



# Kenya Civil Society Priorities Charter

An Advocacy Roadmap for the Global Fund to fight AIDS, Tuberculosis and Malaria  
New Funding Model

September 2014



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International



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## #1 Priority – Health Financing [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Sustainable Financing for Universal Health Coverage

In 2011, Kenya was among three African countries with least health expenditure against total government spending. Funding gaps exist and will continue across the three diseases. A wide variation of health spending is noted across local counties, with allocations ranging from 4% to 30%. More domestic funding is needed to sustain the gains made so far in HIV/TB/malaria programmes, especially as donor funding declines. Civil society's comparative advantage is to push for increased domestic funding for HIV, TB and malaria; critical to meeting Kenya's vision of a HIV free country by 2030. This supports the country's co-financing arrangements with the Global Fund (TGF). Alternative sustainable financing are planned via community level insurance, a HIV/AIDS trust fund and other financing schemes. Civil society will monitor the Trust Fund, which aims to increase domestic HIV funding by 50%, and meet Kenya's commitment to the Abuja declaration for a 15% health budget. Targets include policymakers, parliamentary health committee, MoH, MoF, County Governments, County Health Executives, County Assemblies, the private sector, development partners, civil society organizations (CSOs) and other non-state actors; to be done at national and county levels, from 2015-2017. CSOs are well-placed to lead this initiative. Success measures: % increase in health allocation (nationally and at local/county level) by 2017, aiming for a target of 15% (up from a 4.6% baseline 2009/2010).

### Secondary Priority - Institutional Strengthening on Management and Governance of Health Financing

Civil society can play a stronger role in mitigating the risks of misappropriation or waste of funds, which lead to delayed reporting and inability to account for funds. Management and governance of Global Fund grants and systems need to be strengthened, and current financial resources leveraged for greater impact. Civil society seek to build their technical capacity to engage better in budget-making processes at both national and county levels and in promoting CSO-led tracking, monitoring and reporting on relevant health budgets and expenditure. Needed is better acumen and expertise by relevant stakeholders in health finance management and health governance. This should be led by CSOs. To be targeted: County Assemblies, MoH, PRs, CCM and community members. This should be implemented at both national and county levels, from 2015-2017 and should be led by civil society SRs. Impact and success will be measured through improved Global Fund grant performance, with a target of A1.

## #2 Priority – Community Systems Strengthening [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Core Funding for Community Systems Strengthening (CSS) in Capacity Building and Organizational Development

CSS is not HSS, yet this mistake is made when CCMs fund mostly community health workers (CHWs) under CSS. CSS needs to be understood more comprehensively to include activities beyond CHWs e.g. capacity building and core funding for organizations. TGF supports CSS but when PRs limit HR costs for local grantees to 10% or nothing, this undermines key investment in their long-term development. PRs should follow GF budgeting guidelines allowing justified HR/ other recurrent costs, with sustainability plans, for local organizations to set up systems that will last post-grant. This supports the Fund's focus on strategic/sustainable investment. Also, CSS work needs to be better tracked and documented to build evidence of best strategies and impact of such work. Civil society suggests that grant budgets include a dedicated CSS section that includes activities that will enhance knowledge, adoption and implementation of TGF CSS framework, integrating it into national planning. CSOs should highlight this need in the HIV/TB and malaria concept notes and during national planning. This should be led by national networks/organizations, especially PLHIV/ TB networks working in priority counties. CSO PRs should be the main advocates for this throughout the NFM process. Success measures: CSS results data and improved engagement/coordination among CSOs/ KPs networks.

### Secondary Priority - Mechanisms for Coordinating Networks and Partnerships

Civil society has identified a need for more efficient utilization of resources and strengthened advocacy by ensuring a more functional coordination mechanism for CSOs working on HIV, TB, malaria and maternal health networks. Weak community coordination is a barrier to multi-disease liaison, stigma, poor case detection, adherence and disclosure. Also, communities must be part of planning and programme design from the ground up, and not top down. Targeted CSS implementers must help clarify what "community" and CSS mean in ways that ensure sustainable indigenous community systems. CSOs PRs especially should be the leads in allocating more strategic CSS funding.

## #3 Priority – HIV [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Treatment, Care and Support

AIDS is still Kenya's leading cause of deaths causing 29.3% of total deaths, a trend expected to continue. Yet an estimated 80% of HIV infected people do not know their correct status. A year after starting ART, adult retention to care averages about 80%, but steadily declines to below 60% at four years (KAIS, 2012). Pediatric treatment uptake is also very low, at less than 40% of those in need. Kenya has updated its treatment guidelines to CD4 500, reducing treatment coverage by 31%. Treatment literacy and adherence is needed if the country aims to achieve 90:90:90 and post-2015 sustainable development goals. Needed are improved pediatric linkages to testing, treatment, care and support; better viral load monitoring; stigma reduction and human rights. Civil society will advocate and build capacity to strategically target children, teenagers and men (who often have lower rates of treatment adherence). Certain counties have a high prevalence and need more support during 2016-2017. Implementers should be networks of women living with HIV and PLHIV networks. Success measures: UNAIDS' 90:90:90, reduced HIV morbidity and mortality, improved quality of life, reduced stigma and retention to care.

### Secondary Priority - Combination Prevention

Gender disparities prevail, driving higher HIV prevalence among women (8.8%); men = 5.5% (KAIS, 2012). Civil society's role in addressing social, cultural and structural barriers to prevention/ adherence needs focus in 2015-2017. CSOs propose activities that promote and prioritize testing and counseling, EMTCT, keeping mothers alive (KMA) program and advocacy for new prevention technologies and PWP. Plus in all above, explore better strategies to address social, cultural and structural barriers. Every person living with HIV is eligible for a free viral load test once a year (Kenya). CSOs should track this. Include discordant couples and young women living in high incidence counties in target group. Implementation is 2016-2017, led by PLHIV networks/CSOs/CBOs/FBOs. Success measure: zero new pediatric HIV infections; 90% reduced HIV infections among adults.

## #4 Priority – TB [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Social Protection

The rate of malnutrition among TB patients in Kenya is at 50% making TB-focused social protection a high priority. Needed are a minimum package of social protection services and reform of current social protection systems which exclude TB patients. CSOs propose a social envelope/minimum package of food for entire households, health insurance and a monthly stipend for vulnerable populations in hard to reach areas. Prioritize children, PLHIV, MDR-TB patients and young male TB patients (who have higher levels of non-adherence related to alcohol use). Strategically focus on the sub-county levels, but also the county and national levels. This should be included the HIV/TB concept note and begin end of 2015 or early 2016 and plan for a mid-term review in January 2017. Possible leads include AMREF, TAC, KANCO, KAPTL, NEPHAK, and/or other civil society organizations that are doing TB work. Success measure: 85% of TB patients in need of social protection receiving it by 2017, with long term goals of better adherence to treatment and full recovery of the person.

### Secondary Priority – Improving Civil Society Organizations' Capacity

The number of Kenyan CSOs addressing TB has increased but their capacity is still limited. As a result, community level data is missed in national case management. CSOs seek to enable more local collectors/trackers of community TB data. Needed also as part of the civil society strategy, is TB specific CSS work, human rights and gender (CRG) activities and strengthening of CSO linkages to CHWs. CSOs advocate for there to be CRG staff at TB units to enhance integration. Targets: CSOs, NGOs, CBOs and FBOs at county level. Implementing leads may include AMREF, TAC, KANCO, KAPTL, NEPHAK, and other CSOs implementing TB work. AMREF has done a TB-CSO mapping, but more can be done to promote HIV/TB integration at county level, plus enhance efficiencies in line with the focus on high impact interventions under the new TB NSP (2015-2017). The result of this activity will be the demonstrable collection of useful and reliable community data and the use of that data at community, sub-county, county and national levels.

## #5 Priority – Key Populations [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Access to Key Population-Friendly Prevention Care and Treatment Services

Service uptake is low among key populations (KPs) in Kenya. HIV prevalence among men who have sex with men (MSM) in Nairobi is 18.2%. Few visit MSM friendly clinics and drop in centers - only 13% in Nairobi and 26% in Kisumu (IBBS, 2012). Meaningful engagement of KPs is needed through the entire continuum of care, as is sensitization trainings among service providers. Kenyan CSOs define KPs for HIV/TB as: 1) MSM, 2) prison populations, 3) sex workers (male and female), 4) Adolescents (girls and young women) and 5) truckers. IDUs are also considered as current a KP priority and are covered under the Harm Reduction section below. KPs in malaria and TB are outlined in their respective sections. Counties with high HIV prevalence will be strategically targeted: Nairobi, Kisumu, Mombasa, Homabay, Busia, Siaya and Kisii (KAIS 2012). This should be rolled out from 2015-2017 by CSOs such as BHESP, ISHTAR MSM, LVCT-Health and national and county KP networks, in partnership with other CSOs and government health facilities. Success measure: An increase in service uptake by KPs to a minimum of 50% by mid 2016, up from a 13% baseline, working towards 90% coverage by 2018.

### Secondary Priority - Enabling Legal and Social Environment

An enabling environment for KPs is critical to reduce stigma and discrimination, and increase service uptake. The Kenya Stigma index is at 45%, but is much higher for KPs (64%). Amending laws and policies that criminalize KPs is a high priority, including a review of the HIV Act to support this. Also needed is a broader definition of KPs (beyond the KASF list of MSM, sex workers and IDUs) to include “bridging populations” such as prisoners, adolescents (girls and young women), truckers (often left out from decision-making) and fisher folk. Targets include the national government and high burden counties (listed above), along with the MoH and Parliament. This activity will have a longer timeline, ongoing throughout the new HIV strategic plan (KNSF – 2014-2019). KP-led organizations should lead implementation, including BHESP, ISHTAR MSM, LVCT-Health and KP networks. Success measure: Equal access and availability of health services for KPs, data/results that their human rights are being protected and respected.

## #6 Priority – Malaria [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Behavior Change on Use of Interventions

Knowledge on preventative malaria interventions is at 96% which does not match the resulting behavior - net usage is low, with only 30% using LLINs, although 65% of households own at least one net (2013, MoH/Malaria Control). Intermittent preventive treatment of malaria in pregnancy (IPTp) is only at 22% and case management records show 47% tested and 40% use of national guidelines. CSOs propose scaling up BCC to all hotspots through community outreach and promoting IPT. In addition, awareness about drug adherence is needed. Targets are children under 5 (U5s) and between 6-14 years and pregnant women (PWs), especially those in the lake/ coastal areas including Turkana and Marsabit. Rural and poor populations across the country and most-at-risk areas should be prioritized, starting in 2015, after the Global Fund concept note is submitted. CSOs under the KENAAM network are well placed to achieve the target of 80% LLIN use, up from baseline 31% by 2017. Other targets include case management to 100%, increase IPTp to 80% in target areas and increase use of national guidelines on management to 80% (by 2017). Efforts should be made to widen the number of CSO working on Malaria.

### Secondary Priority - Community Case Management

Community case management is direly needed in Kenya, since malaria testing is only at 15%, with even lower coverage for microscope and RDT (11%) (MoH, 2013, Kenya MTR of the National Malaria Strategic Plan 2009-2017). Further, testing for children under 5 years of age (CU5) is at only 5.3% for 48 hours (KMIS, 2010). At present there is approximately 11% roll out of community case management, which must be scaled up (Noor et al., 2012). Malaria-specific clinics may work, while including integrated interventions (i.e. PMTCT). Civil society proposes making use of existing community structures to include malaria education. Rural poor populations in hot spots in PWs and U5s should be targeted, especially coastal regions such as Kwale, Taita, Taveta, Kilifi, Mombasa and Turkana. This should be rolled out from January 2015 to 2017. AMREF are already implementing this in Nyanza and Western region, but other CSOs under the KENAAM network can work in other hot spots. Success measures: reach 50% coverage of community case management by 2017 (up from baseline 11%); 100% community case detection/ diagnosis for both RDT and microscope; increase testing among CU5.

## #7 Priority – Harm Reduction [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority - Access to Needle and Syringe Programmes (NSP) and Methadone maintenance treatment (MMT)

The current IDU point estimate in Kenya is 18,327. There is a need to reach at least 60% (10,600) to have a positive impact on the HIV epidemic. The current reach is 5,000. In the 2011 Political Declaration on HIV/AIDS, member States committed to reducing transmission of HIV among people who inject drugs by 50% by 2015, but the Kenya NSP has only 27% coverage. Civil society has a comparative advantage to strengthen community-based outreach, targeting indigent and female IDUs, whose prevalence is four times more than male IDUs (IBBS, 2012). Women also require a different/ broader package of services (e.g. MMT for both injecting and smoking heroin users). Integration of harm reduction and PMTCT is also needed. Drop-in centers and health units should be prioritized, starting with planning in September 2015, and running until December 2017 to align with the NFM. LVCT, Harm reduction network, KANCO, among others are well placed to coordinate a team of implementers, and should focus on scale up of existing pilot programs, not the creation of new pilots. Success measure: to reach 10,600 IDUs, providing them NSP and MMT.

### Secondary Priority - Advocating for Domestic Finances

International funding for harm reduction is declining. Only two international donors will remain by 2015 (Mainline Foundation and Family Health Options). Needed therefore, is strong advocacy which targets national and county governments, the Cabinet Secretary for Health, County Secretary for Health, MPs, MCAs and Governors to increase domestic investment on harm reduction. To boost international funding by partners to support NSP and MMT, more domestic funding for civil society organizations is needed to enhance action on human rights and structural barriers that restrict access to HIV prevention, especially sustainable livelihoods programmes for IDUs. CSO action on MSM and sex workers is comparatively much stronger, recognizing the need for greater community engagement around IDUs as a neglected key population in Kenya. National and county forums need to be targeted from September 2015 to December 2017, to align with the KASF. LVCT, Harm reduction network, KANCO, among others are well placed to coordinate implementation, in partnership with other CSOs. Success measure: By 2017, secure at least 1% of domestic financing (from HIV allocation) for harm reduction.

## #8 Priority – Procurement [\(Click here to read the full Civil Society Case Study\)](#)

### Top Priority – Understand Civil Society Role in Procurement Efficiency

Understanding procurement efficiency is vital to minimizing waste; fragmented procurement lines increase costs and risk of fraud. Studies show that Kenyan public dispensaries have potential to provide 27% more goods/services with current levels of investment. Some national CSOs like TI (K) and NEHPHAK have existing procurement citizen monitoring systems. These should be used to target county executives, who make the budgetary decisions. Civil society has a comparative advantage to improve community monitoring at health facility level. Target groups include the County Executive, County Assembly and CSOs tracking procurement at county level. Civil society will acquire the procurement list from NASCOP, then, visits will be conducted to CSOs with tracking programmes (i.e. TI and NEPHAK). Meetings will be held with county executives of four top counties (Oct-Aug 2014). Those well placed to take the lead include HERAF, KANCO, KeNAAM, TAC and NEPHAK. Success measures: Short term – gather data from NASCOP, NTLDD Unit and Malaria Control Unit (2016); Long-term - efficient procurement, end of stock outs, improved results on community monitoring, achieved by 2017.

### Secondary Priority – Transparency around Accessible Information on Commodities in the PSM Pipeline

To ensure cost-effectiveness, civil society must understand how the PSM pipeline works. Transparency at county level allows for constructive oversight but is a challenge to do. Needed is greater transparency at national level around delays caused by counties e.g. in reporting and re-stocking. Improvements are possible by leveraging community monitoring systems. Civil society can improve knowledge on the PSM, building awareness around what is in the system, the number of commodities/price; per funding source explore quality assurance and other problems facing key procurement units. Targeted groups include the County Executive, County Assembly, county health management teams, non-state actors, devolved anti-corruption unit, NEPHAK and TI (K). The first step in implementation will be for CSOs to get a procurement list from NASCOP, followed by a rapid review of PSM pipeline and gaps challenges and then lobbying county level. This should be led by Development Initiatives and TI (K)/ CMKN, NEPHAK, and KANCO.

## Partner Organizations



AIDS Healthcare Foundation (AHF)  
Aidspan  
Amref Health Africa  
Bar Hostess Empowerment & Support Programme (BHESP)  
Development Initiative  
East African National Networks of AIDS Service Organizations (EANNASO)  
Health GAP/ACP  
Health Rights Advocacy Forum (HERAF)  
Isthar MSM  
Kenya Consortium to fight AIDS, TB and Malaria (KECOFATUMA)  
Kenya Network of People who Use Drugs (KENPUDs)  
Kenya AIDS NGOs Consortium (KANCO)  
Kenya Treatment Access Movement (KETAM)  
Lean on Me  
LVCT Health  
Malaria Control Unit

Médecins Sans Frontières (MSF)  
Ministry of Health  
Nairobi Outreach Service Trust  
National AIDS Control Council  
Pamoja TB Group  
Personal Initiative for Positive Empowerment (PIPE)  
Reachout - Kenya Harm Reduction Network (KHRN)  
Regional Technical Support Hub  
TB Consortium  
The East Africa Roll Back Malaria Network (EARN)  
The International HIV/AIDS Alliance  
The Kenya Alliance of NGOs Against Malaria (KeNAAM)  
The National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)  
Water and Farming Aid (WAFA)  
World AIDS Campaign (WAC)  
Wote Youth Development

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