

KENYA COORDINATING MECHANISM
OUTLINE: CONSTITUENCY FEEDBACK MEETING/GC7 DIALOGUE REPORT
VENUE: ESERIANI, NAIVASHA
DATES 14TH TO 15TH APRIL 2023

- 1.1 Cover page
- 2.1 Discussion/key action points/recommendations
- 3.1 GC7 Constituency Priorities
- 4.1 COP 23 Constituency Priorities
- 5.1 Constituency Work plan 2022/2024- (*as per work plan template -annexed*)
- 6.1 Conclusion
- 7.1 Annex (Program, work plan reports, Constituency GC7 an COP 23 Priorities
Participant's list and Photos)



GC7 Constituency Priorities

COP 23 Constituency Priorities

1. HIV/AIDS

Overview of the Gaps

1. Challenges of acceptance
2. Low prioritization of the country's HIV agenda
3. Decentralization of the research ecosystem in this area
4. Linkage of the academia, health sector and the media to be done through
 - a) Technical working groups
 - b) Mentorship

5. Inadequate allocation of resources

PRIORITY GAPS	INTERVENTIONS
Challenges of accessing data from the health sector for research work	<ul style="list-style-type: none"> ▪ Consolidation of data from the various M&E systems. ▪ Create awareness about existence of the consolidated database data to young researchers. ▪ Build capacity on data transfer and sharing. ▪ Policy for sharing data e.g. IPOs. ▪ Establish proper mechanisms for spinoffs of patents. (there is a challenge with UNES, JKUATES etc).
Inadequate access to existing HIV research outputs leading to duplication of efforts	<ul style="list-style-type: none"> ▪ Create targeted awareness at all levels of existence of Maisha Maarifa research hub platform (Online repository that collates studies on HIV and related co-morbidities) ▪ Expand the functionality of the research hub. ▪ Targeted advocacy for its use.
Low prioritization of the Country's HIV Research Agenda	<ul style="list-style-type: none"> ▪ Sensitization of research stakeholders on the Country's HIV Research Agenda ▪ Advocacy for funding and implementation of the HIV Research Agenda ▪ Continued engagement of stakeholders on review and development of the national HIV Research agenda
Uncoordinated research ecosystem: inadequate coordination of research activities coupled with low	<ul style="list-style-type: none"> ▪ Since only half of all counties have county research focal points, there is need to streamline the research ecosystem at the decentralized levels (map out research focal units at county, establish focal units where none exist, capacity build and operationalize the units).

ownership and demand for research by counties	
Inadequate data on the impact of pandemics on HIV programming	<ul style="list-style-type: none"> ▪ Evaluate impact of pandemics on HIV response to generate lessons learnt and inform development of pandemic preparedness frameworks at both national and county levels
Inadequate translation of research to policy	<ul style="list-style-type: none"> ▪ Engage the policy makers from the initiation of the research project-buy in. ▪ Capacity building of key research consumers at the national and county levels for regular generation of required research products ▪ Researchers can produce policy briefs. ▪ Capacity building on policy making, capacity build the implementers at county level. ▪ Alignment of research actors (county gatekeepers, academia, etc) ▪ Link the researchers and policy makers to create synergy.
Low quality of abstract and paper submissions during national HIV Conferences	<ul style="list-style-type: none"> ▪ Capacity built communities on operations research, documentation of best practices and on development of research products such as abstracts and papers. ▪ Mentorship programme for young investigators/researchers.
Inadequate linkages between academia and health sector actors and media	<ul style="list-style-type: none"> ▪ Engagement of key stakeholders in the Research TWGs at all levels.
Inadequate knowledge on HIV recency cases/clusters in general population	<ul style="list-style-type: none"> ▪ Understand the epidemiology of the HIV transmission. ▪ Introduce indicators to determine number of sexual acts with different partners per week. ▪ Identify missed opportunities by self-testing to identify false negative. ▪ Conduct a pool-testing to validate the test outcomes.

Shift in epidemic typologies by population and geography	<ul style="list-style-type: none"> ▪ Model the epidemic trends by specific population and propose appropriate prevention interventions
Inadequate allocation of resources for R&D in health sector	<ul style="list-style-type: none"> ▪ Conduct a cost-benefit analysis of Research, Development and Innovation in HTM. ▪ Ring-fence the 30% of the 2% of the GDP that is allocated to health sector. This should translate to more resources available for R&D.

2. TUBERCULOSIS

Overview of the gaps

1. TB resistance
2. Gap in financing
3. Limited enabling environment
4. Lack of priority for research
5. Limited resources, generally
6. Limited monitoring and evaluation
7. Curriculum review to meet current training needs

Background

Progress has been made in Kenya on the TB response and Kenya is on track to treating and saving lives, however;

- TB incidence is declining too slowly
- People are dying annually from TB
- There are missing cases in the diagnosis of TB
- TB epidemic still rampant in Kenya
- DR/MDR response is slow and prevalent
- There is limited engagement of the private sector
- Gaps in financing

- New tools (Diagnostics, Drugs and Vaccines) are not enough

Research

- ✓ Access feasibility of new strategies or interventions in specific settings or populations
- ✓ Advocate for policy change
- ✓ Improve program outcomes in relation to medical care and prevention

Research landscape where are we today?

- Pursue high quality DOTs expansion
- Addressing TB/HIV and needs of poor and vulnerable
- Contribute to health systems strengthening
- Engage all care providers
- Empower people with TB and Communities

Ample Political recognition

- ✓ Component of WHO's Global Stop TB Strategy
- ✓ GFATM allows 10% of each grant to research; though rarely used!
- ✓ Emphasized by many technical/implementing/donor agencies

There is still, very little Research where the disease burden is greatest

PRIORITY GAPS	INTERVENTIONS
<p>Limited enabling environment</p> <ul style="list-style-type: none"> ▪ Lack of priority: NTP Managers are too busy in service delivery, leaving out research as a priority 	<ul style="list-style-type: none"> ▪ NTP to set up research priorities jointly with academia ▪ WHO guidance is available

<ul style="list-style-type: none"> ▪ Lack of strategic prioritized research agenda ▪ No collaboration with academia, NGOs-Sub-optimal engagement of researchers and regulatory bodies ▪ Donor driven research with lack of ownership by NTP ▪ Lack of priority for publishing research in journals-Dissemination and translation of research work to practice 	<ul style="list-style-type: none"> ▪ Partnership Model-Continued and sustained engagement of key stakeholders in research and other areas of focus ▪ Ownership of Research ▪ Set up a dedicated Research focal point ▪ Integrating research into routine program activities and budgets ▪ Advocate with scientific journals the value of research and need to publish it/leverage research regulatory bodies
<ul style="list-style-type: none"> ▪ Limited resources(infrastructure, trained manpower, dedicated time and funds) 	<ul style="list-style-type: none"> ▪ Allocate resources for research
<ul style="list-style-type: none"> ▪ Limited capacity and structured mentorship-Limited capacity for operational research at national and sub-national level 	<ul style="list-style-type: none"> ▪ Scale up OR capacity building efforts, involving local and international research and learning institutions ▪ Integrate TB in the existing HIV common unit in the pre-service curriculum ▪ Standardize methodology for audits and other data collection processes
<ul style="list-style-type: none"> ▪ Limited data on drivers/risk factors for TB (social research) 	
<ul style="list-style-type: none"> ▪ Limited monitoring of impact of research 	<ul style="list-style-type: none"> ▪ Mal-alignment of research priorities between programmers and researchers ▪ Involvement of researchers in routine and periodic surveys to build research questions that could be answered through the survey

	<p>infrastructure e.g. blood samples - like KENPHIA is now doing</p> <ul style="list-style-type: none"> ▪ Lack of repository of TB research work that is accessible to the public ▪ Setting up pilot projects from research findings/innovations
<ul style="list-style-type: none"> ▪ Fragmented implementation of various audits e.g clinical, mortality that hinders a systematic approach in addressing the problem & comparison across levels and regions ▪ Outdated curriculum TB content in pre-service training <p><i>Priority gaps-Policy & translation to practice</i></p> <ul style="list-style-type: none"> ▪ Electronic Medical Record-UniqueID in TB trailing ▪ International Classification of Diseases (ICD) 11 coding captures TB data but there is limited evidence on the use of this data to inform mortality at the population level 	
<ul style="list-style-type: none"> ▪ Limited data access for academicians and research institutions ▪ Sub-optimal standards of care 	<ul style="list-style-type: none"> ▪ Shift from theoretical training models to practical skills oriented mentorship programs ▪ Models of capacity building, egUNION-MSF & US CDC ▪ SORT-IT(Structured Operational Research and Training Initiative) by WHO

Monitoring the impact of research	
<ul style="list-style-type: none"> ▪ Effective Dissemination ▪ Publication ▪ Policy and practice change 	

4. **RSSH**

1. community systems – improving the workforce for CHBs
2. community lead monitoring and evaluation
3. Community lead advocacy and research, helps social mobilization.

Research gaps

1. Community and academia need to work together
2. Community should be equipped on basic research.
3. The commission for higher education (CUE) should be involved in identification of research gaps
4. Higher education reforms in training to make it competency based
5. Development of curriculum by involving the stakeholders in the health sector
6. Policy on institutional equipment policy
7. National policy that guides acquisition and disposal of equipment.
8. Universities /academia to bench mark on already available data
9. Multidimensional approach –involving other fields such as social scientists, psychologist and other relevant fields in training, curriculum development and joint research.

MODULE	PRIORITY GAPS	INTERVENTIONS
Health Sector Planning and Governance for Integrated People-centered Services	<ul style="list-style-type: none"> ▪ Gaps in leadership 	<ul style="list-style-type: none"> ▪ Integration of HTM leadership and governance across board
Community Systems Strengthening	<ul style="list-style-type: none"> ▪ Gaps in CHVs workforce 	<ul style="list-style-type: none"> ▪ Embrace digital health solutions to reach the beneficiaries at the grassroots ▪ Harmonize GF CHV rates across the 3 disease areas
Health Financing Systems	<ul style="list-style-type: none"> ▪ Limited domestic investment in HTM ▪ Inadequate accountability for the domestic investment in HTM 	<ul style="list-style-type: none"> ▪ Develop a tracking system for domestic investments in HTM ▪ Advocate for accountability of domestic investment in HTM ▪ Effective implementation of the integrated finance management system
Health Products Management Systems	<ul style="list-style-type: none"> ▪ Absence of interface between health systems and the health innovation ecosystem ▪ Regulatory bottlenecks of health products and technologies 	<ul style="list-style-type: none"> ▪ Identify appropriate solution for low resource setting/local solutions ▪ Strengthen capacity of PPB in areas where bottlenecks have been identified in order to streamline the regulatory review processes of health products and technologies in HTM
Human Resources for Health (HRH) and Quality of Care	<ul style="list-style-type: none"> ▪ Limited capacity of health workers to deliver people centered services 	<ul style="list-style-type: none"> ▪ Training of HCWs on people centered services approach ▪ Review HCWs curriculum to assess attitude and provision of people centered services capacity

<p>Laboratory Systems (including national and peripheral)</p>	<ul style="list-style-type: none"> ▪ Inconsistent implementation of policies on lab Siloed lab systems 	<ul style="list-style-type: none"> ▪ Conduct a study to look at the depth of implementation of policies in HTM ▪ Integration/Multi disease approach ▪ Alignment and Strengthening of the lab systems to make them resilient and sustainable ▪ Workforce development ▪ Creation of a program that translates innovative solutions into practice and scale
<ul style="list-style-type: none"> • Monitoring and Evaluation Systems 	<p>Research across board</p>	<ul style="list-style-type: none"> ▪ Build an effective knowledge management system/repository across the disease areas to ensure that lessons learnt from one funding cycle informs interventions in the next cycle. ▪ Conduct implementation research ▪ Research to Influence policy for evidence based decision making