KELIN
Reclaiming Rights, Rebuilding Lives

STRATEGIC PLAN
2021 - 2025

ACRONYMS

AAAQ	Availability, Accessibility, Acceptability, Quality
AU	African Union
EAC	East African Community
CBO	Community Based Organization
CSO	Civil Society Organization
CUC	Court Users Committee
LEA	Legal Environment Assessment
PESTLE	Political, Economic, Social, Technological, Legal, Environmental
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
ToT	Training of Trainers
UHC	Universal Health Care
HIV	Human Immunodeficiency Virus
KELIN	Kenya Legal and Ethical Issues Network on HIV & AIDS
SDGs	Sustainable Development Goals
HIS	Health Information System
STIs	Sexually Transmitted Infections
NCDS	Non-Communicable Diseases

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Mr. Ambrose Rachier
Chairperson
Board of Directors

FOREWORD

Kenya Legal and Ethical Issues Network on HIV & AIDS (KELIN) is a network mandated to promote and advocate for the right to health in Kenya. KELIN will continue to play a pivotal role in advocating for an enabling environment for vulnerable and marginalized populations to realise the highest attainable standard of health.

KELIN has developed a transformative and inclusive 2021-2025 Strategic Plan. This plan takes cognizance of the existing and emerging health-related human rights and provides a framework within which KELIN can engage with challenges and opportunities in relation to advancing the right to health.

The implementation of the plan will support joint efforts through collaboration, coordination and commitment from all like-minded stakeholders including civil society organizations, the national and county governments, private sector and development partners and seek to create synergies to realise the planned impact. The Board is committed to providing oversight and strategic direction for the successful execution of the plan.

Ambrose Rachier

Chairperson, Board of Directors

Mr. Allan Maleche
Executive Director

ACKNOWLEDGEMENTS

The KELIN 2021-2025 Strategic Plan has been made possible through the support, dedication and active involvement of multiple stakeholders who provided technical inputs. The strategic plan is a collaborative effort that involved the staff, board members and partners that have worked with KELIN over the years. In this regard, I wish to thank all KELIN staff members for their tireless and immense contribution to the strategic planning process. The staff, coordinated by the different thematic leads, provided valuable information through consultative meetings and workshops that culminated in linking strategic outcomes to the expected strategic interventions and targets.

We also appreciate the coordination team which constituted the secretariat for the strategic planning process that took the lead in ensuring that consultations were made with all the relevant stakeholders to produce a standard strategic plan.

We wish to recognise the contribution of community, national, regional and international partners who continue to collaborate with KELIN in upholding the right to health within the communities; as well as nationally, regionally and globally. We express our sincere gratitude to all our partners for their frank and in-depth insights on the direction the right to health and health related human rights are taking at the national, regional and global level and why KELIN must remain engaged on these issues.

Special thanks goes to our Board members who have remained engaged during the entire strategic planning process including appointing a sub-committee, co-chaired by Catherine Mumma and Allan Ragi, that worked closely with the consulting team to achieve the expected outcome. We acknowledge the consultants, Rhodah Njuguna and Atieno Odenyo, who spearheaded the technical support required to develop the strategic plan.

Finally, I would like to thank all stakeholders largely drawn from the communities that we serve, health care users including communities of people living with HIV, TB survivors, members of key and affected populations; women & girls; adolescents and young people among others.

Allan Maleche

Executive Director

EXECUTIVE SUMMARY

This document provides the strategic framework under which KELIN shall work towards promoting and protecting health related human rights as guaranteed in the Constitution of Kenya, 2010. The plan covers the period between 2021 and 2025 and has been developed through a participatory, collaborative and consultative process that culminated in the following: a rigorous review process of the previous strategic plan (2015-2019); learning and consensus building exercises; and collaborative development involving the staff and board of KELIN, as well as technical partners.

The plan is informed by KELIN's 2015-2019 strategic plan, leaning heavily on lessons learnt in the implementation of that plan; the evolution of the organisation in that period; and the changing landscape with regard to the right to health. In this period, KELIN learned the significance of its mission and vision and shall continue to promote and protect health related human rights for the full enjoyment of health-related human rights for all. The strategic direction was defined through a consultative process with the board, staff and various partners and informed by key lessons from the implementation of the previous strategic plan. The key lesson throughout this process was that both KELIN and the landscape have evolved and that evolution has to be reflected in the 2021-2025 strategic plan.

The situational analysis is illustrative of the evolution of the landscape, necessitating a need to both stay true to some issues but also broaden our scope. In the previous plan the Constitution played a key role in entrenching a rights-based discourse to health in KELIN's programming. In this plan, the Constitution will play a key role in informing a multi-disciplinary lens to the right to health and health related human rights. The need to expand conversations beyond HIV was a key lesson for 2015; and in 2021 we consider the need to expand conversations beyond health. Significantly emerging issues of governance and community strengthening will play a role in securing the gains made in the past five years and in pursuing impactful, lasting and sustainable gains. Marginalised and vulnerable communities remain the lens through which we work but KELIN has expanded this to consider their interactions with laws,

policies, institutions and systems to work towards a Kenya that is equitable in seeking to redress marginalisation. Health and governance systems shall be unpacked, explored and reconstructed to make them more accountable, transparent and fit for purpose for those made most vulnerable by the same systems.

This plan underscores values and principles that shall guide KELIN's internal operations, programming and outward engagement including: Non-discrimination, inclusivity and diversity; ethics above expedience; results for people; rights-based approaches; a strengths-based perspective; collaboration; and transparency.

The strategic outcomes are the most significant shift from the previous strategy and are illustrative of KELIN's ambition to continue to grow into the space around health-related human rights while offering innovative solutions and nuanced thinking to growing issues and challenges. These are:

i. A rights-based, gender-transformative and enabling legal and policy environment on health at the global, regional, national and county levels is promoted and strengthened.
ii. Transparent and accountable governance in health is enhanced for the implementation of quality, accessible and comprehensive services and protection of health-related human rights.
iii. Communities and community structures are empowered to demand and promote social justice for health and to hold governments accountable to deliver on the right to health.
iv. Policies, practices and programs are informed by expanded, improved and available evidence.
v. KELIN's institutional capacity to deliver on its core mandate is strengthened and sustainability enhanced.

These strategic outcomes are an innovative reimagination of KELIN's strategic direction in its previous plan while maintaining sight of our mission and vision. They seek to build on the work done in the previous years; scale up our reach and impact; improve on our ways of working; and focus on collaboration, cross learning and mentorship. We plan to work in partnership with communities and community structures towards movement building and meaningful collaboration guided by a shared vision and the spirit of solidarity. KELIN shall work towards strengthening evidence-based advocacy for her own programmes and in partnership with various agents to improve the availability, accessibility and quality of evidence available in decision making spaces to improve the lives of the targeted communities. KELIN is nothing without its incredible team and the organisation shall work towards building its institutional strength including: considering improved ways of working; effective utilisation of resources towards sustainability; and creating a conducive and healthy environment where team members can find both passion and purpose.

KELIN remains committed to results-based programming, where its priorities will be set and implemented and the organizational resources and performance will be monitored periodically. The monitoring, evaluation and learning plan highlights this commitment and this shall be read in tandem with the Results Framework which is included as an annexure and shall serve as a guidance tool in the implementation and evaluation of this plan.

1.0 INTRODUCTION

KELIN was established to address the legal and ethical issues related to HIV and AIDS in 2001. KELIN's first strategic plan (2009 to 2014) focused on advocacy and leadership to ensure a rights-based approach to HIV strategies and programmes.

Experience soon showed that carrying out this work required dealing with a number of inter-related factors impacting on individuals and communities' access to health-related human rights given that the right to health was constitutionally guaranteed in 2010. In response, KELIN adopted a holistic approach, advocating the promotion and protection of health-related human rights while still maintaining a focus on HIV and targeting vulnerable and marginalised communities. This is what informed our strategic plan for the period 2015- 2019.

The Strategic Plan 2021-2025 is an innovative reimagination of KELIN's strategic objectives while maintaining sight of its mission and vision. KELIN has revised its strategic objectives to build on the work done between 2015-2019 and scale up its reach and impact, improve on its ways of working, focus on collaboration, cross learning and mentorship. This strategic plan shall explore emerging issues and take a multi-disciplinary lens in the pursuit of health-related human rights.

1.1 Methodology of Developing the Strategic Plan

The approach adopted during the development of the strategic plan was participatory, collaborative and consultative. An initial meeting with the strategic plan steering team to understand the scope of the exercise and define the key deliverables was held in late 2019. This was followed by a review of key documents, including the previous Strategic Plan (2015-2019) evaluation report, Constitution of Kenya 2010, Vision 2030 Medium-Term Plans[1], Right Based Approaches Surveys, the Sustainable Development Goals[2], the Africa Union Agenda 2063[3] and the East Africa Community Treaty amongst other relevant documents. Development and refinement of tools was done before data collection at community, county, national and global levels to inform the strategic direction. A total of 20 key informant interviews and five focus group discussions with various stakeholders from global, regional, national, county, community, board members and KELIN staff were consulted during the process. Findings from literature review and data collection were validated in a workshop that included KELIN and staff and board members.

[1]Third Medium Term Plan 2018 -2020. Available at https://vision2030.go.ke/publication/third-medium-term-plan-2018-2022/.

[2]Available at https://www.undp.org/content/undp/en/home/sustainable-development-goals.html.

[3]Available at https://au.int/en/agenda2063/overview.

2.0 SITUATIONAL ANALYSIS

2.1 Legal and Policy Framework

Article 43(1) (a) of The Constitution of Kenya, 2010, guarantees *the right to the highest attainable standard of health including reproductive health.* Article 43(1) (a) and (2), which guarantee the right to health and access to emergency medical care, are subject to Article 21(2) that requires the State to take legislative and policy measures, including the setting of standards to achieve the progressive realization of the rights in that section. The Constitution further requires that the State addresses the needs of vulnerable groups within the society including persons with disability, children, youth, members of marginalised and minority communities among others[4]. Thus progressive realization ought not to be considered in isolation but should be informed by available resources and by the requirement to address the needs of vulnerable groups and peoples. Children's right to healthcare is governed by Article 53(1), which guarantees the child's right to health care. This is not subject to the progressive realization clause and thus should be interpreted as an immediate obligation for the State.

The right to reproductive healthcare is specifically highlighted in Article 43(1) (a) in the Constitution; this is bolstered by the non-discrimination clause, which prohibits discrimination on the basis of pregnancy. Further Article 26(4), provides an exception to the prohibition against abortion which permits access to an abortion if the life or health of the pregnant woman is in danger; if needed for emergency treatment; and if permitted by any other law. These Articles cumulatively emphasise the significance of reproductive health in the Constitution, 2010.

Since 2014 there have been efforts to consolidate the laws governing health in Kenya into one health law that culminated in the enactment of the Health Act, 2017[5]. The Health Act, 2017 is by far the most comprehensive legislative enactment on the implementation of the right to health. It recognises health as a right and notes that this right shall include: "progressive access for provision of promotive, preventive, curative and rehabilitative services"[6]

[4]Article 21(3).

[5]Other significant legislation that governs health and health services that have been enacted since 2010 include the: Kenya Medical Supplies Authority Act No. 2 of 2013, National Authority for Campaign Against Alcohol and Drug Abuse Act No. 14 of 2013, Science, Technology and Innovation Act No. 28 of 2013 and Public Health Officers (Training, Registration and Licensing Act) of 2013.

[6]Section 5 of the Health Act, 2017.

The Act guarantees reproductive health and rights[7], access to emergency treatment,[8] health information,[9] consent and confidentiality, and stipulates information that ought to be disseminated by government.[10]

There are a number of policies that govern different facets of the right to health. The main policy for the purpose of this strategic plan is the Kenya Health Policy, 2014-2030 which provides strategic guidance on how to improve the overall status of health in Kenya.[11] The policy is significant for a number of reasons: firstly, it seeks to employ a human rights based approach to the progressive realization of the right to health as well as requiring healthcare delivery to integrate human rights norms and principles in their design.[12] Secondly, the principles that guide and in which the policy is grounded include: equity in the distribution of health services; people-centred approach to health; participatory approach to delivery of interventions; multi-sectoral approach to realizing the right to health; efficiency in the application of technology; and social accountability.

[7]Section 6 of the Health Act, 2017.

[8]Section 7 of the Health Act, 2017.

[9]Section 8 of the Health Act, 2017.

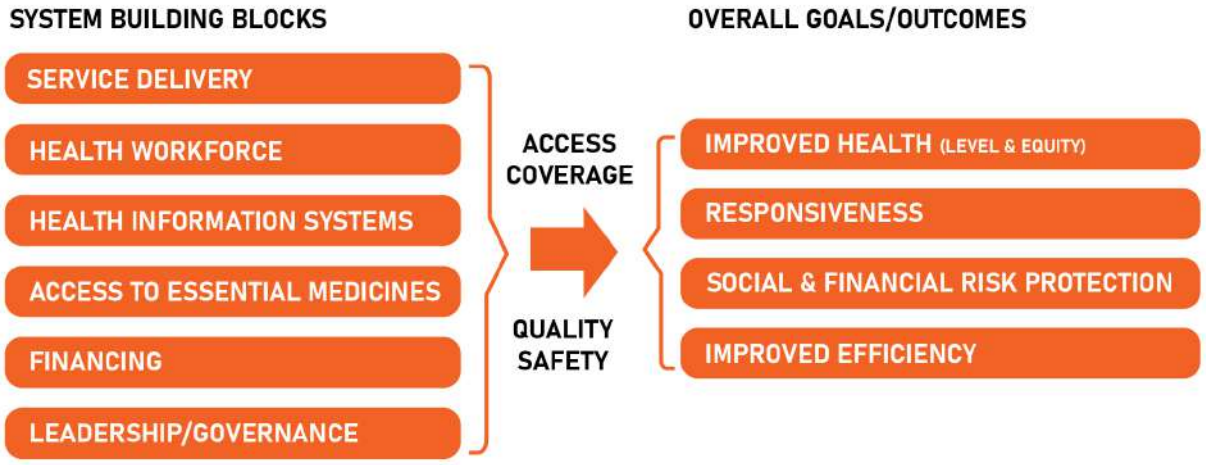
[10]Section 9-11 of the Health Act, 2017.

[11]The policy aims to contribute to the attainment of the country's long-term development agenda outlined in Kenya's Vision 2030. This will be through the provision of high-quality health services with a view to maintain a healthy productive population able to deliver the development agenda.

[12]TheKenya Health Policy (2014-2030) at page 1. Available at https://www.afidep.org/?wpfb_dl=80.

2.2 The Kenyan Health Sector

A health system is defined by the World Health Organization (WHO) as: "all organisations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health improvement activity."[13] In order to achieve its goals a health system has six building blocks and desirable outcomes (Figure one).



THE SIX BUIDLING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

[13]WHO, "Everybody's Business: strengthening health systems to improve health outcomes: WHO's Framework for Action" (2007) available at https://www.who.int/healthsystems/strategy/everybodys_business.pdf.

In Kenya healthcare service delivery is regulated and governed at two levels with the national and county governments playing a role in service delivery. County governments are responsible for county health facilities which are the first five of six facility levels in Kenya including: community services; dispensaries and clinics; health centres, maternity, and nursing homes; sub-county hospitals and medium sized private hospitals; and county referral hospitals.[14] Ancillary to this, counties are charged with promotion of primary health care; ambulance services; veterinary services; licensing and control of the sale of food to the public; cemeteries, funeral parlours and crematoria; and refuse removal and dumps.[15] The national government is charged with national referral hospitals (level 6) and with the development of health policy.[16]

Informed by the Sustainable Development Goals (SDGs) the WHO estimates that 44.5 physicians, nurses and midwives per 10,000 members of the population shall be required to achieve the SDGs, Kenya's ratio stands at 13.8 physicians, nurses and midwives per 10,000 members of the population.[17] Devolution of the health function has resulted in the management of human resources for health changing, with counties being more responsible for local needs, often with push back from both the national government and the healthcare workforce.[18] In addition to significant staff shortages, members of the healthcare workforce are also faced with insufficient resources, poor human resource planning, and unsatisfactory working conditions.[19]

44.5
Physicians per
10,000
members of population are required by WHO to achieve the SDGs.

[14]Schedule IV of the Constitution of Kenya, 2010.

[15]Ibid.

[16]Ibid.

[17]Masibo R., Kiarie H. and Bartilol P. "Human Resources for Health: Gaps and opportunities for strengthening", Ministry of Health, available https://www.health.go.ke/wp-content/uploads/2019/01/Human-Resource-for-Health-Policy-Brief-fin.pdf.

[18]Ibid.

[19]Ibid.

A properly functioning Health Information System (HIS) gets the right information, to the right persons at the right time enabling informed decision making. Availability of reliable and timely information should be the back bone of a health system particularly in resource constrained situations where resource allocation can result in life or death scenarios.[20] Kenya has been developing its HIS since 1976 and while many strides have been made, the country still has some significant gaps, which have been exacerbated with a new governance context, including weak and incomplete data (data quality); poor dissemination and use of data collected; and a lack of precision in the guidance from the Ministry of Health to county governments.[21]

Access to essential medicines is part of the right to health and attaining this is a prerequisite of realising universal access to services. Essential medicines are those that satisfy the healthcare needs of the population and they are selected with due regard to disease prevalence, evidence on efficacy and safety and comparative cost-effectiveness.[22] A household survey conducted showed inequity on access to medicines and while geographic access was not an issue for many (only 10% of households had to travel more than an hour to access a public health facility), availability of medicines needed was problematic with only 32% of households perceiving that public health facilities had the medicines they needed.[23] Poor households spent more time travelling than wealthier households.[24] Economic accessibility or affordability was the more significant part of inequity where 95% of median expenditure for health in poor households being on essential medicines, compared with 50% for richer households.[25]

Only **10%**

of households had to travel more than an hour to access a public helath facility.

Only **32%**

of households perceive that public health facilities had the medicines they needed.

[20]USAID and MEASURE Evaluation (September 2017), "How Kenya monitors Health Information Systems Performance: A case study" (ISBN 978-1-9433-6475-6).

[21]Ibid.

[22]Ministry of Medical Services and Ministry of Public Health and Sanitation (December, 2009), "Access to Essential Medicines in Kenya: A household survey" available at http://digicollection.org/hss/documents/s18696en/s18696en.pdf.15Ibid.

[23]Ibid.

[24]Ibid.

[25]Ibid.

Approximately 50% of all households surveyed had at least one member that had experienced a recent acute illness that required access to essential medicines. Further, in the households reporting chronic illness a higher proportion of the poorest household (45%) did not have the medicine at home compared to 32% of the richer households.[26]

In 2014, Kenya's ranking shifted to a lower middle-income country. While this was generally positive for the country, it resulted in a number of development partners reducing their support, necessitating increased domestic investment.[27] Illustratively Kenya is expected to contribute above 20% for basic commodities such as vaccines, malaria and TB medication, contraceptives and anti-retroviral therapy compared to a previous minimum of 5%. Despite increased responsibility government spending on health has stagnated around 6%, far from the 12% the country hoped to achieve by 2018 and even further from our commitment in terms of the Abuja Declaration on Rollback from Malaria.[28] Lack of adequate financial protection, fragmentation of resources, and low insurance coverage all contribute to low funding.

Governance and leadership is widely recognised as being central to improving health sector performance. Since 2013 Kenya has been going through the process of devolution and this has inevitably had an impact on governance in the health sector; reallocation of resources has impacted power relationships and access for varying actors to decision making and state resources.[29] Good governance in health has been hindered by: a failure to adequately consider the accountability implications of reforms in light of prior contextual norms such as patronage and paternalism that are still very present; varied values by decision making actors with politically popular and visible projects such as infrastructure taking precedence over more invisible investments like community health services; limited capacity for meaningful priority-setting by decision makers; and a failure to invest in genuine community empowerment and engagement for accountability and transparent decision making.[30]

45%

of poorest households reporting chronic illness do not have medicine at home

6%

is the current governement spending on health, far from 12% hoped to be achieved by 2018

Good governance in health has been hindered by: a failure to adequately consider the accountability implications of reforms in light of prior contextual norms.

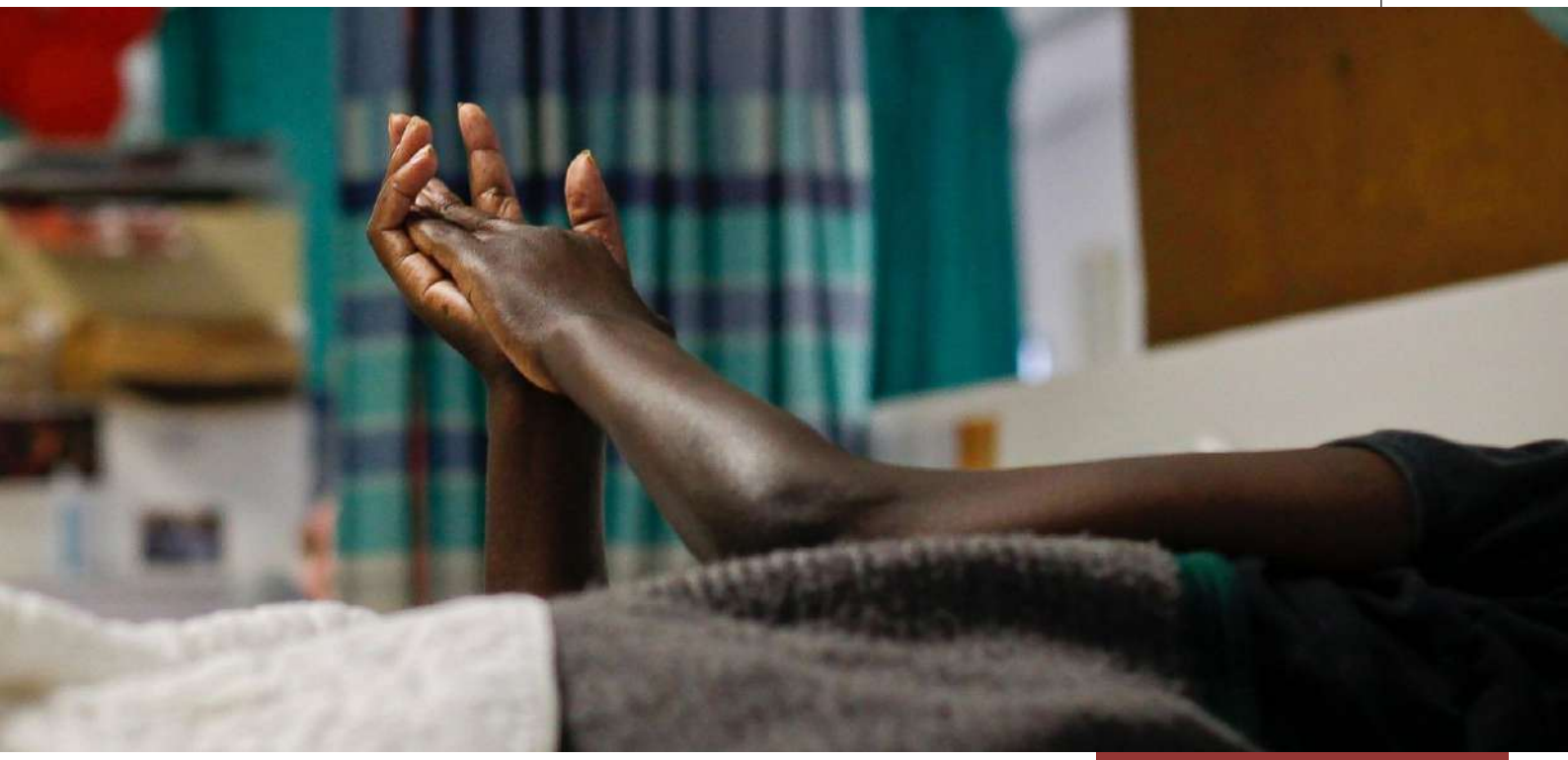
[26]Ibid.

[27]Njunguna D and Wanjala P. "A case of increasing public investments in health: Raising public commitments to Kenya's Health sector" (Ministry of Health) available at https://www.health.go.ke/wp-content/uploads/2019/01/Healthcare-financing-Policy-Brief.pdf.

[28]Ibid.

[29]McCollum R, Limato R, Otiso L, et al 'Health system governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia'BMJ Global Health 2018;3:e000939.

[30]Ibid.



2.3 Vulnerable and marginalised populations

Since its inception KELIN has worked with vulnerable and marginalised populations because of the nuanced ways in which these populations interact with the law and the health sector. This experience has informed KELIN's thematic areas and continues to be a focal point and a lens through which it develops its interventions.

While the HIV epidemic shows a declining pattern, HIV incidence remains high with the national HIV prevalence estimated at 4.9% translating to 1.3 million persons living with HIV.[31] When this data is refined, it is noted that populations are impacted differently by the epidemic; infection is high among women at 6.6% compared to men at 3.1%.[32] Young women of age 10-19 have a 1% HIV prevalence compared to 0.09% young men of the same age. The overall HIV prevalence among children is 0.7% which translates to 139,000 children living with HIV in Kenya.[33] In terms of geographical spread, five counties out of the 47 counties have higher HIV prevalence than the national average. These counties include Busia, Siaya, Kisumu, Homa Bay and Migori. Homa Bay reports the highest prevalence at 19.6% followed by Kisumu at 17.5%.[34]

HIV prevalence is estimated at

4.9%

translating to

1.3M

persons living with HIV

Women experience higher HIV infection at

6.6%

compared to men at

3.1%

[31]National AIDS Control Council, "Kenya HIV Estimates: Report 2018) (October, 2018) available at https://nacc.or.ke/wp-content/uploads/2018/12/HIV-estimates-report-Kenya-20182.pdf.

[32]Ministry of Health, "Kenya Population-Based HIV Impact Assessment – KENPHIA 2018: Preliminary Report" available at https://phia.icap.columbia.edu/wp-content/uploads/2020/04/KENPHIA-2018_Preliminary-Report_final-web.pdf.

[33]Ibid.

[34]Ibid.

Despite being curable tuberculosis remains one of the world's deadliest communicable diseases affecting 11 million people globally every year, 1.7 million of whom eventually die.[35] Kenya is among the top 30 high burden TB countries globally with a prevalence rate of 558/100,000 members of the population an increase from the prevalence in 2015.[36] There were more men than women infected by TB. However, for those above 65 years more women than men were diagnosed with TB. The age set most at risk was 15-34 years. Of note, 83% of those diagnosed with TB were HIV negative, with the urban population being more at risk.[37]

Women and girls, particularly adolescent girls; young women; women and girls with disability; and those from marginalised communities, are vulnerable to a number of health and human rights violations due to: early and unintended pregnancies; unsafe abortions; female genital mutilation; child marriages; STIs; unequal access to land and economic opportunities among others.[38] Gender and equality biases, reflected in gender-assigned roles and other customs, still contribute to the differential treatment of women in Kenya. These inequalities suppress the ability of most women to decide if and when to exercise their sexual and reproductive health and rights.

TB remains one of the world's deadliest communicable diseases affecting

11 M

people globally every year

TB Prevalence rate in Kenya stands at

558 PER 100,000

members of the population

[35]KELIN, "Tuberculosis: Data Assessment in Key, Vulnerable and Underserved Populations in Kenya" (January, 2018) available at http://www.kelinkenya.org/wp-content/uploads/2018/04/TB-Data-Assesment.pdf.

[36]Ministry of Health (2016) "Kenya Tuberculosis Prevalence Survey 2016" available at: https://www.chskenya.org/wp-content/uploads/2018/04/Final-TB-Prevalence-Survey-Report.pdf.

[37]Ibid.

[38]Ibid.

Women and girls' marginalisation is particularly acute in relation to land and property rights. Land is the primary factor for production in Kenya and it is mainly controlled by men. Only 1% of all titles in Kenya are held by women solely; while only 5% are held by women jointly with men despite women accounting for slightly over 50% of the country's population.[39] Despite having very little stake in land, over 89% of the subsistence farming labour force is provided by women, while 70% of labour in cash crop production is provided by women.[40] Women form an overwhelming majority of the labour necessary to make land productive but have significantly been locked out of ownership. Further, ownership is only one issue as women face significant barriers in accessing land as a result of discriminatory laws,[41] cultural practices, and deep-rooted norms against women's land ownership and access. Widow disinheritance; exclusion from inheritance from their birth families; and matrimonial property laws on contribution, work to exclude women from land ownership while exploiting their labour to make land productive.[42] Given the significance of access to and control over land in an agricultural nation, women's exclusion has to be viewed as an equality issue and with access to housing being one of the determinants of health – this is also an issue of health and wellbeing.

Land in Kenya is mainly controlled by men.

Only **1%**

of all land titles are held by women, while

89%

of subsistence farming labour force are women

70%

of labour in cash crop production is provided by women

[39]Federation of Women Lawyers, Kenya, "Women's Land and Property Rights in Kenya: Training Handbook" available at https://land.igad.int/index.php/documents-1/countries/kenya/gender-3/625-women-s-land-and-property-rights-in kenya/file#:~:text=Some%20important%20facts%20on%20women's,by%20women%20jointly%20with%20men.&text=Only%201%20percent%20of%20land,are%20held%20by%20women%20alone.

[40]Ibid.

[41]The Law of Succession Act, Chapter 160 of the Laws of Kenya is illustrative of discriminatory practices entrenched in law: despite providing for equal rihts of inheritance it excludes some gazetted districts under which customary law is applicable. Some provisions give preferential treatment to men, notably with intestate succession if a woman dies, her husband can inherit her property unrestricted; however, if the opposite were to happen a woman would only be allowed to have a life interest over the property.

[42]Nnoko-Mewamu J., Abdi N., "Securing women's property rights in Kenya", (7 March 2020), Human Rights Watch. Available at https://www.hrw.org/news/2020/03/07/securing-womens-property-rights-kenya.

2.4 Emerging health issues

Issues relating to health and health related human rights have emerged between 2015 and 2019 that have guided some strategic changes in KELIN's scope and mandate. The COVID-19 Pandemic has affected most countries in the world and Kenya is no different. Kenya, like many other countries was caught flat footed with the COVID 19 Pandemic and from the time the first case was confirmed on 12th March 2020, a number of measures were put in place to manage the Pandemic. Numerous significant issues arose early on from the pandemic response resulting in growing distrust between Kenyans and their government. These include: failure to provide accurate, timely and life-saving information; use of police to enforce public health measures often resulting in brutality; failure to guarantee essential services resulting in increased unintended pregnancies, births without access to skilled birth attendants and unsafe abortions; failure to protect frontline workers and ensure occupational safety resulting in loss of lives and strikes during the pandemic; and finally the pandemic response was not gendered and disproportionately affected marginalised communities like women, children, informal sector workers among others.[43] The inequalities experienced with access to COVID-19 vaccines have reignited the conversation on the need to rethink the global health architecture. Stark inequalities continue to exist with low-income countries having received just 0.2 per cent of all COVID-19 shots given as at July 2021.[44]

The COVID-19 challenges has provided an opportunity to bolster KELIN's understanding of health systems, and underscore the measures to be taken to build resilient health systems.

[43]KELIN et al, (March 2020), "Advisory note on ensuring a rights-based response to curb the spread of COVID-19: People – not messaging – bring change" available at https://www.kelinkenya.org/wp-content/uploads/2020/03/letter2.pdf. Also see Maleche A., Imalingat T., Were N. (14 May 2020), "Excessive Law Enforcement in Kenya" Verfassungsblog on Matters Constitutional available at https://verfassungsblog.de/excessive-law-enforcement-in-kenya/; and Maleche A. and Were N., (21 May 2020), "Kenya's growing anti-rights public health agenda during the COVID-19 Pandemic" Bill of Health available at https://blog.petrieflom.law.harvard.edu/2020/05/21/kenya-global-responses-covid19/?fbclid=IwAR1YJRA3_-FLHvKS-Tumg8309hxF65G84dBTq5FWBWHGHU-8xEpWYMzjPJ5c.

[44]https://news.un.org/en/story/2021/04/1089392

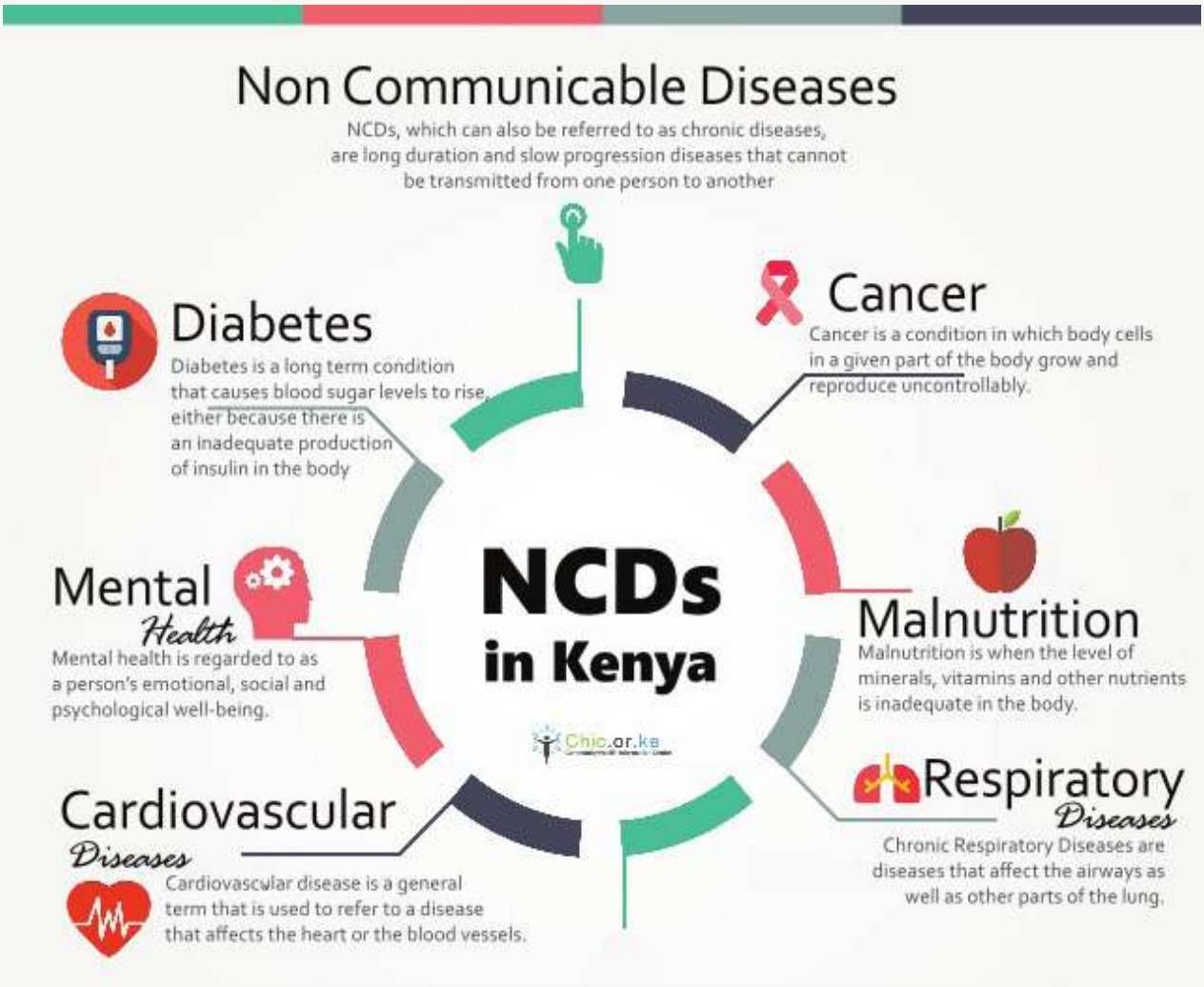


Illustration of the Non Communicable Diseases in Kenya by www.chic.or.ke

Kenya is in the middle of an epidemiological transition with an increase in non-communicable diseases. While communicable diseases still place a significant burden on the country; urbanisation, decreased physical activity, unhealthy diets, tobacco and alcohol have been recognised as some of the risks for non-communicable diseases.[45] Between 2004 and 2012 the contribution of non-communicable diseases to the total disability-adjusted life years shifted from 20.3% to 24.9%; and the total deaths from 21.9% to 26.6%.[46]

Additionally, non-communicable diseases account for 50% of total hospital admissions and 55% of hospital deaths.[47] Like many lower middle income countries, this shift will continue if not well managed and Kenya will find herself grappling with an increased disease burden.

Between 2004-2012, non-communicable diseases increased by

4.6%

and total deaths by

4.7%

[45]Onyango E.M., Onyango B.M., "The rise of non-communicable diseases in Kenya: An examination of the time, trends and contribution of the changes in diet and physical inactivity", Journal of Epidemiology and Global Health, 2018: 8 (1-2), 1-7.

[46]Ministry of Health, Kenya National Bureau of Statistics, World Health Organization, "Kenya STEPwise Survey for Non-Communicable Diseases: Risk Factors Report 2015" available at: https://www.health.go.ke/wp-content/uploads/2016/04/Steps-Report-NCD-2015.pdf.

[47]Ibid.

Finally, while not a new issue in the health sector, malfeasance, and corruption have gained prominence with increased civic space, a more critical media and ease of access to information. Since 2013 there have been multiple corruption allegations both at county and national government level including: Unreasonable and non-compliant expenditure of funds from the Global Fund to Fight Against AIDS, Malaria and Tuberculosis by the National Tuberculosis, Leprosy and Lung Disease Programme amounting to Kes.8.1 million;[48] the Medical Equipment Services Scandal which unearthed governance questions and a usurpation of functions that was eventually termed as a 'criminal enterprise shrouded in opaque procurement procedures" by the Senate Ad Hoc Committee established to investigate it.[49] In a 2016 audit by the Global Alliance for Vaccine and Immunisation, a reported Kes.160 million was misappropriated and had to be repaid with tax payer funds;[50] and an Auditor General Report for the financial year 2015/2016 noted manipulation of the Integrated Financial Management System to log in fraudulent transactions amounting to Kes.5 Billion. These illustrations and many other instances are evidence of the need to improve governance in the health sector to work towards, transparent and accountable governance systems that serve Kenyans.

Kes.8.1M

Medical Equipment Services Scandal was termed as a "**criminal enterprise shrouded in opaque procurement procedures**" by the Senate Ad Hoc Committee established to investigate it.

Kes.160M

was paid back to Global Alliance for Vaccine and Immunisation for misappropriated funds in a 2016 audit

[48]Office of the Inspector General of the Global Fund to Fight AIDS, Tuberculosis and Malaria, "Investigation Report – Global Fund Grants to the Republic of Kenya: Fraudulent Activities in NTLDP Activities", (9 February 2019), Geneva, Switzerland. Available at https://www.theglobalfund.org/media/7169/oig_gf-oig-18-004_report_en.pdf?u=636541321380000000.

[49]Republic of Kenya, The Senate, 12th Parliament, 4th Session, "Report of the Investigation of the Managed Equipment Services by the Ad Hoc Committee to investigate the Managed Equipment Services", (8 September 2020), Nairobi, Kenya. Available at https://www.kelinkenya.org/wp-content/uploads/2020/09/Final-Version-of-MES-Committee-Report-for-Tabling_08092020.pdf.

[50]KELIN et al, "GAVI Audit Report-Request for Information", (14 November 2016), (Nairobi, Kenya). Available at https://www.kelinkenya.org/wp-content/uploads/2018/05/GAVI-AUDIT-LETTER.pdf.

3.0 KELIN STRATEGIC PLAN 2021-2025

Below is a summarized infographic of the KELIN Strategic Plan 2021- 2025

VISION

The full enjoyment of health related human rights for all

MISSION

To promote and protect health related human rights for all

FOCUS AREAS

- HIV, TB, Key and affected populations
- Health and Governance
- Sexual and Reproductive Health and Rights
- Strategic Litigation
- Women Land and Property Rights

STRATEGIC RESULT

By 2025, vulnerable and marginalized communities in Kenya have access to available, accessible, acceptable and quality health services, their health-related human rights are protected and social justice for health is promoted

	Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
OUTCOMES	A rights based, gender-transformative and enabling legal and policy environment on health at the global, regional, national and county levels is promoted and strengthened.	Transparent and accountable governance in health is enhanced for the implementation of quality, accessibe and comprehensive services and protection of health-related rights.	Communities and community structures are empowered to demand and promote social justice for health and to hold government accountable to deliver on the right to health.	Policies, practices and programs are informed by expanded, improved and available evidence.	KELIN's institutional capacity to deliver on its core mandate is strengthened and sustainability enhanced.
HIGH LEVEL INDICATORS	1. Number of legal and policy frameworks strengthened at national and county level. 2. Number of legal and policy frameworks strengthened at regional and global level.	1. Number of health facilities in the targeted counties that meet the minimum requirements of AAAQ. 2. % budget allocation to health at national and county levels allocated to vulnerable and marginalized communites. 3. % expenditure of health allocations at national and county levels. 4. % budget processes influenced by CSO input.	1. Number of communities & CSOs actively engaged in promoting social justice for health. 2. Number of interventions by communities & CSOs holding county and national government accountable to deliver on the right to health. 3. % of the intervention by communities & CSOs on holding both levels of government accountable to deliver on the right to health that are successful.	1. Number of global policies influenced by organizational research and programme evidence. 2. Number of national & county law/policies/guidelines influenced by organizational research and programme evidence. 3. Number of negative practices found repugnant and positive practices enhanced as a result of organizational research and programme evidence. 4. Number of journal articles, policy briefs, research papers published.	1. % of institutional policies fully implemented. 2. % of cost savings due to implementation of strengthened systems and policies. 3. % increase of funding and diversification of donor base. 4. Number of identified core competencies that have been addressed to fulfil KELIN's mandate.

3.1 Summary of the Outcome Areas

Below is a summary of each of the outcome areas, taking into account that the outcomes at each level are inter-related and many of the actions contribute to achieving more than one outcome.

OUTCOME 1: A rights based, gender-transformative and enabling legal and policy environment on health at the global, regional, national and county levels is promoted and strengthened

The aim of this outcome is to strengthen the legal and policy framework at all levels so that it is adequate enough to promote and protect health related rights for all. The use of the rights based and gender transformative approaches will ensure that the interventions respect human rights, promote the principles of equality and non-discrimination, seek to empower communities through a participatory process and promote sustainability for lasting solutions. There will be an emphasis on using various strategies including strategic litigation to influence laws and policies, monitoring development of new laws and policies at the national and county level to ensure they are aligned with national level legislation and policies; that they address rights of vulnerable and marginalized populations, and that budgets are allocated for their implementation. As with all laws and policies, it is essential to ensure that those in charge of upholding rights have the requisite capacities to do so; and the relevant systems and procedures are in place; as well as ensuring strategic partnerships at all levels to enhance advocacy and coordination.

OUTCOME 2: Transparent and accountable governance in health is enhanced for the implementation of quality, accessible and comprehensive services and protection of health-related human rights

This outcome will endeavour to contribute towards policy and decision making on improved health service delivery and to highlight and address the impact of inadequate investments in health systems and services at county and national levels on vulnerable and marginalized populations. This will be done by working towards enhancing the availability, accessibility, acceptability and quality of health services for marginalized and vulnerable groups at national and county levels. KELIN will strengthen rights holders' ability to monitor transparency and accountability in health governance which includes health financing, financial systems, operations, procurement etc; and enhancing public participation in health governance at the county level. Healthcare service delivery within the public sector will be rights based. The rights-based approach will be enhanced through review and improvement of relevant operating procedures; advocacy for increased domestic financing for health; for continued financing of HIV and TB responses, for financing of SRHR services and commodities; and for inclusion in UHC package.

KELIN will undertake advocacy to ensure emergency responses are responsive to specific issues related to gender, sex, age, ability, ethnicity, economic status, specific vulnerabilities and marginalization. In addition, we will promote multi-stakeholder engagement to monitor, review, act and seek remedy in case of violations.

OUTCOME 3: Communities and community structures are empowered to demand and promote social justice for health and to hold government accountable to deliver on the right to health

This outcome will seek to strengthen communities to advocate for and implement health related human rights as well as build social justice partnerships and movements. This also requires supporting the institutional strengthening of established CBOs to undertake key actions on social justice for health; as well as strengthening formal structures such as community health volunteers and court users' committees.

OUTCOME 4: Policies, practices and programs are informed by expanded, improved and available evidence

Under this outcome emphasis will be on producing evidence-based research in specific areas, especially those with research gaps, to inform the development of policies and interventions (practice guidelines, legislation, programme delivery strategies) and the promotion of innovative models on human rights programming. This will require strengthening internal capacities for research and innovation on SRHR, HIV, TB, Key Populations, Health Governance, Women, Land and Property Rights; human rights and health as well as engaging more effectively with strategic partners and contributing to global policy targets and processes in alliance with other actors. It will also be important to make research findings more accessible through more effective and expansive dissemination of the research findings. A knowledge management system will be established as well as strengthening of the M&E system to capture relevant data.

OUTCOME 5: KELIN's institutional capacity to deliver on its core mandate is strengthened and sustainability enhanced

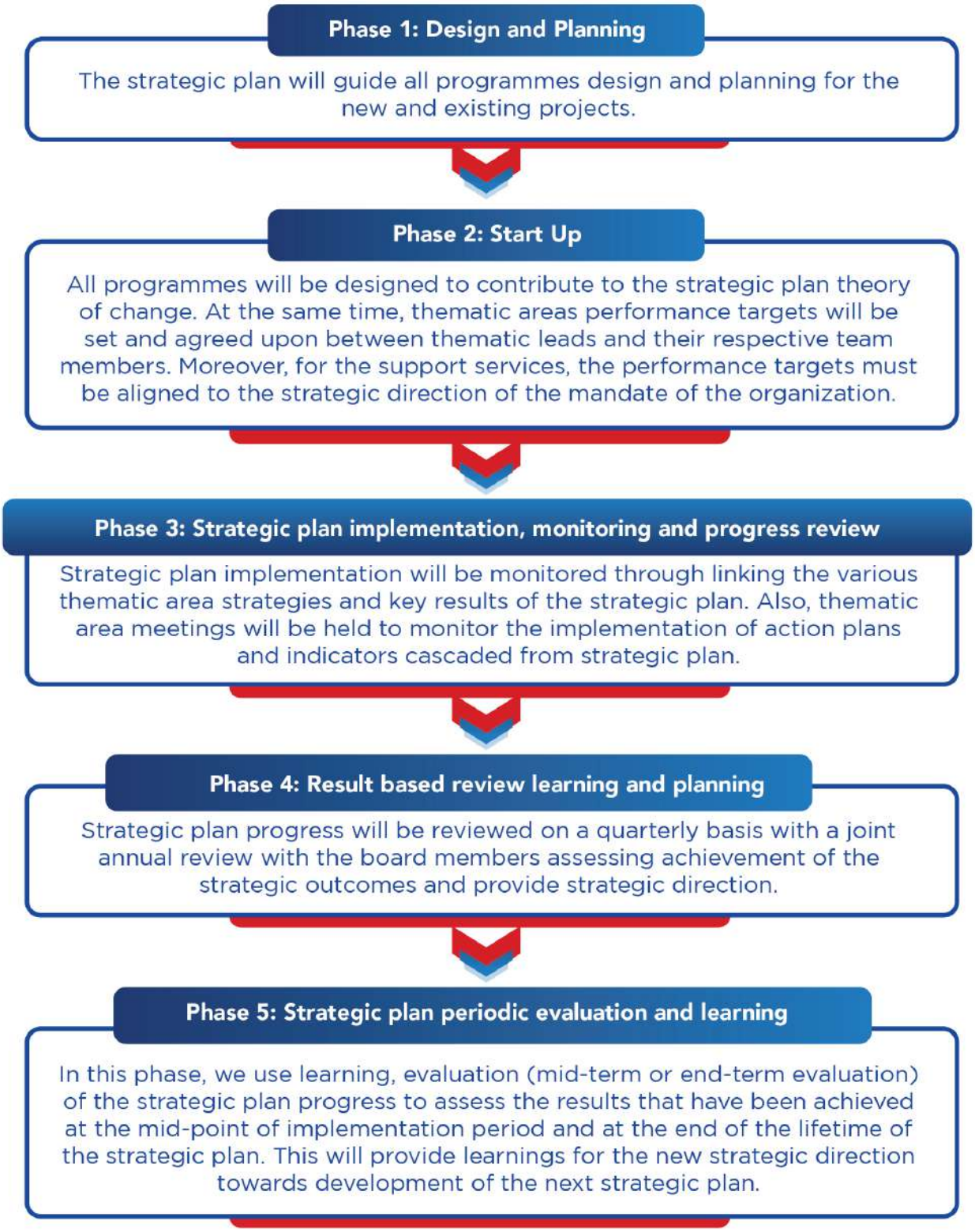
Outcome five will entail focusing on strengthening KELIN's institutional framework for the transparent and accountable management of resources to implement the outcomes of the strategic plan. This will include ensuring human resource and organizational policies and plans are in place, implemented, and in line with ethical standards; a fully integrated digitalized management system is in place and implemented; and that there is a concerted focus and effort towards supporting the growth and capacity development of a new generation of KELIN staff. KELIN will design and implement an effective, targeted online presence and enhance organizational and individual staff skills in ICT; to increase visibility of the organization. KELIN will also work on strategies to enhance long term sustainability of the organization with varied funding streams.

3.2 Guiding Principles

KELIN is committed to being guided by the following principles;

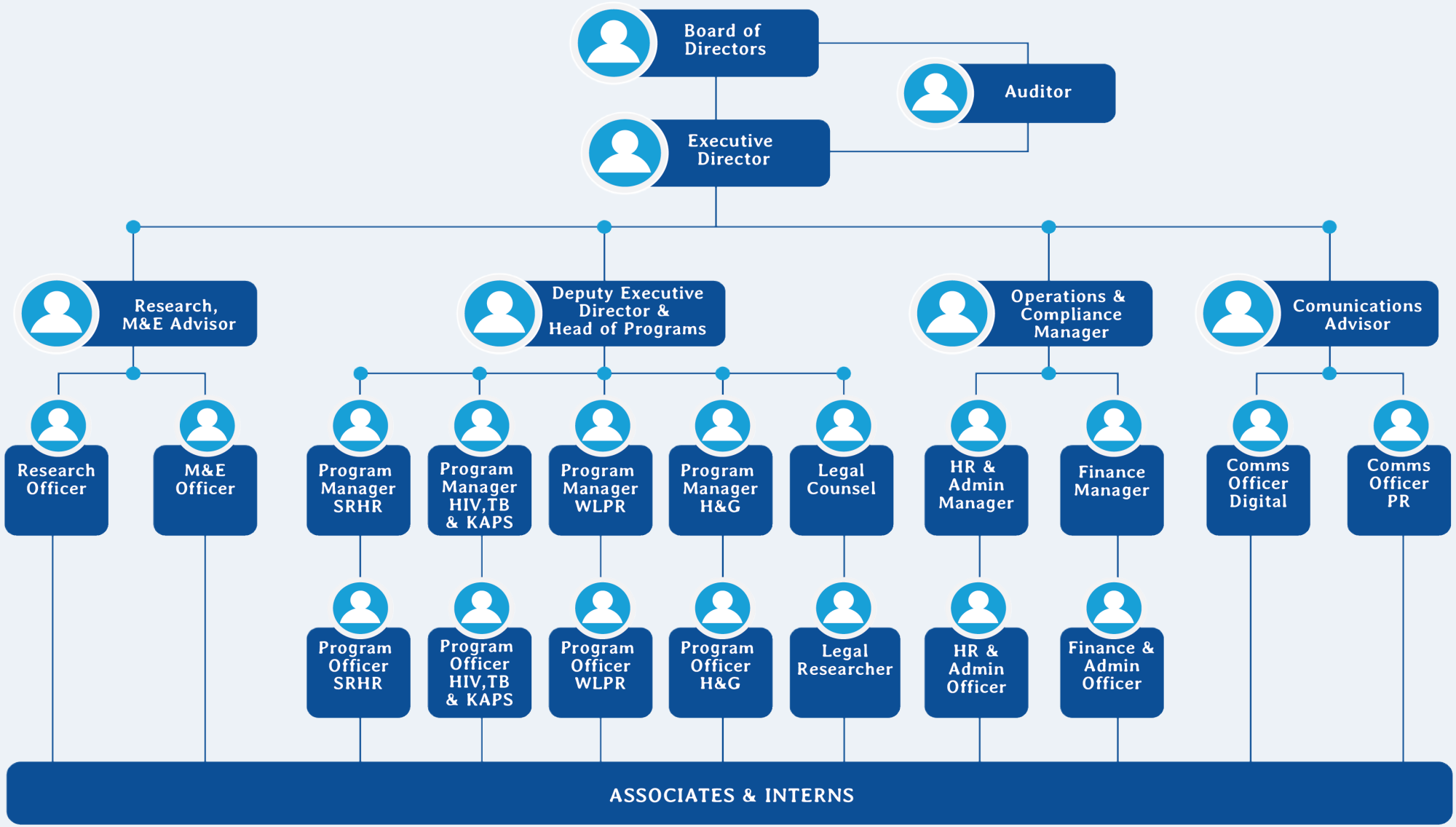
4.0 MONITORING, EVALUATION AND REPORTING

KELIN has developed a robust internal results-based monitoring and evaluation system. This system aligns to the project cycle management system which describes the order and details of each step that KELIN programmes' teams follow in planning, implementing monitoring and evaluating of projects. The new Strategic plan will inform implementation and routine monitoring of the different programmes in the five phases of the project cycle management system which include:



5.0 KELIN ORGANIZATIONAL STRUCTURE

Below is a summarized infographic of KELIN's organizational structure



6.0 RISK MITIGATION PLAN

A summary of the potential risks that we may encounter as we implement the strategic plan and possible mitigation actions are outlined below.

Table 1: Potential risks and mitigation plans

Potential Risks		Mitigation Strategies
Increased shrinking civil society space occasioned by crackdown on human defenders by oppressive		- Building CSO movements and strengthening the - Spreading the risk by engaging with partners partners in the governance sector to ensure continued respect for the Bill of Rights
Global epidemics		- Develop and entrench an online platform to establish remote working by staff ensuring continuity of tasks remotely - Develop a disaster/risk mitigation plan highlighting health and governance issues that may affect the organisation with an implementation plan to mitigate possible risks.
Reduced donor funding		- Explore other avenues to generate income, diversify donor funding pools and explore non funding partnerships.
Deprioritization Rights Issues during health pandemic response		- Use WHO and other guidelines and lessons learned from Ebola and HIV to show how neglecting human rights in the response to COVID 19 makes people more vulnerable to the virus and to social and economic shocks. - Advocacy towards strengthening the Pandemic response using rights based approaches that will prioritise securing health and wellbeing holistically and encourage meaningful priority setting.
Deprioritization of HIV and TB and other chronic health issues as resources are used to respond to emerging		- Use evidence to demonstrate how neglecting underlying health issues makes people more vulnerable during pandemics and advocate for the hts of people affected with HIV, chronic illnesses. - Advocate for the inclusion of HIV and TB services in an essential package of care within the Universal Health Coverage model.
Poor implementation of existing laws and policies and Inadequate legislative and regulatory framework both at County and National		- Collaborate with the relevant stakeholders in advocating for National or County pass/review and monitor implementation of relevant legislation - Use human rights reporting mechanisms to advocate for free civic spaces (use Kenya's regional and international law obligations)

Political interruptions occasioned by political process such as elections and		- Create an online database to facilitate access to data and relevant information for partners and - Develop a disaster/risk mitigation plan highlighting health and governance issues that may affect the organisation with an implementation plan to mitigate possible risks. - Develop and entrench an online platform to establish remote working by staff ensuring continuity of tasks remotely, monitoring implementation and providing access to online knowledge management and a datab
Effectiveness and availability of digital platforms and virtual ways of working and		- Source organisations with considerable technical expertise in appropriate technology solutions, working closely with key stakeholders to find out what works best for them in their situation. - Develop solutions after conducting feasibility studies for virtual engagements as no 'one size' will
Staff Turn Over		- Ensure there is proper knowledge management - Offer competitive rates for staff to promote - Incentivise staff through training and other development opportunities - collaboratively with staff to create an enabling work environment and culture. - Employ rights approaches in the KELIN workspace
Inadequate internal capacity for programme Implementation		- Strengthen adoption and implementation of result management strategies including performance evaluation systems to improve accountability culture at institutional and individual - Review and improve staff capacity to deliver on their - Review institutional policies to assess their ability to enhance efficacy and improve upon them to enhance institutional capacity to meet our mandate
Inadequate Stakeholder Engagement to fulfil health rights mandate		- Adopt public participation and encourage consultations with stakeholders to enhance - creation of programs with stakeholders to enhance ownership and realisation related rights/right to health.

Annex(s) will be provided upon request.


KELIN
Reclaiming Rights, Rebuilding Lives