings would be conducted. At the national level there are schemes for staff training especially for specialized services but health professionals have been sceptical of their continuity in the devolved units. There are also concerns regarding the retention of highly qualified health professionals at county levels as there is already high competition for the few personnel especially high cadre medical workers. It remains a challenge on how counties prevent migration to the other counties especially where one county pays more, offers better benefits like staff housing and risk allowances among others as legally one cannot bar someone from taking the job. A key concern has been on how counties can enhance their capacities to avert and/or handle strikes in the health sector.

Health budgets in Kenya do not yet demonstrate that health is a critical resource for development, without which investment in all other sectors would go to waste. In most counties, their budgets for health are greater than 15% of the total county budget. This is a great step but taking a closer look at the budgets reveals that most of the allocated health budgets are used for recurrent expenditures (mostly salaries and wages) instead of being used for development agendas, utilities and supplies. The poor in Kenya bear the heaviest burden of out-of-pocket health expenditures, irrespective of where they seek health care.

With the outlined challenges in mind, HERAF in 2015 enhanced its efforts to increase the understanding amongst stakeholders on how devolution in the health sector is supposed to be realised. In addition HERAF ensured civil society organisations partner with specific county government health management teams to facilitate periodic meetings and engagement forums to sensitize activities on the legal policy framework. In so doing, stakeholders, the CHMT and the HCWs included, had a good understanding of the systemic challenges in the health sector, including their root causes, parties and offices responsible, and possible solutions for further action. HERAF calls upon all health stakeholders to rise up to the challenge and urgently address the issues at hand. Continued formal and meaningful engagements at various levels will ensure that the right to health as stated in the constitution becomes a reality.

This year's success could not have come to fruition without the support from Open Society Institute of East Africa (OSIEA) and the Open Society Budapest Foundation (OSI), Institute for Economic Affairs

(IEA), Christian Aid, Action Aid, Positive Action for Children Fund (PACF) and Centre for International Private Enterprise (CIPE).

We look forward to a more strengthened partnership with them, other development partners and various stakeholders in Kenya's health sector. We also hope to strengthen our alliances with like-minded organizations beyond our borders to ensure that the right to health is a prioritized agenda in Africa as a whole.

Thank you

Dr. Andrew J. Suleh
Chairman

Message from the Executive Director

HERAF in 2015 put more effort in promoting informed participation of health sector stakeholders including healthcare workers, civil society organizations (CSOs) and the public in general in development and implementation of laws and policy frameworks for the realization of the right to health in Kenya's Constitution. The organization was instrumental in empowering Kenyans to enjoy the right to health through increased human rights awareness, evidence based policy advocacy, strengthening citizens participation in health sector governance, and the budgeting processes.

HERAF embarked on increasing health sector stakeholders' levels of awareness on rights and responsibilities in the Constitution in devolution of health, development and implementation of health legislations, policies and guidelines required by the Constitution. This was achieved through development and dissemination of reader friendly and targeted information, education and communication materials; fact sheets, fliers, posters and newsletters, website, media, social accounts, workshops and organized discussion forums to disseminate information on health devolution as stated in the Constitution, and the progress of health legislations and policies.

The organization continuously monitored the key health laws, legislations and policies in the sector making her a one stop source for information for CSOs on the progress of the development of health laws, legislations and policies. This was very important as it ensured all stakeholders in the sector were up to date on the progress of the documents hence their vivacious engagement in the processes. HERAF as well organized and held consultative forums to discuss the key health laws, legislations and policies' making certain that policy advocacy was evidence based.

HERAF worked with 16 health facilities in Nyeri, Embu, Narok, and Kwale counties so as to strengthen community participation in health sector governance. This was done by Scaling up community participation in monitoring health services delivery, planning and accountability in management of health budgets at county and national levels. It was achieved by engagement with the community through courtesy call meetings, community dialogue forums, trainings, focus group discussions and participating in organized community health action days in targeted facilities.

Within the year, advocating for an efficient health care financing system remained influential. It was achieved by circulating information and promoting participation of health stakeholders in the budget making process in the national and county governments. Moreover, the process was done for especially the Annual Operation Plans and the Medium Term Expenditure Framework (MTEF), analysis and expenditure monitoring and tracking. There was also advocacy efforts carried out for transparency and accountability in the planning, allocation and management of resources allocated to the health sector in both the national and county governments.

In 2015, HERAF got several opportunities to engage and participate in meetings, workshops and other forums organized by members and partner organizations. HERAF seized these opportunities to establish partnerships, collaborations and networking relationships with other human rights organizations working in the health sector and related areas.

I am lastly grateful to all our development and collaborating partners that supported us technically and financially so as to record these achievements. Specifically, I pass our gratitude to the Government of Kenya, from Open Society Institute of East Africa (OSIEA) and the Open Society Budapest Foundation (OSI), Institute for Economic Affairs (IEA), Christian Aid, Action Aid, Positive Action for Children Fund (PACF) and Centre for International Private Enterprise (CIPE).

Thank You

Beatrice Gachambi
Executive Director

1.0 Increasing Awareness on the Right to Health

1.1 Awareness on the Right to Health in the Constitution

5 years from the promulgation of the Constitution of Kenya 2010 and three years into the implementation of the same constitution, the health system in 2015 experienced a tonne of challenges considering the fact that implementation of the entire devolution process had just hit three years of the transition period. The list of challenges, ranged from country-specific issues such as restructuring to accommodate devolution and universal aspects such as quality, cost and access as well as the high disease burden and the changing patterns of diseases. Health services devolution means counties take up responsibilities to deliver essential health services whilst the central government focuses on policies and regulations. This division of roles and responsibilities between central and county governments, and equitable resource allocation has the potential to improve health service delivery and enhance accountability. This potential can only be realized if due care is paid to successful management of the transition process, equitable distribution of resources including use of targeted funding and conditional grants, redefining the role of the government and the National Health Insurance Fund (NHIF) as purchasers of healthcare, and strengthening the processes and transparency of the procurement system.

In light of this, HERAF throughout the year participated in partnerships and collaborative meetings organized by her strategic partners, both national and county governments and made presentations on the right to health in 5 different counties Narok, Nyeri, Embu, Kwale, and Nairobi.

The organisation was supported to facilitate trainings; in conjunction with the School for International Training (SIT) Study Abroad Kenya trained a group of students from various institutions of higher learning in the USA. The training was aimed at increasing the students understanding of the concepts of human rights, the right to health and implementation of the constitution in Kenya. As a result of the training, HERAF is proud to note that the students; gained an insight into the concept of and realization of human rights, were able to understand the meaning of the Right to the highest attainable standard of Health care, got information on the Human Rights Based Approach, learned about the implementation of the Constitution in the health sector in Kenya and understood on the overreaching values and Principles in Health.

The year 2015 saw increased awareness among community members on the roles of rights holder and duty bearers. It created an urge in community members to constantly seek information regarding the work of their health care workers, with the promises that they would provide the best services possible. The Health care workers in the targeted communities reported cases of informal and formalized queries about what is going-on at the facility by community members, a change which has been attributed to HERAF's intervention.

1.2 Increasing Awareness on HIV prevention, human rights issues and gender-based violence

In 2015, HERAF went on to dedicated its advocacy efforts in strengthening the capacity of adolescents, women living with HIV (WLHIV), Community Health Workers (CHWs) so as to strengthen community initiatives to eliminate new HIV infections among children and keeping mothers alive in Mazeras and Kafunduni community health units of Kinango Sub County, Kwale County in the Coast region of Kenya. HERAF mobilized and conducted three forums in Kwale County which had 31, 32 and 33 participants respectively. The meetings aimed at increasing knowledge and building skills among adolescents, WLHIV and CHWs on human rights and health rights under the Kenyan constitution, HIV and AIDs prevention and control Act 2006, stigma and discrimination related to MTCT, linkages between gender and HIV, sexual and reproductive health rights, Preventing Mother-to-Child Transmission of HIV, and access to paediatric services to children born by WLHIV.

1.3 Providing Health Rights Information

HERAF continued to provide accurate and up to date information to its target audience (publics) on the right to health as a fundamental human right. We educated and created awareness to healthcare workers, CSOs including other health stakeholders in order to enhance their skills and understanding of

the right to health. This was achieved through production and dissemination of IEC materials namely; two (2) fact sheets (each with 1000 copies), two (2) flyers (with 1000 and 500 copies respectively), and one (1) booklet (with 500 copies). The titles of the IEC materials were My Health My Right Factsheet, Health Financing: What options are there for Kenyans? Fact sheet, Defining the Right to Health Flyer, Prevention Of Mother To Child Transmission Flyer, and a booklet of resource information for CHWs. Over 100 participants benefitted. The dissemination was done to different target audience in line with each theme which included workshops, training forums, at civil society organizations and to other health stakeholders forums organized during the year.

1.4 Information dissemination on social media

In a bid to keep up with revolution in the information, communication and technology sector, which has seen the popularity of new media, including websites, blogs, Facebook and Twitter accounts rise extraordinarily. HERAF, in her case has not been left behind in such developments and has accounts on each of the aforementioned media channels, which are consistently updated, with project activity reports and articles. All developed IEC materials were also added to the HERAF website for wider circulation.

Further, HERAF has also published articles on various issues in the health sector and discussed health in the context of devolution on her website and blog while at the same time sharing reports on its trainings on human rights; the human rights based approaches, the right to health, and devolution in the health sector and social accountability in the resources center component of the website.

2.0 Health Sector Policy Advocacy

2.1 Health Sector Framework

Having worked in the devolved system for three years, the organisation took interest in the following structures; County Health Management Teams, Sub-County Health Management Teams, Commission for the implementation of the Constitution, Health Civil society organizations, Health NGOs Network, and the International Budget Office. Some of the frameworks that were of interest to HERAF during the year included Integrated County Development Plans, County Health Sector Strategic, County Investment Plans, Health Policy Framework (2014 – 2030) and the Health Bill, 2014

With reference from some Articles in the Constitution including Article 10 and 118, the Constitution requires that the people of Kenya participate in the process of implementing the Constitution including participation in the process of law making. It is with this regard that HERAF's health policy advocacy initiatives were grounded on the Rights-Based Approach (RBA), recognizing the principle roles and responsibilities of the power and right holders and value for contributions and participation of citizens in the shaping choices and decisions, design, formulation, execution and monitoring. That the principles and standards of human rights are integrated in policy making and management of health programs with the objective of promoting accountability, transparency, empowerment, non-discrimination and equality.

2.1.1 The Health Bill 2014

During 2015, HERAF participated in the development of health policies and laws such as the Health Bill 2014, Kenya Health Policy Framework (2014 -2030) and the Kenya Aids Strategic Framework development meetings that she participated in to ensure that the issues of human rights and the right to health are incorporated and well addressed; meetings organized by the county governments of Kwale, Nyeri and Embu to develop and disseminate health policies and also meetings organized by civil society organizations where her main objective has been to put the right to health agenda at the fore front

The organization was also a source of information and coordination for health CSOs and she was very instrumental in passing information on the laws and policies to various stakeholders. For instance, HERAF mobilized CSOs and health stakeholders to attend a stakeholders meeting organized by the Commission for the implementation of the Constitution (CIC) and submit their inputs and proposals into the Health Bill, 2014. Through the forum, the HERAF was able to submit proposals and compiled recommendations into the health bill that had been developed earlier in the project.

The Health Bill, 2014 is yet to be finalized and awaits the 2nd reading at parliament for enactment as a law while the Health Policy Framework 2014 – 2030 was approved by the cabinet but its implementation

is yet to kick off. Health bill that is aimed at governing the design and management of MNCH programmes. This is one of the areas that HERAF seeks to improve hence it was a very strategic and timely move where she used the information and evidence gathered from her various projects to inform policy.

2.1.3 Legislation on the Governance and Management of the Level 5 Hospitals

In an effort to enhance her advocacy in development and implementation of health policies and legislations to implement the constitution within the health sector and as such ensure the realization of the right to health, HERAF collaborated with the Kenya Aids NGOS Consortium (KANCO) to assess the impact of the conditional grant offered to level 5 hospitals in Nyeri and Embu counties. The initiative was aimed at informing the legislation on the governance and management of the level 5 hospitals which act as regional referral hospitals and yet it is not yet clear how they will be funded.

These initiatives led to the development of two policy briefs; one on the fact that parliament must provide more oversight of conditional grant to level 5 hospitals, and the other urging the national and county government to allow level 5 hospitals to retain and manage their facility improvement fund collections. The two briefs were used as advocacy tools to ensure the realization of the right to health within the specified hospitals.

2.1.4 Kenya National Aids Strategic Framework

HERAF went on and collaborated with NACC to develop the Kenya National Aids Strategic Framework which aims at Contributing to achieving Vision 2030 through universal access to comprehensive HIV prevention, treatment and care for all. HERAF was part of the HIV prevention task team where she ensured that the human rights issues in prevention were taken into consideration including the need to ensure that prevention options are available for all Kenyans without discrimination in terms of age, gender, and race. HERAF is also a member of HIV ICC chaired by NACC.

2.1.5 East African Health Platform (EAHP)

Throughout 2015, HERAF was a part of the East African Community (EAC) which is a regional intergovernmental organization composed of the Republic of Burundi, Republic of Kenya, Republic of Rwanda, United Republic of Tanzania and Republic of Uganda. With the vision to have a prosperous, competitive, secure, stable and politically united East Africa, its mission is to widen and deepen Economic, Political, Social and Cultural integration in order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investment. In terms of health, a lot of progress has been made by the EAC partner states; however, a lot still needs to be done. During the year the platform was able to advocate for the integration of rights based approach to the EAC RMNCAH Policy and Strategy in the region. Members were able to share experiences, lesson learned, challenges and opportunities for advocacy for rights based approach for RMNCAH strategy and policy in East Africa and related matters at regional and national levels and received project update from EAHP and EAC.

A fact sheet on the rights to universal health coverage in East Africa and a brochure on the Right Based Approach to Maternal Health Policy and Strategy in East Africa were developed to be used as advocacy tools.

2.2 Partnership for successful devolution of health functions

In 2015, HERAF organized for the Devolution of Health Systems Conference on the 9th and 10th December 2015 in Nairobi, Kenya. The Conference aimed at looking at the strides, constraints and next steps in the devolution of the health systems in Kenya since 2013. It also intended to provide a learning and experience-sharing platform on the dynamics of health devolution in Kenya for key stakeholders, gap identification in Kenya's devolution and making practical recommendations on health devolution for the National and County Governments and Civil Societies.

The Conference was organized around six thematic areas: Legal Framework, Policies and Strategies Guiding Implementation of Devolved Structures; Leadership and Governance of Devolved Health

Structures; Human Resources for Health and Devolution; health Financing in the Devolved Structures; Procurement and Supply Chain in the Devolved System and; Health Service Delivery. The presentations were done by various stakeholders. There was diverse representation drawn from Health care professional Associations, Human rights organizations, Ministry of health representatives, County Executive Members for health, Development partners in health, Civil Society Organizations including FBOs working in the health sector, Policy makers/Parliamentary committee on health, Media professionals, Research and learning institutions, Private sector, Health Parliamentary committee, and the Council of Governors.

From the conference, it was clear that devolution had happened and it was everyone's responsibility to ensure that it works for all the 47 counties without any county being left behind. It was clear that for health services delivery in Kenya to flourish; social accountability was to be used as a complementary method to make the government and service providers accountable to their work and promises. The conference delegates were urged to implement what had been shared so as to ensure health rights are available for all Kenyans.

2.2.1 Human Rights Violations

KELIN has been a key partner in 2015 as HERAF has referred all the legal issues that have arisen during the implementation of HERAF's work to KELIN which includes human rights violations. HERAF referred such cases to KELIN who have been following up to ensure that human rights violations are addressed. At HIV ICC meetings KELIN has been identified by CSOs to guide them in electing representatives to Kenya Coordination Mechanism (KCM for Global Fund. That is overseeing the elections for NGO, Communities of TB, Malaria and HIV representatives to KCM.

2.3 Health Sector Stakeholders Forum

During the year, HERAF participated in several stakeholders' fora and gave input on the rights based approach. HERAF was part of a technical working group initiated by PATH that was working towards the development of the Maternal Newborn and Child Health (MNCH) bill that is aimed at governing the design and management of MNCH programmes. This is one of the areas that HERAF seeks to improve with the project and hence it was a very strategic and timely move where she used the information and evidence gathered from the project to inform policy.

HERAF has collaborated with NACC to develop the Kenya National Aids Strategic Framework which aims at Contributing to achieving Vision 2030 through universal access to comprehensive HIV prevention, treatment and care for all. HERAF was part of the HIV prevention task team where she ensured that the human rights issues in prevention were taken into consideration including the need to ensure that prevention options are available for all Kenyans without discrimination in terms of age, gender, and race. HERAF is also a member of HIV ICC chaired by NACC.

The organisation was represented at a meeting organised by the Ministry of Health, WHO and World Bank. The purpose of the meeting was to consult with counties on key RMNCAH interventions that can improve indicators and also share with counties global and country initiatives to improve RMNCAH. The key steps were the development of RMNCAH Strategy and investment case through consultative process, prioritize areas and interventions for investment, mobilize resources internally and externally, including new mechanisms such GFF, harmonize and align resources towards the investment case, and joint monitoring and review of performance.

World Aids Campaign International (WACI), International Community of Women Living with HIV (ICW), New HIV Vaccine and Microbicides Advocacy Society (NHVMAS), Kenya AIDS Vaccine Initiative (KAVI), and International AIDS Vaccine Initiative (IAVI) organized for a seminar which HERAF was represented. The seminar sought an update on the current advances of HIV/AIDs Research and also informed CSOs how the HIV/AIDs vaccines sits around health financing and discussed the priority for advocacy strategies. HERAF also took part in commemorating the World AIDS Vaccine Day (WAVD May 18) a day to educate communities and world leaders about the importance of preventive HIV vaccine research. HERAF was also represented in a launch organized by National AIDs Control Council (NACC), the purpose for the launch was to have a database that is key to guide and facilitate county planning,

prioritization and county stakeholder coordination as requested by Governors. It will further enhance national level coordination of the response through availability of information on interventions and resources for HIV across the country. This will in turn accelerate attainment of results outlines in KASF. It is an online tool for the annual reporting and has been piloted with 31 Civil Society Organizations.

HERAF participated in Dissemination Workshop on EAC Health Projects and Programs organized by EAC Secretariat, Ministry of Health (MoH), World Bank. The Workshop aimed at enhancing knowledge on EAC Health sector, improving support; buy in, ownership and implementation of EAC Health projects and programs, coherence in policy development and implementation of health programs within the government and enhancing information sharing. Representation from; Ministry of Agriculture, Ministry of Health, CDC, County Director of Health, Murang'a County, EAC, State Department of East Africa Affairs, Department of Health, Kitui County, Chief Officer of Health, CEC Health, Kajiado County, County Director of Health, County Government of Nakuru, FHI 360, NASCOP, EAC OHI, EAC Tanzania, EAC Burundi, EAC Uganda, EAC Rwanda

In the course of the year, HERAF participated in MACS workshop as organized by Family Care International (FCI) and FEMNET. The Workshop sought to engage MACS partners / MACS Alliance in the evaluation process and use. MACS partners are both key stakeholders in the project and have specific expert knowledge about their contexts and the work carried out under the MACS project i.e. RMNCH. The involvement of the MACS partners and country staff in creating the evaluative rubrics was, therefore, to enable Family Care International (FCI) bring critical end-user perspectives into the assessment of the MACS project.

3.0 Community Participation in Health Sector Governance and Management

3.1 Community Monitoring

HERAF continued to scale community participation in monitoring health services delivery, planning, and accountability in management of health budgets at County and National levels. The targets were Kwale, Nyeri and Embu Counties and the target health facilities were four (4) dispensaries, and six (6) health centers.

During the year, HERAF organized and held 10 data collection for the community score card process forums for community monitoring. The participants for the forums were drawn from the 10 select facilities in Nyeri, Embu and Kwale Counties that were selected to benefit from the projects making a total of 426 participants. From the discussions in the data collection process, the facilities were able to discuss the issues affecting them which they would have otherwise not had an opportunity to discuss without the forum. For every score given, there was a reason and this acted as the guide for the discussions. As a result, there was a better understanding between the community members and the staff working at the health facilities and also the facility management committees. It was a forum where the community members were able to hold the duty bearers who in this case were the health facility in charges, facility staff and facility management committees accountable for the decisions that they made in governing and managing the health facility on their behalf.

HERAF then organized and held 10 action planning meetings at the 10 health facilities. It was during the forums that the communities, the health facilities and committees were able to come up with action plans on how they would address the various issues identified during the data collection process and therefore leading to improved health service delivery at the health facilities. It was interesting to note that even before the action planning meetings during project execution, the health facilities were in their own way addressing the issues identified during the data collection process. The community score card process was considered an eye opener to the health facilities on the areas that they needed to address in improving delivery of health services.

"*If the data collection process was done right now, we would score very highly as a committee sought to address the issues raised during the data collection. Thanks to HERAF we were able to understand the issues that were ailing our facility and now we are able to address them." Chairman, Karau Dispensary*

The forum also acted as an avenue through which the county governments' health department representatives provided feedback to the communities who they make health decisions on behalf of. For instance, in the three counties, the issue of drugs stock outs was prominent and also the gazettment of the health facility committees which had taken so long to happen. The dialogue between the county governments, the facility staff, the health facility management committees and the committees was incredible. As a result, HERAF's work in social accountability has been used by the county governments to demonstrate community participation in health governance and management. Essentially, the county governments consider HERAF a great partner in ensuring community participation in health governance and management.

3.2 Community Ownership

Community monitoring increased partnership between and among duty bearer's and rights holders in the targeted facilities. It enabled community members to comprehend and own their responsibilities of monitoring services provision, electing health facility management committees into office, demanding for quality health services, and attending community health action days and dialogue forum, which in the past had not been attended by the community members.

Some of the human rights issues that emerged during the forums organised by HERAF included drugs stock out that were experienced at health facilities after devolution. For instance, in Nyeri County, at a certain facility, a point on considering the disabled while constructing wash rooms was an issue identified during the development of the community monitoring score card. The disabled used the pit latrines that were not well maintained and their floors were always wet. When the action planning process was being conducted, one of the facility HCWs identified that one of the staff washrooms had been transformed to one that a person living with disability could use since it also had the rails on which they could support themselves.

In a bid to minimize the negative perceptions among communities that rights were theirs to seek/demand, the facilitators took note to highlight the responsibilities of rights holders, and the rights of duty bearers in line with the human Rights Based Approach (RBA). At the end of each forum, participants reported being more informed about human rights, the services to expect at health centres and dispensaries, and community monitoring. As a result of this, community members are expected to be more vigilant in monitoring health services delivery, use of resources and governance at community and county government levels

3.3 Support to community theatre groups

Community theatre groups were used as a key communication strategy to ensure targeted information dissemination within the community. In using community theatre groups as a channel for information dissemination, HERAF experienced the effectiveness of the groups as they are mobile, versatile and popular among community members.

HERAF supported three community theatre groups to make performances aimed at educating the communities on the right to health and the community monitoring concept. The support was inform of capacity trainings to enable them comprehend the concept of human rights and its linkage to health, technical support on how to develop simple and concise messages for dissemination to public through music, songs, role plays, drama etc. Some of the messages that the community theatre groups passed included the need for communities to seek health services in a timely manner and also the need to complete doses given to them at the health facilities. The theatre groups also conveyed messages on the services available at the respective health facilities in an effort to create more demand for health services and also correct the negative image that communities over the past have had on public health facilities.

3.4 Community Score Card Dissemination fora

During the year, HERAF developed reports on the community monitoring process at each county including the score card with action plans for each facility. With the report, HERAF organized for a stakeholder's meeting in selected counties with the main purpose of disseminating the score cards developed with the action plans, selection of lead persons to spear head implementation of action plans

and creating dialogue and feedback between the facility heads, the community and the county health departments.

A lead person from each facility was selected with the main purpose of leading the implementation of action plans as there are in the score card reports. The forums provided a platform for learning and experience sharing among the facilities that the project was implemented as it brought all of them together at a central place. It also provided an avenue for holding the county health management teams to account over the decisions that they made in regards to the health facilities. It was evident that such feedback fora are very important as they help raise issues affecting delivery of quality health services at the facility level that would otherwise have not been discussed; equally the introduction of respective members under the HFMC to community members was done. This was to enhance the cordial working relationship between the community and the service providers.

3.5 Video documentation on community monitoring of health services

In 2015, HERAF purposed to document the community monitoring activities with a sole aim of producing an audio - visual documentation on HERAF work in community monitoring. The documentation was done in the form of photos, video recordings, and interviews with select community members engaged in the project. The documentary is for use in marketing the community monitoring approach as well as promoting HERAF's work globally.

Another purpose of the audio - visual documentation was to provide the Counties HERAF works in with documented audio - visual records of the project implementation process from the existing conditions in their select health facilities through to the final completion of the project and the changes that took place. The video's objective was also to produce video clips to create awareness on the concept of community monitoring and how it benefits communities with the aim of broadcasting through distribution networks.

The documentary will go a long way in educating health stakeholders on social accountability in health work as well as call both the national and county governments to action in regards to issues raised by communities in ensuring provision of quality health services. It has documented the process of community monitoring and hence will be a resource material for stakeholders who want to engage in social accountability work.

3.6 Programme Partnership Agreement (PPA) - Health Governance

It is also during 2015 that HERAF entered into a partnership with Christian Aid to support its in NarokCounty on Health Sector governance and aimed at enhancing community member's, community leaders, health care workers, health management committee members and Narok county government officials understanding of human rights, the constitution, health policy framework and the concept of citizens participation in decision making and accountability processes in health sector. It also aimed at achieving improved health for women, people living with HIV, children and men through supporting interventions related to HIV, TB, Malaria and Maternal Child Health (MCH). The targets were Narok County and the target health facilities were two (2) dispensaries, and four (4) health centers. This was a partnership that was informed by the lesson learnt from HERAF's community monitoring work and can actually be termed as a scale up of the project to other counties that were not part of it.

3.7 Community monitoring partnership

HERAF continued with her collaboration with IHUB who had been supporting HERAF in designing and utilizing creative technology platforms for communicating and mobilizing engagement on accountability in health. IHUB has participated in the community sensitization meeting at Embu County and gave very good feedback on how to better HERAF's engagement with the communities. It is expected that in the next phase, IHUB will work with HERAF in developing a more user friendly, efficient and technologically adept tool.

4.0 Promoting Efficient and Sustainable Health Care Financing System

4.1 Participation in the budget process at the National and County levels

With lack of effective citizen participation in the budget making process in Kenya and more so now when we are operating in the devolved governments has been blamed among others on the lack of access to information on budget making calendar and dates for budget stakeholders at health facility, county and national level by grassroots organisations, community based organisations and other health sector stakeholders. There has been a lot of confusion as a result of devolution whereby communities are not fully aware on the county and national functions and as such are not able to effectively engage in the budget making process.

In recognition of this, HERAF in the course of the year sought to mobilize citizens to engage in national and county government budget making processes in the four (4) counties; Narok, Nyeri, Embu, and Kwale. This was by facilitating our partners on the ground such as the Centre for Health Solutions (Central Region), and the Mt. Kenya Focus Group on HIV/AIDs to attend the meeting by dispatching the information in a timely manner on the dates and locations of meetings. In sending the partners and hence communities to the meetings, HERAF made a point of sharing budget documents that she had acquired to each of the partners through Email. The documents were very instrumental in the partner's presentations during the public budget hearings organised.

In an effort to acquire the budget documents in a timely manner, HERAF conducted courtesy call meetings to the budget and finance offices at the county level to get a buy in and also build a good working relationship that would enable her acquire necessary budget documents in a timely manner to facilitate her effective engagement in the budget making process.

During the year, we were also part of a budget engagement initiative organized by KANCO that aimed at understanding the budgetary allocations to the level 5 hospitals in Embu and Nyeri Counties. The findings from the initiative were to be used to inform advocacy initiatives on how the level 5 hospitals would be financed and managed considering the fact that they were regional referral hospitals and as it is now, it is not yet clear how the financing of the same will be done. This in the overall will affect the delivery of services to communities and therefore the need to come up with factual information on the same and concrete recommendations based on facts on the ground.

However, it is worth noting that engagements with the county budget making processes have been challenging due to the fact that the counties are also learning on how to develop the budgets i.e. there is need to build on their capacity at different cadres. Most of the counties especially Nyeri County has had a lot of delays in following the budget calendars and actually to date, the budget calendar /circular which was supposed to be released to the public is yet to be released hence making it hard for communities and the civil society to know when and how to engage. It is hoped that this will improve as the county governments learn on the budget making processes

4.2 Budget advocacy meetings

HERAF in an effort to advocate for increased budget allocations to health engaged in budget advocacy at the national and county levels. HERAF analysed and disseminated the national health budget for the year 2015/16 and shared it during a health stakeholder's forum. It is worth noting that the national health budget had allocations for some of the devolved functions including allocations to non-communicable diseases.

At the county level, HERAF conducted an analysis of the county health budgets for the two project years and organised and held advocacy forums. The advocacy forums brought together civil society organizations with an interest in influencing the health budgets with an aim of disseminating the health budgets analysis and as such providing evidence to their advocacy towards increased health budgetary allocations by the county governments. From the forums, it was evident that access to budget documents is still a major issue at the county level making it hard for the non-state actors to engage in the budget making process. The capacity and ability of organizations at the county level to analyse the budget is still very low and hence the project was very timely in addressing this gap. There is however need to continually build the capacity of these organization if they are to be effective in budget advocacy.

4.3 County budget forums

HERAF and its coalition partners planned and implemented three key activities aimed at influencing the budget making process in Nyeri County. Reviewed /updated the database of sectoral civil society organisations involved or interested in Nyeri county level budget making processes for use in mobilising, reaching out, sharing information and requesting for alternative budget proposals. Organised and carried out courtesy call to the Nyeri county government finance and planning department in preparation for the participation of CSOs in 2015/2016 Nyeri County budget making process. This was followed by the gathering of the preparatory documents for the project including the CIDP and budget documents. All these were conducted to ensure participation of CSOs and health related stakeholder from Nyeri County in the 2015/2016 Nyeri County budget making process.

4.4 NTA

HERAF during 2015 continued collaborating and partnering with the National Taxpayers Association in her budget engagement and community monitoring work. Specifically, in engagement in the Nyeri County budget work, HERAF has worked very closely with the NTA Nyeri office especially in accessing county budget documents. Further, NTA has supported HERAF in reviewing the community monitoring work and the two organizations continue to learn from each other on how to monitor the quality of health services more effectively and efficiently. HERAF has had a complimented budget advocacy work with NTA

5.0 Institutional Strengthening

5.1 Internal System Strengthening

HERAF in 2015, embarked on implementing the organizational manuals on governance, organization planning, resource mobilization, finance management, project management, and monitoring and evaluation. The organisation has improved in all areas of operations from the implementation of the organizational manuals. HERAF is now a bigger, better, more efficient and experienced NGO that is strategically placed to take health rights a notch higher and for others to learn from. It is evident in the way projects are designed and implemented and one can confidently say that HERAF has systems and structures in place to realize her mandate.

5.2 Staff capacity development

HERAF in 2015 ensured that the staff capacity was also developed as one of the Institutional Strengthening objectives. HERAF staffs were able to attend a number of training workshops key among them included:

5.2.1 ESA Regional COPASAH Meeting

From the 5th to 8th May 2015, HERAF was represented at the “ESA REGIONAL COPASAH MEETING” that was held in Kampala, Uganda organized by the Uganda National Health Consumers' Organisation (UNHCO). Several organizations in Africa doing community monitoring work attended. With the aim of sharing experiences and way forward for ESA community monitoring work, the objectives of the workshop revolved around coming together as different stakeholders to share experiences, lessons, discuss the status of Social Accountability in the region and actions for going forward.

5.2.2 Training workshop on Revenue Analysis

One of HERAF staff represented HERAF at the IEA/CIPE training workshop on Revenue Analysis from 22nd – 24th April 2015 at Maanzoni Lodge. The meeting brought together budget advocacy civil society organisations. The purpose for the training was to introduce taxation to CSOs and initiate their interest in tax policy issues. The workshop took to answer the question “Why should CSOs get involved in tax policy?” Some of the outcomes from the training included issues like CSOs should stop shying away from revenue policy issues, CSOs should advise government on how to reallocate funds, Getting into revenue policy issues enables CSOs have a clear understanding where to get money to provide better services. It was clear that there is need for CSOs to protect revenue sources despite the fact that CSOs are rarely represented in public hearings, and that Division of revenue needs to be debated.

6.0 Annual Report and Financial Statements for the Year Ended 31 December 2014

6.1 Management Committee

Dr. Andrew Juma Suleh	-	Chairman
Beatrice Kuria	-	Treasurer
Beatrice Gachambi Theuri	-	Executive Director
James Kamau	-	Member
Winfred Lichuma	-	Member
Dr. Bactrin Kilingo	-	Member
Lucy Simiyu	-	Member
Miano Munene	-	Member

6.1.1 Management Committee Report

The Management Committee submit their report and the audited financial statements for the year ended 31 December 2015, which disclose the state of affairs of the organisation.

Health Rights Advocacy Forum (HERAF) is a non-governmental organization that works through strategic partners in the form of Health Professionals Bodies and Associations, Non-Governmental Organizations (NGOs), Patients' Organizations, Faith Based Organizations (FBOs), Research Institutions and Universities involved in health issues, Health, HIV&AIDS and Human Rights Networks to promote human rights based approach in health care delivery. It was established in 2006 and registered as a Non-Governmental Organization (NGO) in Kenya by the NGO Coordination Board in 2007.

HERAF Vision

Kenyan community where health is upheld and enjoyed as a human right

HERAF Mission Statement

To empower Kenyans to enjoy the right to health through increased human rights awareness, evidence based policy advocacy, strengthening citizens participation in health sector governance, and budgeting processes.

PRINCIPAL ACTIVITIES

The organization principal activity is to promote, protect and empower Kenyans to enjoy the right to health at all times.

RESULTS FOR THE YEAR	**2015**	2014
	Kshs	Kshs
Grant income	**17,991,165**	22,899,040
Expenditure	**(18,522,572)**	(21,442,439)
(Deficit) / surplus for the year transferred to general fund	**(531,407)**	1,456,601

AUDITOR

The organisation's auditor, DMC Associates has expressed its willingness to continue in office in accordance with NGO Coordination Act.

BY ORDER OF THE BOARD

……..……
CHAIRMAN

……21/03/2016……

6.1.2 Statement of Management Committee Responsibilities

The NGO Coordinating Act requires the Management Committee to prepare financial statements for each financial year that give a true and fair view of the state of affairs of the organization as at the end of the financial year and of its operating results for that year. It also requires the Management Committee to ensure that the organization maintains proper accounting records that disclose, with reasonable accuracy, the financial position of the organization. The Management Committee is also responsible for safeguarding the assets of the organization.

The Management Committee accept responsibility for the preparation and fair presentation of financial statements that are free from material misstatement whether due to fraud or error. They also accept responsibility for:

i) Designing, implementing and maintaining internal control relevant to the preparation and fair presentation of the financial statements;
ii) Selecting and applying appropriate accounting policies; and
iii) Making accounting estimates and judgements that are reasonable in the circumstances.

The Management Committee are of the opinion that the financial statements give a true and fair view of the state of the financial affairs of the organization as at 31 December 2015 and of its operating results and cash flows for the year then ended in accordance with the International Financial Reporting Standard and the requirements of the NGO Coordination Act .

Nothing has come to the attention of the management committee to indicate that the company will not remain a going concern for at least twelve months from the date of this statement.

Approved by the Management Committee on ……21/03/2016…….. and signed on its behalf by:

…… **……..**

Chairman **Executive Director**

6.2 Report of the Independent Auditor to Members of

6.2.1 Report on the financial statements

We have audited the accompanying financial statements of Health Rights Advocacy Forum set out on pages 6 to 14 which comprise the statement of financial position as at 31 December 2015, statement of comprehensive income and expenditure, statement of changes in equity, and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory notes.

6.2.2 Directors' responsibility for the financial statements

The Management Committee are responsible for the preparation and fair presentation of these financial statements in accordance with the International Financial Reporting Standards and the requirements of the NGO Coordination Act. This responsibility includes: designing, implementing and maintaining internal control relevant to the preparation and fair presentation of financial statements that are free from material

misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

6.2.3 Auditor's responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Management Committee, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

6.2.4 Opinion

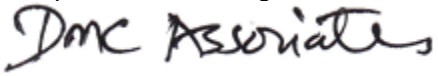
In our opinion the accompanying financial statements give a true and fair view of the state of financial affairs of the organization as at 31 December 2015 and of its financial performance and cash flows for the year then ended in accordance with the International Financial Reporting Standards and the NGO Coordinating Act.

6.2.5 Report on other legal requirements

As required by the NGO Coordination Act we report to you, based on our audit, that:

i) we have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purposes of our audit;
ii) in our opinion proper books of account have been kept by the organization, so far as appears from our examination of those books; and
iii) the organization's statement of financial position and statement of comprehensive income and expenditure are in agreement with the books of account.

The engagement partner responsible for the audit resulting in this independent auditor's report is CPA Joseph Macharia Chege-P/NO. 1555.



DMC
Associates
Certified Public Accountants
Nairobi
……22/03/2016……

6.3 Statement of Income and Expenditure

		2015	2014
Income	**Note**	**Ksh**	Ksh
Grant income	4	**16,044,132**	20,545,476
Amortisation of capital gains		**1,424,893**	1,438,268
Other income	5	**522,140**	915,296
		17,991,165	22,899,040
Expenditure			
Health Rights Education		**2,642,578**	566,150
Evidence-Based Advocacy for Reforms in Health Policies		**1,193,624**	499,500
Promoting Health Sector Management and Governance		**3,467,425**	4,044,021
Promoting an efficient health care financing system		**1,487,187**	1,728,254
Organizational development		**-**	3,699,542
Staff expenses		**6,132,233**	7,697,252
Administration		**2,174,632**	1,769,452
Depreciation		**888,658**	902,033
Amortisation		**536,235**	536,235
		18,522,572	21,442,439
(Deficit) / surplus for the year transferred to fund accounts		**(531,407)**	1,456,601

6.4 Statement of Financial Position

	Note	**2015 Kshs**	2014 Kshs
ASSETS			
Non-current assets			
Property, plant and equipment	7	**974,814**	1,758,607
Intangible assets	8	**1,072,471**	1,608,706
		2,047,285	3,367,313
Current assets			
Receivables	9	**348,840**	372,838
Cash and bank balances	10	**1,612,073**	3,729,568
		1,960,913	4,102,406
TOTAL ASSETS		**4,008,198**	7,469,720
FUNDS AND LIABILITIES			
Fund accounts			
General fund		**191,352**	702,221
Capital fund		**2,047,283**	3,367,311
		2,238,635	4,069,532
Current liabilities			
Deferred income	11	**1,383,688**	3,033,591
Payables	12	**385,875**	366,596
		1,769,563	3,400,187
TOTAL FUNDS AND LIABILITIES		**4,008,198**	7,469,720

The financial statements on pages 6 to 14 were approved for issue by the Management Committee on ……21/03/2016…… and were signed on its behalf by:

 CHAIRMAN  EXECUTIVE DIRECTOR

6.5 Cash flow Statement

	Notes	**2015** **Kshs**	2014 Kshs
Cash generated from operations			
(Deficit) / surplus for the year		**(531,407)**	1,456,601
Adjustments for:			
Capital grant receipts		**104,865**	769,005
Changes in working capital:			
- Change in trade and other receivables	9	**23,999**	52,162
- Change in trade and other payables	12	**19,278**	(966,933)
- Change in deferred income	11	**(1,649,903)**	512,327
- Previous year adjustment		**20,538**	-
Cash (absorbed in) / generated from operations		**(2,012,630)**	1,823,162
Investing activities			
Purchase of property, plant and equipment		**(104,865)**	(769,005)
Net cash absorbed in investing activities		**(104,865)**	(769,005)
Net (decrease) / increase in cash and cash equivalents		**(2,117,495)**	1,054,157
Movement in cash and cash equivalents			
At start of year		**3,729,568**	2,675,411
At end of year	10	**1,612,073**	3,729,568

STATEMENT OF CHANGES IN GENERAL FUND ACCOUNTS

	General fund	Capital fund	Total
	Shs	Shs	Shs
Year ended December 31 2015			
At start of year	702,221	3,367,311	4,069,532
*Prior year adjustment	20,538	-	20,538
Deficit for the year	(531,407)	-	(531,407)
Assets capitalized	-	104,865	104,865
Grants amortized for the year		(1,424,893)	(1,424,893)
At end of year	**191,352**	**2,047,283**	**2,238,635**
Year ended December 31 2014			
At start of year	(754,380)	4,036,574	3,282,194
Surplus for the year	1,456,601	-	1,456,601
Assets capitalized	-	769,005	769,005
Grants amortized for the year		(1,438,268)	(1,438,268)
At end of year	702,221	3,367,311	4,069,532

*Prior year adjustment relates to unclear, old and overdue balances being written back.

6.6 Notes to the Financial Statements

1. General Information

Health Rights Advocacy Forum (HERAF) is a non-governmental organization that works through strategic partners in the form of Health Professionals Bodies and Associations, Non-Governmental Organizations (NGOs), Patients' Organizations, Faith Based Organizations (FBOs), Research Institutions and Universities involved in health issues, Health, HIV&AIDS and Human Rights Networks to promote human rights based approach in health care delivery. It was established in 2006 and registered as a Non-Governmental Organization (NGO) in Kenya by the NGO Coordination Board in 2007.

2. Basis of preparation and summary of significant accounting policies

These financial statements have been prepared on a going concern basis and in compliance with the International Financial Reporting Standards issued by the International Accounting Standards Board. They are presented in Kenya Shillings (Shs). The measurement basis used is the historical cost basis except where otherwise stated in the accounting policies below.

a) Revenue recognition

Income/ funding comprise grants from various donors. Revenue grants are recognised as income in the year it is expended. Capital grants are amortised to income over the useful life of the related fixed assets.

b) Expenditure

Expenditure comprises costs incurred directly for organisation activities. These are recognised when payments are made. Appropriate accruals are made for expenditure incurred and not paid for at the year end and for prepaid expenses

c) Property and equipment

Items of property, plant and equipment, are measured at cost less accumulated depreciation and any accumulated impairment losses.

Depreciation is charged so as to allocate the cost of assets less their residual values over their estimated useful lives, using the straight line method. The following annual rates are used for the depreciation of property and equipment:

Furniture and fittings	12.50%
Office equipment	20.00%
Computers	33.33%

If there is an indication that there has been a significant change in depreciation rate, useful life or residual value of an asset, the depreciation of that asset is revised prospectively to reflect the new expectations.

On disposal, the difference between the net disposal proceeds and the carrying amount of the item sold is recognised in statement of income and expenditure.

d) Impairment of non-financial assets

At each reporting date, property, plant and equipment and investments in associates are reviewed to determine whether there is any indication that those assets have suffered an impairment loss. If there is an indication of possible impairment, the recoverable amount of any affected asset (or group of related assets) is estimated and compared with its carrying amount. If estimated recoverable amount is lower, the carrying amount is reduced to its estimated recoverable amount, and an impairment loss is recognised immediately statement of income and expenditure

Similarly, at each reporting date, inventories are assessed for impairment by comparing the carrying amount of each item of inventory (or group of similar items) with its selling price less costs to complete and sell. If an item of inventory (or group of similar items) is impaired, its carrying amount is reduced to selling price less costs to complete and sell, and an impairment loss is recognised immediately in statement of income and expenditure.

If an impairment loss subsequently reverses, the carrying amount of the asset (or group of related assets) is increased to the revised estimate of its recoverable amount (selling price less costs to complete and sell, in the case of inventories), but not in excess of the amount that would have been determined had no

impairment loss been recognised for the asset (group of related assets) in prior years. A reversal of an impairment loss is recognised immediately in statement of income and expenditure.

e) Financial liabilities

Trade payables are obligations on the basis of normal credit terms and do not bear interest. Interest bearing liabilities are subsequently measured at amortised cost using the effective interest method

f) Intangible assets

Software costs are stated at historical cost less accumulated amortisation and any accumulated impairment loss. Amortisation is calculated using the straight line method to write down the cost of the software to its residue value over the estimated useful life at an annual rate of 33.33%

g) Retirement benefits costs

The organization is a member of CFC Life defined contribution pension scheme for its employees. The Organisation also contributes to the National Social Security Fund (NSSF), contributions are determined by the local statute and are currently limited to Kshs 200 per employee per month. Contributions made to the two schemes are charged in the statement of comprehensive income in the year of contribution.

h) Employee entitlements

The monetary liability for employees' accrued annual leave entitlement at the statement of financial position is recognised as an expense accrual.

i) Deferred income

A grant received in the current year for which related expenses are to be incurred in the future period is deferred to that future period.

3. Key sources of estimation uncertainty

No significant judgements have been made by the management committee in preparing these financial statements.

		2015	2014
		Kshs	Kshs
4	**Grant income**		
	OXFAM HPAF	**-**	938,751
	Open Society Initiative for East Africa	**8,482,019**	7,545,984
	USAID FANIKISHA	**-**	8,182,764
	UNDP-Amkeni wakenya	**-**	787,550
	Iinstitute of Economic Affairs	**-**	257,910
	CHRISTIAN AID	**4,282,498**	2,629,067
	Center for International Private Enterprise	**220,675**	203,450
	PACF	**3,058,940**	-
		16,044,132	20,545,476
5	Rental income	**90,000**	436,949
	Interest income	**72,584**	44,664
	Miscellaneous income	**359,556**	433,683

522,140	915,296

6 Staff costs

Salary and wages	**5,772,595**	7,092,676
Medical insurance	**232,838**	388,064
Pension contributions	**-**	188,700
NSSF contributions	**30,800**	27,812
	6,036,233	7,697,252

7 Property, plant and equipment

	Computers	Furniture & fittings	Office equipment	Total
	Shs	Shs	Shs	Shs
Year ended 31 December 2015				
Cost				
At start of year	1,888,981	944,549	1,923,984	4,757,514
Additions	49,880	-	54,985	104,865
At end of year	1,938,861	944,549	1,938,861	4,862,379
Accumulated depreciation				
At start of year	1,359,477	534,833	1,104,598	2,998,907
Charge for the year	374,795	118,069	395,794	888,657
At end of year	1,734,272	652,901	1,500,392	3,887,565
Carrying amount				
At end of year	**204,589**	**291,648**	**438,469**	**974,814**
Year ended 31 December 2014				

Cost				
At start of year	1,374,976	944,549	1,668,984	3,988,509
Additions	514,005	-	255,000	769,005
At end of year	1,888,981	944,549	1,923,984	4,757,514
Accumulated depreciation				
At start of year	960,309	416,764	719,802	2,096,874
Charge for the year	399,168	118,069	384,796	902,033
At end of year	1,359,477	534,833	1,104,598	2,998,907
Carrying amount				
At end of year	529,504	409,716	819,386	1,758,607

		2015	2014
		Kshs	Kshs
8	**Intangible Asset**		
	Cost;		
	At start of year	**2,681,176**	2,681,176
	Additions	**-**	-
	At end of year	**2,681,177**	2,681,176
	Amortisation;		
	At start of year	**1,072,470**	536,235
	Charge for the year	**536,235**	536,235
	At end of year	**1,608,706**	1,072,470
	Carrying amount;		
	At end of year	**1,072,471**	1,608,706

This relates to computer software acquired.

		2015	2014
		Kshs	Kshs
9	**Receivables**		
	Other receivables	**348,840**	372,838
10	**Cash and bank balances**		
	Cash at bank	**1,608,693**	3,728,463
	Cash in hand	**3,380**	1,105
		1,612,073	3,729,568

11 Revenue grants

Donor	At start of year Kshs	Receipts Kshs	Expended in the year Kshs	At end of year Kshs
OSIEA	242,643	8,725,944	(8,482,019)	486,568
CHRISTIAN AID	2,745,198	2,106,000	(4,282,498)	568,700
CIPE	45,750	262,120	(220,675)	87,195
UHC	-	259,765	-	259,765
PACF	-	3,040,400	(3,058,940)	(18,540)
	3,033,591	**14,394,229**	**(16,044,132)**	1,383,688

Deferred income	**1,383,688**	3,033,591

12 Payables

Other payables	**385,875**	366,596

APPENDIX

		2015	2014
		Shs	Shs
1	**DIRECT EXPENDITURE**		
	Health Rights Education	**2,642,578**	566,150
	Evidence-Based Advocacy for Reforms in Health Policies	**1,193,624**	499,500
	Promoting Health Sector Management and Governance	**3,467,425**	4,044,021
	Promoting an efficient health care financing system	**1,487,187**	1,728,254
	Organizational development	**-**	3,699,542
	Staff expenses	**6,132,233**	7,697,252
	Adminstration	**2,174,632**	1,769,452
	Depreciation	**888,658**	902,033
	Amortisation	**536,235**	536,235
		18,522,572	21,442,439