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A Strategic Blueprint for Health Civil Society Collective Action in Kenya

A practical guide for collective action, coordination,
and influence in a changing health landscape

Hennet
Health NGOs' Network



Foreword and Acknowledgements

Kenya's health civil society stands at a defining moment. The systems that have long shaped how we fund, govern, and deliver health are being redrawn all at once: the transition to the Social Health Authority, the contraction of external donor support as Kenya advances through middle-income status, the opening of government-to-government financing, and the political turnover that the 2027 elections will bring. Each of these shifts, on its own, would test us. Together, they demand that we work differently.

For too long, our sector's strength (its diversity, its closeness to communities, its independence) has been undercut by fragmentation. We have advocated in parallel rather than in concert, competed for shrinking resources rather than pooling our influence, and too often carried hard-won relationships with government as individual goodwill rather than durable institutional partnerships.

This Strategic Blueprint is a collective decision to change that.

What makes this document different is not that HENNET or any single organisation authored it, but that health civil society built it together. Over more than a year, through two in-person gatherings, a dedicated working group, and wide consultation, Kenyan CSOs, networks, community actors, and grassroots organisations made sense of a changing landscape and named what we must protect, what must evolve, and where our collective effort can achieve what none of us can achieve alone. The four priorities set out here — strengthening representation and accountability, focusing advocacy on health outcomes and resources, building durable government partnerships, and reinforcing the coordination that connects us — are not aspirational statements. They are practical, urgent, and within our reach.

The Blueprint also asks something of us that is harder than agreeing on priorities: it asks us to work differently, especially when resources are scarce, and pressure is high. The commitments to share before we compete, to prioritise collective impact, and to stay accountable to communities and to one another are the foundation on which everything else rests. They will be tested. Honouring them is how we will hold.

HENNET's role in this process, alongside Humentum, has been to convene, facilitate, and help translate collective wisdom into a usable resource, not to own the outcome. This Blueprint belongs to the health civil society collective, and its future depends on all of us carrying it forward through the Civil Society Roadmap to Resilience Kenya (CSO-R2R-Ke). On behalf of HENNET, I want to thank every organisation, network, and individual who contributed their time, evidence, and honesty to this work.

The road ahead is uncertain, but our direction is clear. Let us walk it together.

Dr. Margaret Lubaale

Executive Director, HENNET

Introduction

Kenya's health civil society is operating in a period of profound transition. Funding models, governance structures, and expectations of civil society organisations (CSOs) are all changing simultaneously. These shifts put pressure on organisations, but they also create an opportunity to strengthen how civil society works together, engages government and communities, and influences the health system.

No single organisation can navigate this transition alone. Health civil society needs stronger coordination, a clearer collective voice, and practical ways to protect its essential roles while adapting to a changing health landscape.

This Strategic Blueprint is a practical guide for collective action. It identifies what health civil society must protect, what needs to evolve, four priorities for collective action, the relationships needed to advance them, and shared commitments for how organisations work together—especially when resources are scarce and pressure is high.

It is not a comprehensive sector strategy or a finished implementation plan. It is a shared foundation from which more specific action can grow.

The Blueprint grew from more than a year of collective sensemaking and action led by Kenyan health civil society, supported by HENNET and Humentum. Through convenings, a working group, consultation, and an in-person *From Blueprint to Action* gathering, the process moved from making sense of a rapidly changing landscape to identifying priorities, testing dilemmas, and beginning to organise around action.



A Shifting Health Landscape

Kenya's current legal, political, health, and governance realities represent a set of pressures that make coordination, representation, accountability, and resilience urgent rather than aspirational.

A devolved health system

Health in Kenya is a devolved function. The national government sets policy, standards, and norms, manages national referral facilities, and coordinates health financing and human-resource policy.

The 47 county governments deliver most health services, running county and sub-county facilities, community health, and the primary care most Kenyans actually experience. Counties differ widely in fiscal capacity, technical capacity, disease burden, and political priorities, so a strategy that works in one county cannot simply be copied into another.

Civil society therefore has to engage at two levels at once: national policy and 47 distinct county systems, and to connect what happens in each to the other.

Health financing in transition

The financing landscape is being redrawn. The transition to the Social Health Authority and its funds, alongside wider reforms intended to advance Universal Health Coverage, is changing how care is paid for and which accountability questions matter.

At the same time, external donor funding is contracting as Kenya's middle-income status reduces concessional support, and government-to-government (G2G) arrangements are opening new pathways for national ownership of financing.

The combined effect is a growing emphasis on domestic resource mobilisation and on making the most of shrinking budgets, which raises the stakes for civil society advocacy on how public health money is raised, allocated, released, and spent.

The legal space for civil society

The Public Benefit Organisations (PBO) Act now provides a formal legal framework for civil society in Kenya, creating clearer space to operate, register, and engage. Alongside constitutional provisions on public participation and the right to health, this gives civil society legitimate entry points into policy and budget processes, though enforcement and the practical opening of these spaces remain uneven.

A political transition on the horizon

The 2027 general election is approaching. Elections bring turnover in county leadership and administration, and hard-won relationships and agreements with government partners can be disrupted when the people who made them move on. Any partnership civil society builds now has to be designed to survive that transition rather than depend on individual goodwill.

This is the external environment that health civil society is operating in, and it is the reason now is the time for increased coordination, collective action, and joint influence.

What this means for civil society:

- Devolution and county variation make coordination essential
- Shrinking external funding and a shifting financing system make a shared, evidence-based advocacy voice essential
- The legal space and public-participation provisions make representation and accountability both possible and necessary
- The 2027 transition makes resilience — the ability to absorb shocks and carry gains forward — a condition for everything else



How the Strategic Blueprint Fits Together

The Blueprint is organised like a building. **How We Work Together** forms the foundation: without trust, shared behaviours, and accountability, collective action will not hold. The priorities, engagement approach, and civil society's role and value build on that foundation. A **Shared Vision and Collective Narrative** forms the roof: the direction health civil society is working towards together.

At the heart of the Blueprint is a shift away from fragmented, project-based and solo efforts towards more coordinated collective action. In practical terms, the Blueprint calls for health civil society to:

1. **Strengthen legitimate representation and accountability** in government-to-government (G2G) and other health decision-making spaces.
2. **Advocate collectively for health outcomes and resources**, using shared evidence and focused policy and budget asks.
3. **Establish stronger and more durable ways of working with government**, particularly at county level.
4. **Strengthen coordination across health CSOs, Public Benefit Organisations (PBOs), and networks**; reducing duplication and making collective action easier.

The Blueprint also names the difficult choices that come with this shift: how to gain access to government while protecting independence; how to match ambition to limited capacity; when to strengthen what exists and when something new is needed; how to balance collective and organisational interests; and how to move urgently without sacrificing inclusion.



HOW TO USE THIS BLUEPRINT

Using this Blueprint within Kenya

This Blueprint provides a shared direction: what health civil society wants to protect and change, where collective effort should focus, how organisations engage others, and how they commit to working together.

Civil Society Roadmap to Resilience Kenya

(CSO R2R-Ke) is the emerging action and learning journey that carries the Blueprint forward. Priority groups are beginning to translate the shared direction into practical action, testing what works and adapting as they learn. *See Appendix B for emerging action ideas.*

Using this Blueprint outside Kenya

This Blueprint was developed by and for health civil society in Kenya. It is not intended as a universal model. For readers interested in adapting the process to other contexts, the Learning & Practice Appendices document the journey, tools, and lessons behind the Blueprint. Take what is useful, adapt it to your context, and leave what is not.

Our Role & Value

What health civil society uniquely contributes, what must stay, and what must evolve.

Four Core Civil Society Roles to Protect

Four core civil society functions must be protected as the health landscape evolves. Health civil society plays a critical role in holding government accountable, amplifying the voices of communities (especially marginalised groups), and ensuring that health systems respond to real needs. It bridges the gap between policy and people, strengthens service delivery where systems fall short, and advocates for equitable, rights-based health outcomes.

1. **Accountability:** civil society helps ensure government and other duty-bearers follow through on commitments, use resources responsibly, and uphold people's rights.
2. **Service delivery:** civil society helps deliver or extend services where government systems don't fully reach.
3. **Intermediary:** civil society helps close the information and accountability loop between people's lived experience and the health system.
4. **Advocacy and agenda setting:** civil society helps shape what government prioritises and how policies, budgets, and decisions respond to people's needs and rights.

Core function	Critical roles	What would be missing if civil society did not exist?
Accountability	• Holds government to account for implementing commitments and regulations • Pushes for what is necessary, not just politically expedient • Acts as a human-rights watchdog • Uses tools such as strategic litigation	• Fewer watchdogs monitoring public resources, implementation, and government action
Service delivery	• Bridges government and communities in delivery • Complements government in last-mile delivery • Mobilises donor resources to extend government efforts	• A growing gap between government services and community needs
Intermediary between citizens and government	• Ensures diverse voices are represented and amplifies marginalised communities • Brings community experience and evidence into government decision-making, identifying gaps between policy commitments and lived reality • Creates feedback loops between communities and decision-makers, bringing community needs and experience to government and information back to communities • Translates technical health, policy, and financing information into accessible language and strengthens public understanding • Connects national and county-level decision-making	• Reduced representation of marginalised voices and visibility of community needs • Less understanding of where policy and services are falling short in practice • A weaker flow of information between communities and decision-makers
Advocacy and agenda setting	• Advocates for policy change and better governance • Brings marginalised needs into policy spaces • Generates and uses evidence to influence policy and decision-making • Ensures nuance in policymaking • Adds detail to broad budget allocations • Protects the needs and rights of communities that might otherwise be excluded	• Reduced policy advocacy and civic engagement • Less inclusive, less responsive policymaking • Less evidence and community experience informing policy priorities

What Must Evolve

Protecting these core functions does not mean protecting the status quo. As the health landscape changes, the ways civil society performs them must evolve.

To remain relevant and sustainable, health civil society organisations will need to move:

- From fragmented service delivery → towards coordinated systems influence
- From separate advocacy asks → towards shared positions and collective voice
- From speaking for communities → towards strengthening community voice and agency
- From duplication → towards coordinated roles and complementary action
- From dependence on donor funded projects → towards more diverse and locally rooted approaches to sustainability
- From demonstrating organisational activity → towards demonstrating and communicating collective impact
- From expecting accountability externally → towards strengthening transparency and accountability within civil society itself

To support these shifts, civil society will need to pay particular attention to maintaining strong bi-directional communication channels, and to create opportunities for communities to meaningfully participate directly in the health landscape.

Build and protect feedback loops

Two of these roles, the accountability watchdog and the community bridge, depend on feedback that moves in every direction.

Civil society should build, maintain, and prioritise feedback loops: from communities to CSOs, from CSOs to networks and decision-making spaces, and back to communities in accessible language. Feedback loops are not a soft extra; they are what make accountability and community-bridging real rather than nominal.

Community voice and agency

Communities should not only be represented or spoken for by CSOs. They must have their own voice, leadership, and agency. Civil society's role is to create pathways for communities to participate directly in priority-setting, advocacy, accountability, implementation, and learning, and to carry the responsibility of communicating decisions and progress back to communities in language they can use.

How We Engage with Others

How health civil society works with government and other stakeholders – where we partner, influence, inform, and hold others accountable.

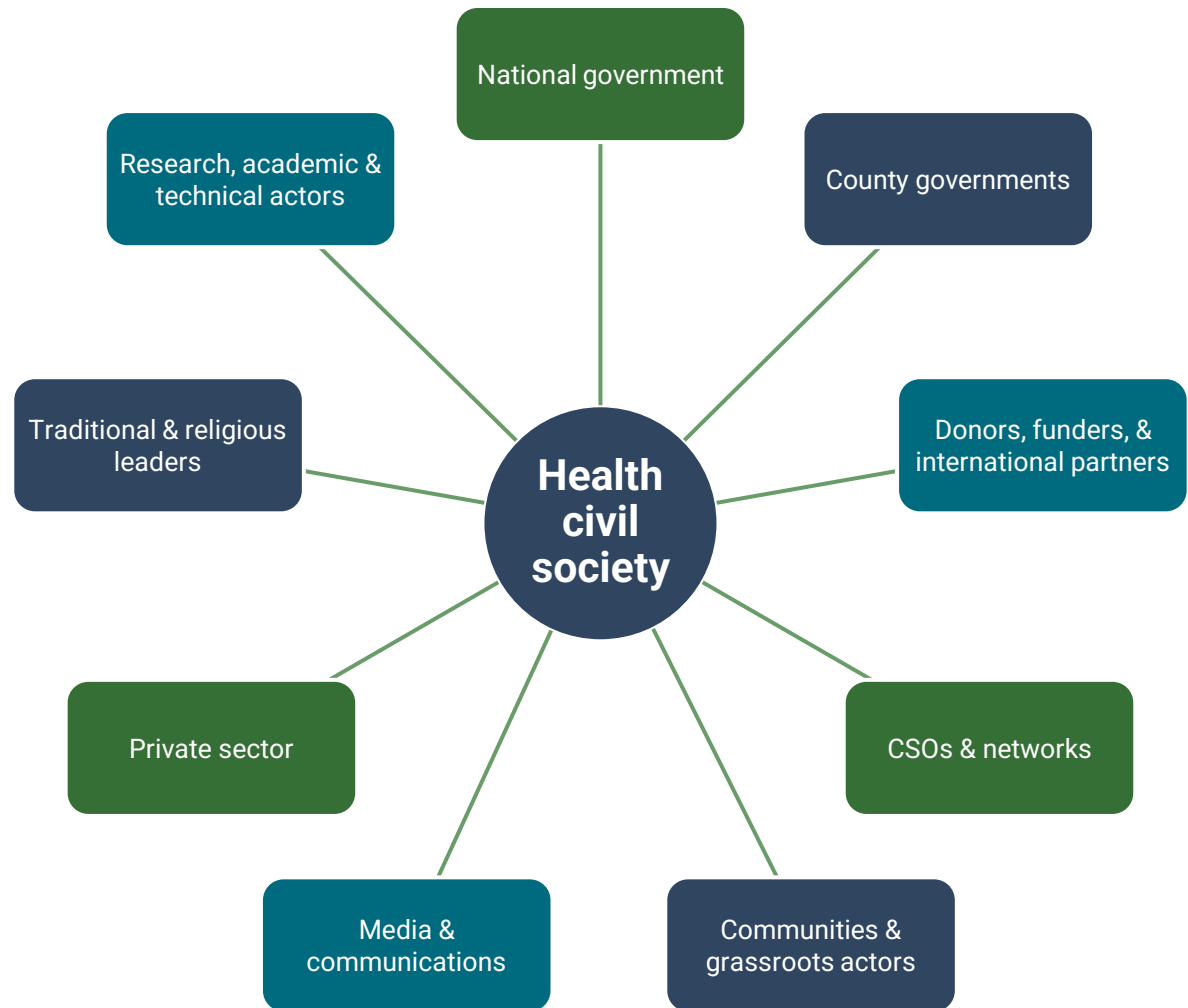
Health civil society does not operate alone; it partners, influences, informs, and holds accountable a variety of stakeholders.

Its ability to deliver services, represent communities, influence decisions, and hold power to account depends on relationships across a wider health ecosystem.

Different relationships require different forms of engagement. Civil society may partner closely with an actor in one context, seek to influence them in another, or hold them accountable in another. These roles can coexist. Being clear about the purpose of engagement helps civil society build productive relationships without losing its independence or accountability to communities.

The nature of engagement will vary by actor and by purpose. The table below focuses on the relationships most central to collective action in the current moment.

The goal is not to engage every actor in the same way, but to be deliberate about who needs to be involved, why, and what kind of relationship is needed.



Stakeholder	Why they matter	How civil society engages
National government	Sets national policy, regulation, financing frameworks, and health priorities.	Influence • Advocate • Bring community evidence • Hold accountable
County governments	Deliver most health services and make key implementation and resource decisions.	Partner • Influence budgets and priorities • Monitor • Connect communities and decision-makers
Donors, funders, & international partners	Shape resources, incentives, and ways of working.	Influence funding practices • Align resources with local priorities • Resource collective action • Hold to commitments
Private sector	Brings resources, technology, delivery capacity, and commercial influence.	Partner where interests align • Influence practice • Protect community interests • Hold accountable
CSOs & networks	Bring different expertise, relationships, and reach. Their collective influence depends on how effectively they connect and coordinate.	Share • Coordinate • Build collective positions • Reduce duplication • Hold one another accountable
Communities & grassroots actors	Bring lived experience, knowledge, and legitimacy. Grassroots actors are often first to respond to need but can be furthest from formal policy, financing, and coordination spaces.	Listen • Partner • Strengthen voice and agency • Create routes into decisions • Close feedback loops
Media & communications	Shape public understanding, narratives, and accountability.	Inform • Share evidence • Translate complex issues • Engage as storytellers and accountability partners
Traditional & religious leaders	Hold community trust and influence beliefs and participation.	Inform • Build trust • Mobilize • Engage on accountability and rights
Research, academic, & technical actors	Generate evidence, expertise, and new approaches.	Generate evidence • Translate research • Identify gaps • Test and learn

What This Means for How We Engage

Engagement is more than access.

Representation must be connected to deliberate feedback loops, so community experience reaches decision-makers and decisions and progress travel back.

Different actors hold different forms of power.

Government holds formal authority; funders shape resources and incentives; media and trusted leaders shape narratives; researchers shape evidence; communities bring lived experience and legitimacy. Effective engagement means understanding the power each actor holds and engaging accordingly.

Partnership does not remove accountability.

Civil society can collaborate with government, funders, and private actors while also influencing and holding them accountable. Clarity about the role being played protects civil society's independence and accountability to communities.

Our Shared Priorities

Where health civil society focuses collective effort at this moment.

The four priority areas are urgent, high impact, require coordination, and are feasible to advance in the short to medium term.

These priorities are intended to be practical: they build on work already underway and identify areas where acting together can achieve more than organisations acting alone.



Representation and Accountability

Get legitimate access while remaining accountable and independent.

WHY THIS MATTERS

Civil society needs meaningful access to decision-making spaces to influence decisions and hold government accountable. But representation only works when those in the room are connected and accountable to the wider sector and communities they represent.

THE PRIORITY:

Strengthen legitimate civil society representation and accountability in health decision-making spaces.

WHAT THIS COULD LOOK LIKE:

- Secure meaningful civil society representation in key health decision-making spaces, including G2G processes.
- Establish representation that reflects county, grassroots, community, and marginalised voices.
- Develop shared positions on issues where a collective civil society voice would have greater influence.
- Create stronger accountability between representatives, the wider civil society sector, and communities.
- Maintain civil society's independent watchdog role alongside constructive government engagement.

EARLY PRACTICAL STEPS:

- Identify the priority decision-making spaces where civil society representation is needed.
- Agree on transparent criteria and a process for selecting and rotating representatives.
- Define representatives' mandate and what they are authorised to speak about on behalf of the collective.
- Establish a simple **consult** → **represent** → **report back** feedback loop.
- Develop a shared position on the priority issue before representatives engage.
- Create a mechanism for tracking government commitments and reporting progress back to the wider group.
- Clarify how delegated representatives and independent watchdog/advocacy actors maintain distinct roles.

Health Outcomes and Resource Allocation

Focus collective advocacy on specific outcomes and follow resources through to results.

WHY THIS MATTERS

Policy and budget commitments do not automatically translate into better health outcomes. Resources can stall between allocation, release, expenditure, and implementation. Civil society can help track where progress breaks down and hold decision-makers accountable for turning commitments into results.

THE PRIORITY:

Focus collective advocacy on policy and budget changes that improve health outcomes.

WHAT THIS COULD LOOK LIKE:

- Develop a shared advocacy agenda around priority health outcomes, policies, and budgets.
- Agree on a small number of specific policy or budget changes to pursue collectively.
- Use a shared voice and credible evidence to question health outcomes, identify gaps, and advocate for change.
- Advocate for adequate and equitable health resources, including increased county health budget allocations.
- Track commitments through allocation, release, expenditure, implementation, and ultimately health outcomes.

EARLY PRACTICAL STEPS:

- Select one or two priority health outcomes where collective advocacy could make a tangible difference.
- For each, define a specific, evidence-based and costed policy or budget ask.
- Identify the relevant county or national decision-making process, key decision-makers, and policy or budget window.
- Assemble the evidence needed to support the ask, including credible baseline health and budget data.
- Agree on a shared advocacy position and coordinated approach to engagement.
- Develop a simple tracking mechanism that follows the ask from **commitment → allocation → release → expenditure → implementation → health outcome**.
- Periodically review the evidence and adjust the advocacy approach based on what is—or is not—changing.

Government Partnership and Implementation

Turn relationships with government into structured, durable implementation partnerships.

WHY THIS MATTERS

Civil society already works closely with government, particularly at the county level. More structured and durable arrangements can turn those relationships into implementation and help protect progress through political and administrative transitions.

THE PRIORITY:

Establish clear and lasting ways for civil society and government to work together.

WHAT THIS COULD LOOK LIKE:

- Establish more structured and consistent ways for civil society and government to work together.
- Strengthen formal partnerships with county governments.
- Coordinate civil society engagement with government where a shared approach would increase influence or reduce duplication.
- Build meaningful community participation into government–civil society partnerships.
- Explore mechanisms such as social contracting where appropriate.
- Build partnerships that can withstand political and administrative transitions.

EARLY PRACTICAL STEPS:

- Identify where strong government–CSO partnerships already exist and what can be learned from them.
- Identify a county, issue, or existing relationship where a more structured partnership approach could be tested.
- Develop or adapt a Memorandum of Understanding (MOU) that includes a joint workplan, roles and responsibilities, indicators, community participation, and a regular review process.
- Institutionalise agreements with departments and structures rather than relying on individual relationships.
- Build continuity and non-performance safeguards into agreements, particularly ahead of the 2027 transition.
- Agree how participating CSOs will coordinate before government engagement and communicate afterwards.

Coordination and Collective Action

Strengthen the connective tissue that allows the sector to share, coordinate, and act together.

WHY THIS MATTERS

Kenya does not need another parallel coordination structure. It needs stronger connective tissue between the many CSOs, PBOs, county networks, thematic networks, and platforms that already exist.

THE PRIORITY:

Strengthen the connections, information flows, and coordination mechanisms that enable civil society to act collectively.

WHAT THIS COULD LOOK LIKE:

- Strengthen the connective tissue between existing health CSOs, networks, and platforms.
- Improve timely information and knowledge sharing across the sector.
- Create a regular rhythm for coordination around shared priorities and emerging issues.
- Connect existing networks and initiatives to reduce duplication and identify opportunities for joint action.
- Establish light-touch mechanisms for collective decision-making when coordinated action is needed.
- Build on existing structures rather than creating another parallel institution.

EARLY PRACTICAL STEPS:

- Map active CSOs, PBOs, county, and thematic networks, and existing coordination platforms, including their reach, focus, strengths, and level of activity.
- Seed the mapping with HENNET's membership data and the 37+ health networks already identified rather than starting from scratch.
- Identify where networks overlap, where gaps exist, and which existing mechanisms could be better connected.
- Agree on a shared information channel and what kinds of information should routinely be exchanged.
- Establish a practical rhythm for exchange - for example, regular check-ins plus rapid coordination when an issue emerges.
- Agree on a simple process for deciding when an issue requires information sharing, coordination, or deeper collaboration.

How the priorities work together

These priorities reinforce one another rather than operating as four separate workstreams:



From Blueprint to Action

These four priorities are already beginning to generate possible areas for collective action through CSO R2R-Ke. The initial ideas are still being developed and tested; not all may move forward.

See Appendix B: Emerging CSO R2R-Ke Initiatives.

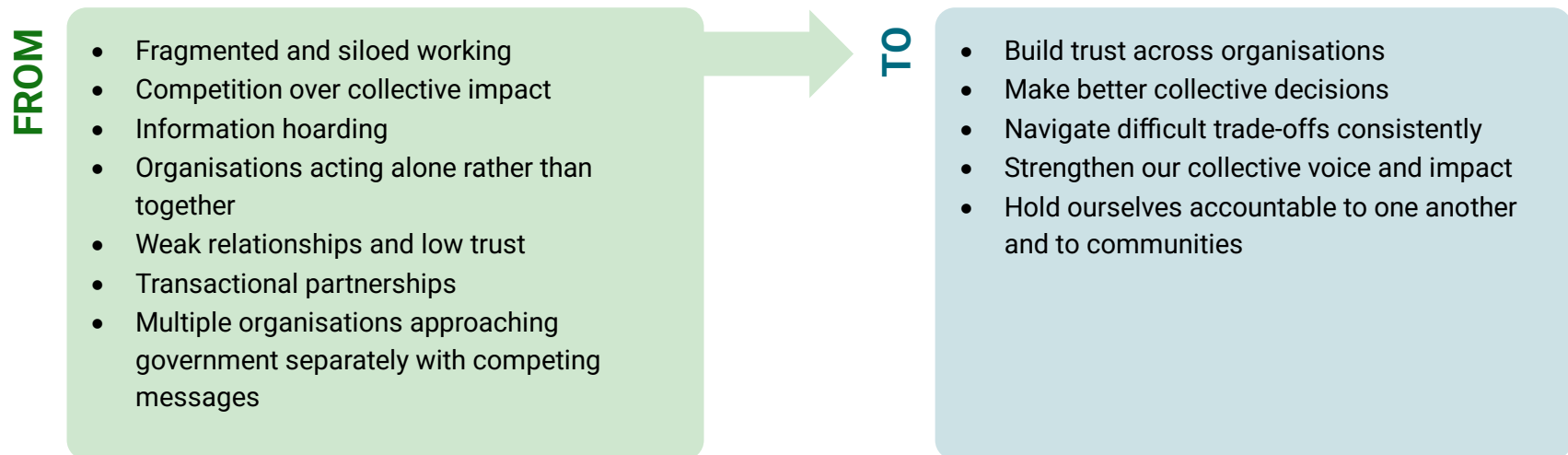
How We Work Together

The principles and behaviours that guide us – especially under pressure. The foundation that makes everything else possible.

Stronger collaboration does not happen because organisations agree on priorities. It happens because they choose to work differently.

Health civil society cannot achieve the priorities in this blueprint through isolated action. The commitments outlined below capture behaviours essential for building trust, increasing collective impact, and strengthening the role of health civil society in Kenya. They are intended to guide everyday decisions and ways of working across organisations, coalitions, and partnerships. Because of this, they become even more important when resources are scarce, pressure is high, or difficult trade-offs arise.

The greatest threat to collective action is not only shrinking resources, but the behaviours that scarcity can produce. Therefore, these commitments help us move:



Our shared commitments:



These are not abstract values. Each commitment describes what it asks of us in everyday practice—and what it asks of us when collaboration becomes difficult.

COMMITMENT 1: We Share Before We Compete

Commitment Statement

We Share Before We Compete.

Collaboration



Behaviours and Actions

Everyday Commitments

- Share information, learning, opportunities, and resources openly.
- Build trusted relationships through regular communication and mutual support.
- Learn from one another through peer exchange, referrals, and shared problem-solving.
- Align around shared priorities to reduce duplication and increase collective impact.
- Recognise and build on one another's strengths through shared leadership and teamwork.

When This Commitment Is Tested

When resources are scarce or pressure increases, we...

- Resist territorial behaviour, gatekeeping, and blaming others.
- Put the mission ahead of organisational recognition or individual ego.
- Increase transparency and communication rather than withdrawing.
- Strengthen relationships instead of retreating into silos.
- Stand in solidarity with one another, especially when collaboration becomes most difficult.

COMMITMENT 2: We Prioritise Collective Impact

Commitment Statement

We Prioritise Collective Impact.

Collective Action



Behaviours and Actions

Everyday Commitments

- Coordinate advocacy and engagement before approaching government independently.
- Build shared positions and consistent messaging wherever possible.
- Invest in coalitions and long-term partnerships, not just project-based collaboration.
- Listen actively and seek alignment around common priorities and sector goals.
- Engage diverse stakeholders strategically to strengthen our collective voice.
- Measure success by the impact we create together, not the visibility of individual organisations.

When This Commitment Is Tested

When difficult choices arise, we...

- Stay focused on the shared goals that bring us together.
- Use available resources strategically for the greatest collective benefit.
- Resist acting alone when coordination can increase impact.
- Continue pursuing [SMART advocacy](#) even when circumstances change.

COMMITMENT 3: We Stay Accountable to Communities

Commitment Statement

We Stay Accountable to Communities.

Community-Centred



Behaviours and Actions

Everyday Commitments

- Keep communities and health outcomes at the heart of every decision.
- Work with communities as partners in planning, implementation, learning, and decision-making – not just beneficiaries.
- Strengthen community voice, leadership, and agency so people can advocate for themselves.
- Create two-way feedback loops: listen to communities, bring their priorities to county and national decision-makers, and communicate decisions and progress back in ways people understand (using simple words and multiple languages).
- Invest in relationships beyond the project cycle by building on existing community structures, trust, and leadership.
- Follow through on commitments by communicating openly, sharing progress, and explaining when plans need to change.

When This Commitment Is Tested

When circumstances become difficult, we...

- Stay transparent about progress, challenges, and changing realities.
- Listen first and respond without becoming defensive.
- Honour commitments—or communicate decisions honestly when plans must change.
- Work alongside communities to adapt and find practical solutions.
- Continue engaging through existing community structures rather than bypassing them.
- Respond with empathy, respect, and consistency.

COMMITMENT 4: We Hold Ourselves Accountable

Commitment Statement	Behaviours and Actions
We Hold Ourselves Accountable. <i>Integrity</i> 	Everyday Commitments • Hold ourselves accountable for how we work together as organisations and as a network. • Demonstrate the same transparency and accountability that we expect from others. • Build trust through ethical practice, openness, and consistency. • Create opportunities for honest feedback and continuous learning. • Share information and evidence openly to strengthen collective decision-making. • Reflect on our work and adapt based on evidence, experience, and lessons learned. When This Commitment Is Tested When setbacks occur, we... • Acknowledge challenges early rather than hiding them. • Take responsibility instead of assigning blame. • Reach out for support when we need it. • Have difficult conversations respectfully and constructively. Learn from setbacks and adapt our approach. • Focus on solutions that strengthen the collective response.

Strategic Dilemmas and Trade-offs

The hard choices we have surfaced but not yet resolved - the questions health civil society must continue to grapple with.

Collective action involves difficult choices. In some cases, two things we value can pull us in different directions. The five dilemmas below name tensions that health civil society will need to continue working through.

There is no single right answer. The possible responses below are starting points to test and adapt as the work moves forward. Naming these tensions now makes it easier to recognise and work through them when they arise.

1. Access to government vs. independence from government

The tension | Priority 1 asks civil society to secure a meaningful seat in government decision-making spaces, including G2G. But closer relationships with government can make it harder to challenge government when needed. Access and independence pull against each other. As one participant put it: *"When you have food in your mouth, you don't talk."*

One way we could respond | Make sure that gaining access does not weaken the watchdog role. This could mean different organisations taking different roles: some representing civil society in government spaces, while others retain greater independence to monitor, challenge, advocate or litigate when needed. The important thing is to agree on these roles deliberately rather than assume the same organisation must do both.

*"When you
have food in
your mouth,
you don't talk."*

WORKSHOP
PARTICIPANT

2. Ambition vs. capacity

The tension | All four priorities matter. But organisations are already stretched, and trying to move everything at once could mean making little progress on any of them.

One way we could respond | Be realistic about what you can do now. Start with the priorities where there is energy, capacity, and opportunity, while recognising that the four priorities depend on one another. It is better to make meaningful progress on fewer things than spread limited capacity too thinly.

3. Strengthening what exists vs. creating something new

The tension | Kenya already has many health CSOs, networks, and coordination platforms: 37+ relevant networks alone. We want to build on what exists rather than create another structure. But not every existing network is active or connected, and fragmentation remains a problem.

One way we could respond | Start by understanding what already exists: which networks are active, what they do well, where they overlap, and where gaps remain. Strengthen connections between functioning structures before creating something new. If a new mechanism is proposed, ask: *does this reduce duplication or add to it?*

4. Collective voice vs. organisational interests

The tension | Collective action asks organisations to share credit, align messages, and sometimes put the collective voice ahead of their own visibility. But branding and funding dynamics can pull in the opposite direction: one partner may dominate, while organisations may feel pressure to demonstrate their individual value and visibility, particularly when competing for shrinking resources.

One way we could respond | Make space for both collective and organisational interests. Agree how contributions and credit will be recognised, be transparent about funding and visibility pressures, and design collective work so participating organisations can demonstrate the value of their contribution. Collaboration is more sustainable when organisations do not feel they must disappear inside the collective. Solidarity is more durable when it is not financially self-sacrificing.

5. Urgency vs. inclusion

The tension | Some decisions cannot wait. G2G structures are forming, funding is changing, and the 2027 transition is approaching. But moving too quickly can exclude the people whose participation gives collective action its legitimacy.

One way we could respond | Be clear about which decisions are genuinely urgent and which need broader participation. For urgent issues, a smaller group may need to act with a clear mandate and report back. For longer-term decisions, make time for wider participation and discussion. Not every decision needs the same process.

What Success Looks Like

The test of this Strategic Blueprint is whether it changes how health civil society works together, engages others, and translates collective effort into greater influence and better health outcomes.

One year from now, we would expect to see tangible progress across the four priorities:

1

Stronger representation and accountability

- Health civil society speaks with a more unified voice in key decision-making spaces, including G2G, with recognised representation backed by credible, agreed positions.
- Closer access to government has not diluted civil society's accountability and watchdog role; independence is deliberately protected.
- Communities have stronger routes into advocacy and decision-making—not only being represented by CSOs but increasingly speaking for themselves.

2

Collective advocacy focused on health outcomes

- Coordinated advocacy on at least one shared health policy or budget ask has reached a county or national decision-making process.
- Civil society is increasingly bringing evidence and joint positions to decision-makers rather than multiple competing asks.
- Progress is being tracked beyond commitments and allocations to implementation and health outcomes.

3

More durable government partnership

- At least one county has a functioning government–CSO partnership, supported by an operational MOU or similar mechanism.
- What works is being documented and adapted elsewhere rather than every county starting from scratch.
- Partnerships are designed to withstand political and administrative transitions rather than depending solely on individual relationships.

4

Stronger coordination and collective action

- The connective tissue between existing networks is stronger: there is greater clarity about which networks are active, how they connect, and where different strengths sit.
- Information, evidence, and opportunities are shared more consistently through common channels rather than remaining within individual organisations or networks.
- Civil society organisations spend less time duplicating efforts and competing over the same opportunities, and more time on coordinated, higher-leverage work.

And we know that not all progress will be visible through outputs or milestones. Success also shows up in how organisations behave with one another, particularly when resources are scarce or pressure is high. These changes are better understood through regular reflection and outcome harvesting than through output counting alone.

Signs of progress might include:

- information, evidence, and opportunities being shared rather than hoarded;
- joint positions replacing competing individual asks where collective action is needed;
- more transparent decision-making and shared leadership;
- greater trust and mutual accountability between organisations; and
- communities seeing information and decisions flow back to them, not only being asked to provide input.

These one-year markers matter, but the longer-term ambition is greater than delivering a set of activities. External shocks, funding contractions, political transitions, and health system reforms will continue. Success means building the relationships, habits, and collective capacity that allow health civil society to anticipate change, adapt together, and continue advancing its role even as the context shifts.

The longer-term test is not whether civil society can predict what comes next, but whether it is increasingly able to answer together: *How do we prepare ourselves?*



A Call to Action

This Blueprint is a starting point, not an endpoint. Its value will come from what people do with it. We invite health civil society leaders and partners to:



Use it.

Bring the Blueprint into your organisation, network, and partnerships. Use it to test your own priorities, relationships, and ways of working.



Challenge it.

Confirm, sharpen or challenge the priorities, dilemmas, and commitments it proposes. Silence is not the same as agreement, and the Blueprint should continue to evolve through use.



Contribute to it.

Choose where your organisation can bring people, evidence, relationships, resources, or leadership to advance the collective priorities.



Join the next phase.

CSO R2R-Ke will carry the Blueprint from shared direction into action. Four priority groups are beginning to translate the priorities into practical 6–9 month action: defining objectives, contributions, relationships, milestones, measures of success, and learning. **See Appendix B for the emerging action ideas.**



Act together.

Look for opportunities to share information, coordinate positions, and take collective action rather than automatically working alone.



Hold one another accountable.

Hold HENNET, participating organisations, and partners accountable for carrying the work forward—and for living the commitments to communities and one another that the Blueprint sets out.

No single organisation can deliver this Blueprint. Its promise lies in what becomes possible when civil society organisations, communities, government, funders, and other actors each play their role, and when health civil society has the relationships and collective capacity to act together when it matters.

Learning & Practice Appendices

How to Use the Learning & Practice Appendices

These appendices serve two purposes:

1. **To show our work**
They document how the Blueprint was developed, whose perspectives shaped it, what analysis informed it, and how ideas moved from discussion towards action.
2. **To share what may be useful elsewhere**
They offer questions, process choices, lessons, and emerging examples that other networks and civil society actors can adapt to their own context.

These appendices capture a selection of the learning behind the Blueprint. Additional tools, frameworks, and lessons from the process may be shared separately as the work continues.

This is not a recipe. The Kenya process responded to a particular moment, ecosystem, and set of relationships. Take what is useful, adapt it, and leave the rest.

Want to understand how the Blueprint was built? → [Appendix A](#)

Want to see how priorities are moving towards action? → [Appendix B](#)

Want to know who convened and contributed? → [Appendix C](#)

Appendix A: How This Blueprint Was Built

This blueprint was co-created over one year between August 2025 and August 2026 through a series of virtual working groups, in-person convenings, and broad consultation webinars.

Why this process?

The process that produced this Blueprint was not designed all at once. It evolved in response to a rapidly changing context.

It began in August 2025, when a group of sexual and reproductive health and rights (SRHR) civil society leaders came together in Nairobi following significant funding disruptions to collectively make sense of the present and explore emerging futures. Those conversations surfaced a broader challenge: civil society was navigating major change while still working through many of the silos, hierarchies, and competitive dynamics that made collective action difficult.

As the work continued and HENNET and Humentum formed a strategic partnership, the focus widened from SRHR to Kenya's broader health civil society ecosystem. The announcement of the bilateral health agreement between the governments of Kenya and the United States of America added new urgency and raised practical questions about civil society's role, representation, and influence as the health financing landscape changed.

The process therefore evolved with the context: from making sense of disruption, to identifying what health civil society needed to protect and change, to defining shared priorities, and ultimately to beginning to organise around action.

At the heart of the process was a question of agency. Change was already happening. How could health civil society help shape that change rather than simply respond to decisions made around it?

That meant the process mattered as much as the product. If the Blueprint was intended to strengthen collective agency, its development also needed to create opportunities for civil society actors to make sense of change, surface disagreement, make choices, and build the relationships needed to act together.

Who shaped it?

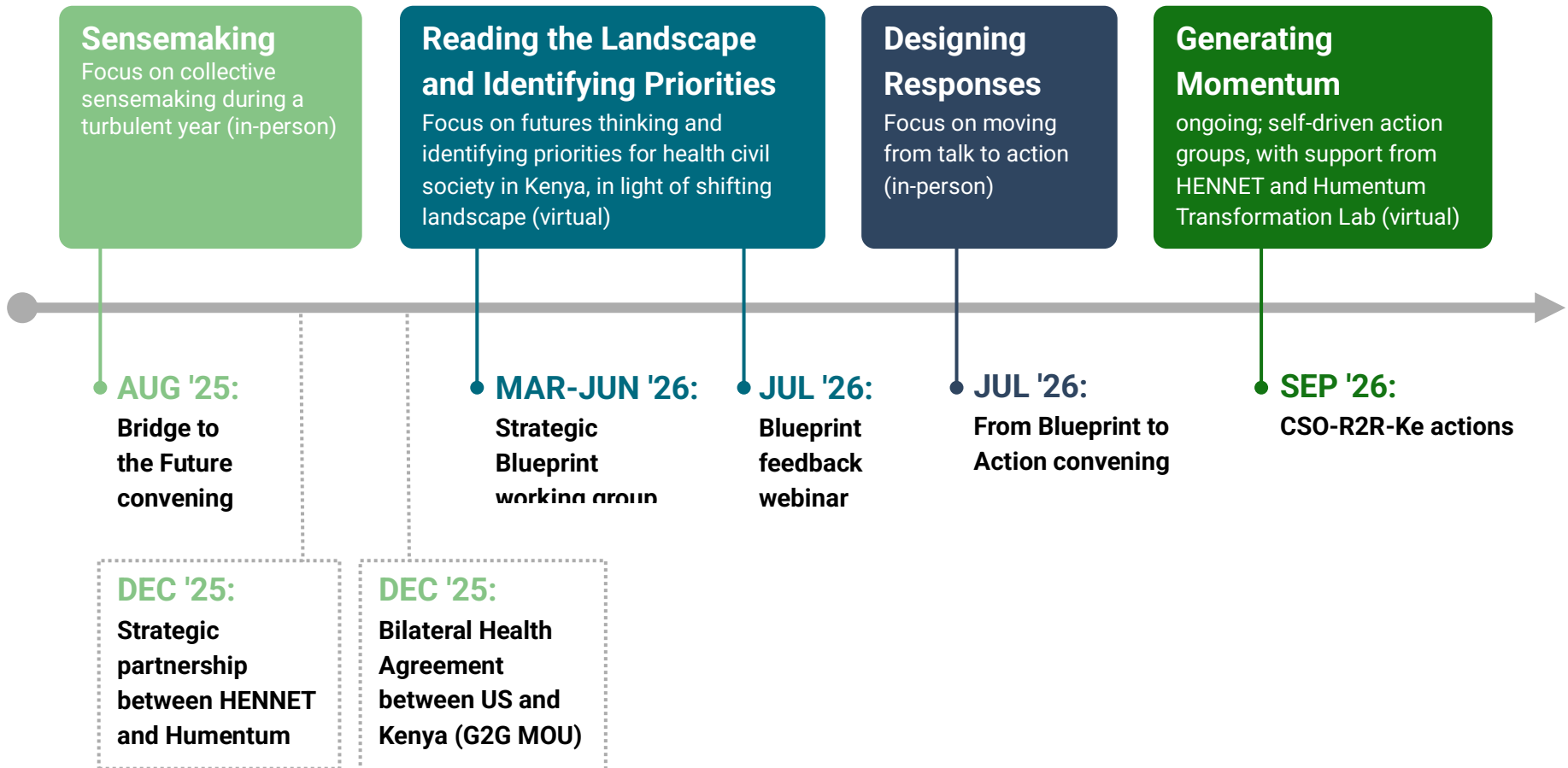
The three primary convening groups brought together health civil society actors from across Kenya, representing grassroots community-based organisations, county-level advocacy networks, national policy engagement bodies, and global institutional reporting and advocacy.

After the HENNET and Humentum strategic partnership was formed, participants were drawn from organisations already active in HENNET's network and partner ecosystem, with deliberate attention to including voices beyond the national-level institutions that typically dominate such convenings.

The process was designed to bring together different parts of the health civil society ecosystem, but it was not exhaustive or fully representative of every organisation, county, constituency, or perspective. The Blueprint should therefore be understood as a strong shared foundation to continue testing and expanding through use.

The journey

Over the course of a year, three primary convening groups shaped this blueprint. This process has unfolded over four major phases.



How we worked

The process combined structured inquiry, facilitated reflection, and collaborative sensemaking. Rather than asking participants to validate a pre-drafted strategy, each stage built on the one before it: understanding the changing context, examining civil society's role, identifying relationships and priorities, agreeing how to work together, and beginning to translate those choices into action.

This process deliberately made room for disagreement as well as consensus. Priorities, commitments, and dilemmas emerged iteratively through discussion, testing, and refinement. Where a tension could not be resolved, it was retained in the Blueprint rather than smoothed over. Naming an unresolved trade-off was treated as a legitimate outcome—and something the collective would need to continue navigating in practice.

This does not mean every participant agreed with every element of the final Blueprint. Its legitimacy comes instead from the breadth and depth of the process through which the ideas were surfaced, challenged, refined, and carried forward.

The three main stages:

Bridge to the Future Convening

August 2025

In August 2025, Humentum’s TIME Transformation Lab brought together 22 SRHR organisations in Nairobi, Kenya. The purpose was to create a strategic space for SRHR CSO leaders to collectively make sense of the present, explore emerging futures, and coordinate bold, actionable steps for transformative change.

Day & Theme	Agenda Items
Day 1: Understanding the Moment – Power, Context, and Complexity	• Begin mapping power dynamics, current system challenges, and roles in transformation
Day 2: Shaping the Future – Rehearsing Possibilities and Aligning Visions	• Explore multiple possible and probable futures for the SRHR sector • Identify enabling conditions for CSO leadership and influence
Day 3: Bridging to Action – Strategies, Commitments, and Learning Loops	• Identify practical acceleration ideas and priority actions • Build a shared vision of collective work moving forward

Strategic Blueprint Working Group

March – June 2026

This Blueprint was co-created through a structured working group convened by HENNET and Humentum's TIME Transformation Lab between February and April 2026. The Strategic Blueprint Working Group had 21 engaged health organisations. Over six bi-weekly sessions between February and April 2026, the working group moved from ecosystem mapping through to shaping the blueprint itself, as set out below.

Session & Theme	Core questions	What it contributed to the Blueprint
Session 1: Sensemaking	- Who is here and what can we each contribute? - How can we make sense of the health ecosystem in Kenya in 2026? PESTLE brainstorm: Where are the shifts happening?	- Context - Completed PESTLE table
Session 2: Working Together and Shared Goals	- Is health civil society ready and able to navigate this moment? - How do we show up as a community? What are we good at? Where are there tensions and challenges?	A clear sense of who we are as a community and what we want to achieve together
Session 3: Defining our Role	- What is our unique value? What would be missing if civil society didn't exist? What is our biggest impact? - What needs to stay and be strengthened? - What needs to be let go of, or evolve?	What the role of health civil society needs to be / should be
Session 4: How We Engage With Others	- With whom do we regularly engage with? - Who matters most in this moment of change? - How do we show up differently with each of them? - Where do we need to shift how we are currently engaging?	Stakeholder approach with key stakeholders identified and civil society roles for each stakeholder group
Session 5: Identifying Shared Priorities	- Given our roles and the shifting landscape, where do we need to act collectively? - Where does acting alone weaken our influence? Where do we need a shared voice? Where are we duplicating efforts?	4 priority areas for collective action that meet the following criteria: high impact, urgent, requires coordination, feasible
Session 6: How We Work and Act Together	- If we wanted to guarantee that health civil society fails to work together effectively in this moment, what would we do? - What behaviours or ways of working would help us move in the opposite direction? - Given our role and where we need to engage, how do we work together to do this effectively?	4 commitments for how to work together

From Blueprint to Action Convening

July 29-31, 2026

Following the initial drafting of the blueprint, HENNET and Humentum brought together 28 organisations (drawn from over 200 applicants) in Nairobi, Kenya. Individuals represented 8 counties. The purpose of the convening was to refine the shared blueprint for collective action and develop practical tactical plans for priority areas where coordinated action can drive meaningful progress.

Day & Theme	Agenda Items
Day 1: Grounding & Sensemaking	• Build a shared understanding of the context shaping health civil society in Kenya. • Refine the Strategic Blueprint through collective feedback. • Identify opportunities to coordinate across organisations and initiatives.
Day 2: From Insights to Strategic Concepts	• Agree on the values and behaviours that will underpin how we work together moving forward. • Co-design practical concepts for collective action.
Day 3: From Strategic Concepts to Planning & Commitments	• Develop practical action plans for priority workstreams. • Clarify ownership, next steps, and immediate commitments. • Reflect on what we have learned about collaboration through this process. • Strengthen relationships for continued collaboration beyond this convening.

Appendix B: From Blueprint to Action – Emerging CSO R2R-Ke Initiatives

At the From Blueprint to Action convening, participants began translating the four Blueprint priorities into possible areas for collective action. Four initial ideas emerged. They are included here to document where the process currently stands and to invite further participation and development.

These are ideas in development, not agreed projects or commitments. Some may move forward, others may change significantly, combine with existing efforts, or not proceed. This is consistent with the Blueprint's purpose as a living foundation for action and learning. Each initiative will need its own leadership, partners, resources, and decision-making arrangements. Inclusion here does not mean that HENNET or Humentum will necessarily lead or fund it.

These action ideas will be useful learning in their own right. Future updates should document not only what moved forward, but what changed, stalled, combined with existing work, or was intentionally stopped, and why.

Priority 1: Representation and Accountability

Emerging action idea	Establish a representative civil society delegation and a mechanism for consultation, reporting and tracking commitments.
What success could look like in 6–9 months	An agreed representation process, a joint civil society position and a formal request for representation in a relevant G2G or government structure.
Who needs to be involved	National and county CSOs, grassroots organisations, communities, young people, women and girls, persons with disabilities, marginalised groups, government and media.
What it may require	Community consultation, travel, research, accessibility, communications, and independent monitoring, existing relationships
Questions still to resolve	Who holds the seat? Who gives the mandate? How are representatives selected and rotated? Who leads the independent watchdog role?

Priority 2: Health Outcomes and Resource Allocation

Emerging action idea	Develop and advance one or two shared, evidence-based and costed health policy or budget asks.
What success could look like in 6–9 months	A joint advocacy brief and a formal ask presented through at least one county budget, policy or mid-term review process.
Who needs to be involved	County health departments, county budget committees, CSOs, communities, youth budget champions, media, FBOs, and technical experts.
What it may require	Budget analysis, community consultation, advocacy materials, training, travel, media engagement, and implementation tracking, involvement of key stakeholders
Questions still to resolve	Which health outcome? Which county? What is the exact costed ask? What budget window will be targeted? How will allocation and implementation be tracked?

Priority 3: Government Partnership and Implementation

Emerging action idea	Pilot a formal county government–CSO partnership model around an agreed health priority.
What success could look like in 6–9 months	Pilot a formal county government–CSO partnership model in one or more counties, with at least one signed and operational MOU with a joint workplan, indicators and progress-review mechanism.
Who needs to be involved	County health departments, county treasury, county assembly, CSOs, CBOs, communities, media, FBOs, and relevant national actors.
What it may require	Existing county government relationships; participating CSOs and community structures; legal or technical support for developing the agreement; facilitation, travel, monitoring, and documentation resources.
Questions still to resolve	Which county or counties? What shared health issue will the MOU address? Who signs for civil society? What happens if commitments are not implemented?

Priority 4: Coordination and Collective Action

Emerging action idea	Establish and test a light-touch coordination mechanism connecting active health CSOs and networks.
What success could look like in 6–9 months	A verified network map, one shared information channel, and at least one coordinated action.
Who needs to be involved	Health CSOs, CBOs, county networks, thematic networks, community organisations, media and researchers.
What it may require	HENNET membership and existing county and thematic networks; coordination and mapping capacity; a simple communications platform; facilitation, travel, and documentation resources.
Questions still to resolve	Who will host the mechanism? How often will it meet? How will decisions be made? What joint action will be prioritised?



Appendix C: About the Partners & Contributors

HENNET and Humentum convened and supported the process that produced this Blueprint. Their role was to create and facilitate the process, connect participants and perspectives, synthesise learning, and support the translation of collective input into a usable resource.



About HenNet

HENNET (the Health NGOs Network of Kenya) is a national membership network that coordinates and amplifies the collective voice of health-focused civil society organisations, working to advance equitable, quality, and accessible healthcare for all Kenyans. It connects members across national and county levels, strengthens their capacity, and represents the sector in policy, financing, and accountability spaces. <https://hennet.or.ke/>



About Humentum

Humentum strengthens social good organisations through practical expertise, curated resources, and collective problem-solving. Our experience working with funders and their partners and thousands of NGOs and nonprofits around the world translates into deep understanding and visible results. We deliver tailored solutions and accompany organisations through consulting, training, and membership to improve operational capacity for sustainable mission delivery. www.humentum.org

Contributors

The Blueprint reflects contributions made across the Bridge to the Future convening, Strategic Blueprint Working Group, consultation process, and From Blueprint to Action convening. The organisations listed below participated in one or more stages of that journey.

Participation in the process does not imply that every organisation formally endorses every statement or recommendation in the final Blueprint. The list recognises the breadth of organisations and perspectives that contributed to its development.

AFRICII	Green Chepalungu	Ngao Inclusive Hub	The SUPERB Community Based Organisation
AFROPAC	Hakijamii	Ngazi EdNet	Tunza sista Community based organisation
Akina Mama wa Afrika	HERAF Kenya	NivalishePad Initiative	WACHA Health
Alliance for Action Kenya	Hope for Girls Foundation	ONE	WETEC Kenya
APDK	JDO	Peers Action YCBO	Women Empowered Under Social Integration (WEUSI)
Centre for the Study of Adolescence	LVCT Health	RADA Initiative	Wote Youth Development
Clara Lumina Foundation	Lwala Community Alliance	Radio Africa Group - The Star Newspaper	Y+ Kenya
Community Change advocate	Mamboleo peer empowerment group	REDO Kenya	Youth Empowerment Movement Kenya (YEM Kenya)
Crawn Trust	Manee Kenya	RUKA SRHR NETWORK	Youth for Sustainable Development
Diplomats For Health In Resilient Community (DFHRC)	Most At Risk Young Mothers and Teenage girls living with HIV initiative (MOYOTE Kenya)	Saidika Organisation	YSW Kenya
Eldoret Inner Harbour Resort	MSHWARI	The Barrier Breakers CBO	
FAWS	Nairobi Community Missions	The Lady's Heart Organisation	
FIDA-Kenya		The National Women Steering Committee	

