



# Family Planning and Women's Health in Kenya

*The Impacts of U.S.  
Investments*

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*Charting a Vision for U.S. Global Leadership*



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# Family Planning and Women's Health in Kenya

## The Impact of U.S. Investments

Janet Fleischman and Katherine Peck<sup>1</sup>

### Executive Summary

*“Family planning is the core of women’s health. You cannot tell me you are investing in economic growth in Kenya if you’re not investing in women’s health.”*—Dr. Nicholas Muraguri, Director of Medical Services, Kenyan Ministry of Health, interview with CSIS, Nairobi, September 11, 2015

Voluntary family planning is one of the most transformative interventions in global health, critical to improving women’s health and to saving the lives of women and children in some of the world’s most vulnerable communities. Beyond the direct health benefits, family planning is essential for women’s empowerment and sustainable development, contributing to improvements in education, economic growth, and the prevention of mother-to-child transmission of HIV. As the global leader in supporting family planning, the United States has a vital role to play in helping countries improve the lives of women and families.

To understand the impact of U.S. investments, this report examines U.S. support for family planning in Kenya at a pivotal moment for these issues globally. As a regional leader in family planning and a priority country for U.S. family planning and maternal-child health assistance, and the President’s Emergency Plan for AIDS Relief (PEPFAR), Kenya provides a lens through which to assess the opportunities and challenges in expanding access and transitioning to greater sustainability. Kenya has made significant progress in family planning, with one of the highest contraceptive prevalence rates in the region at 58 percent, yet faces important challenges in maintaining momentum.

In the polarized U.S. political environment, funding for family planning programs faces persistent challenges. There is a risk that without clear U.S. commitment, these critical interventions could be derailed. Strong, bipartisan leadership is required to depoliticize these issues and to highlight the importance of voluntary family planning and healthy timing and spacing of pregnancies to improve women’s health, prevent

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<sup>1</sup> Janet Fleischman is a senior associate at the CSIS Global Health Policy Center. Katherine Peck is a program manager and research associate with the CSIS Global Health Policy Center. This report is based largely on their visit to Kenya in September 2015.

unintended pregnancies, increase child survival, avert millions of abortions, and improve economic and social development.

U.S. policy toward Kenya is in many ways a laboratory for the region with lessons for other countries. This report focuses on three key questions:

- 1. How will changes in PEPFAR strategy present challenges for the scale and sustainability of family planning-HIV integration?** The impact of PEPFAR 3.0 on family planning and maternal-child health services highlights the need for more ample, secure, and dedicated funding for these services. U.S. investments in voluntary family planning and in integrated service platforms with maternal-child health and HIV/AIDS have had a significant positive impact in Kenya, helping improve health outcomes for women and children. While U.S. funding for family planning and maternal-child health in Kenya has remained fairly steady in recent years, integration with HIV/AIDS is highly dependent on PEPFAR funding and strategy. PEPFAR's refocused approach, which will target resources to 20 of Kenya's 47 counties with high HIV burden, will present challenges for integrated services.
- 2. How can the United States assist Kenya to address ongoing challenges in family planning access and quality, especially in the context of decentralized health services?** Kenya has shown leadership in developing policies supportive of family planning and integration of health services, propelled by advocacy from international partners and domestic civil society. To move implementation forward and to overcome key challenges, Kenya will need increased domestic resources for and commitment to family planning. This takes on new urgency in the midst of the extensive political decentralization in Kenya known as devolution, which has meant that responsibility for family planning services now rests with county governments. The Kenyan national and county governments will have to develop adequately funded budgets to ensure the availability of the full range of family planning methods (including long-acting methods such as implants and IUDs) and quality services. This may require returning authority for procurement of contraceptive commodities to the national level to avoid stock outs and to ensure efficiencies of scale and equity.
- 3. How can U.S. investments in family planning and maternal-child health yield the greatest impact, at a time when the international financing frameworks are shifting to include greater roles for the private sector and domestic resources?** Now a lower-middle-income country, Kenya is also a front-runner country for the new Global Financing Facility (GFF) for reproductive, maternal, neonatal, child and adolescent Health (RMNCAH). However, the government's continued reliance on its external donors to finance family planning services and commodities—especially USAID—underscores the challenges of transitioning to sustainable financing.

## Impact of U.S. Family Planning Investments in Kenya

*“Now, when we talk about U.S. assistance in Kenya for maternal health and family planning, sometimes people ask me: why do we do this? We do it because we believe we have a common destiny, as human beings sharing this world together. We do it because we believe investing in people—their health, their security, their prosperity—is the key to a better future for us all.”*

—U.S. Ambassador Robert Godec, Address to Kenyan Members of Parliament, November 13, 2014

### Kenya Health Statistics

- Contraceptive prevalence rate: 58 percent
- Total fertility rate: 3.9
- Maternal mortality rate: 495 deaths/100,000 live births
- HIV prevalence: 7.6 percent (female), 5.6 percent (male)

USAID has a history of strong engagement on family planning in Kenya. In the 1970s and 1980s, U.S. support for family planning and for community-based distributors<sup>2</sup> contributed to reducing the total fertility rate<sup>3</sup> from an average of 8 children per woman in the late 1960s<sup>4</sup> to around 5 in the mid-1990s<sup>5</sup> to 3.9 according to the 2014 Kenyan Demographic and Health Survey. Indeed, this support helped make Kenya a family planning success story. However, USAID significantly reduced its support for Kenya’s family planning program in the 1990s, and many U.S. and Kenyan officials point to this as a contributor to the virtual collapse of Kenya’s family planning program. The 2003 Kenyan Demographic and Health Survey was a wake-up call; it showed that decreases in total fertility rates and under-five mortality rates had stalled or reversed between 1998 and 2003.<sup>6</sup>

Kenya is now a USAID family planning and maternal and child health priority country. USAID is the largest donor in supporting Kenya’s national family planning program, reaching most parts of the country through U.S. implementing partners involved in family planning, PEPFAR, and the Maternal Child Survival Program. U.S. partners provide technical assistance for service delivery and expanding the contraceptive method mix, behavior change communication, and advocacy. Maternal-child health activities focus on health worker training for antenatal and emergency obstetric care. The United States provides direct support to the Kenyan government in

<sup>2</sup> Community-based distributors are community health workers who distribute basic family planning commodities such as pills and condoms.

<sup>3</sup> According to the World Bank, “total fertility rate represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with current age-specific fertility rates.” See World Bank, “Data: Fertility rate, total,” 2015, <http://data.worldbank.org/indicator/SP.DYN.TFRT.IN>.

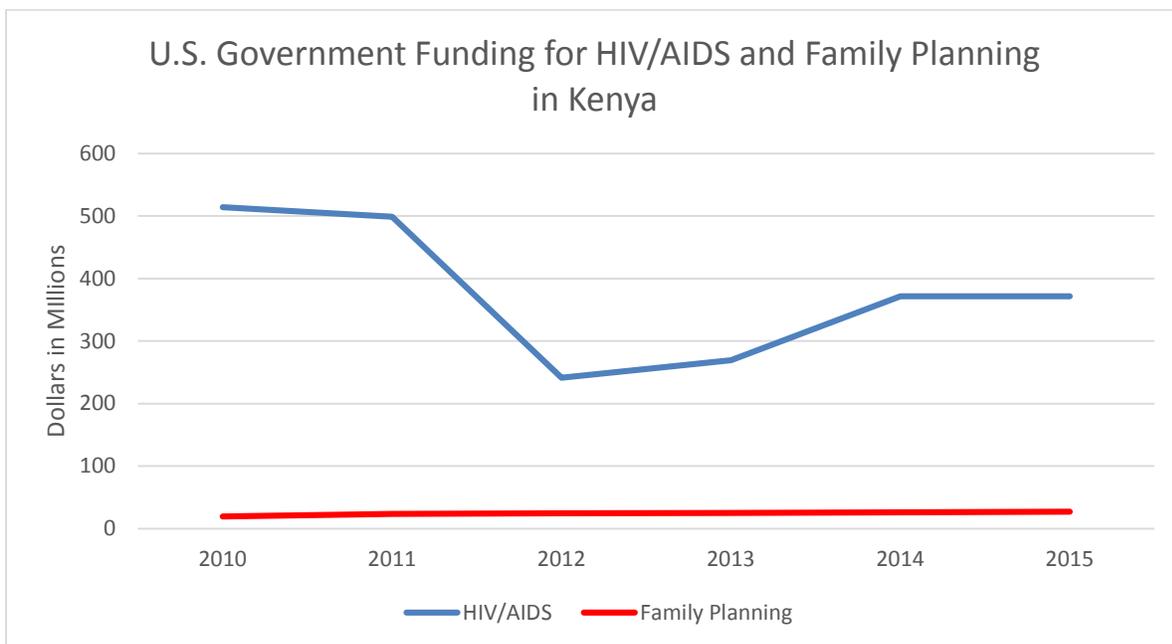
<sup>4</sup> According to UN Data. See Sandra Yin and Mary Kent, “Kenya: The Demographics of a Country in Turmoil,” Population Reference Bureau (PRB), January 2008, <http://www.prb.org/Publications/Articles/2008/kenya.aspx>.

<sup>5</sup> Peter Ngure Ngethe, “Family Planning in Kenya: A Review of National and District Policies and Budgets,” DSW, May 2014, 11, [http://www.dsw.org/uploads/tx\\_aedswpublication/family-planning-kenya\\_update.pdf](http://www.dsw.org/uploads/tx_aedswpublication/family-planning-kenya_update.pdf).

<sup>6</sup> The 2003 Demographic and Health Survey reported that the total fertility rate rose from 4.7 in 1995–98 to 4.9 in 2000–03 (p. 55), and that under-five mortality rose from 110 deaths per 100,000 live births to 115 in 2003 (p. 114). See Central Bureau of Statistics et al., “Demographic and Health Survey 2003,” July 2004, <https://dhsprogram.com/pubs/pdf/FR151/FR151.pdf>.

providing contraceptives, supporting county-level service delivery, and developing national policies and strategies. Since 2013, in the context of devolution, USAID’s health sector strategy began focusing greater attention and resources to strengthening systems and services at the county, as opposed to the national, level.

Kenya is also a PEPFAR focus country.<sup>7</sup> USAID has invested in an integrated service delivery platform (the AIDS, Population, and Health Integrated Assistance program, discussed below), which has helped expand access to a package of services including HIV, family planning, maternal-child health, and nutrition. Note that PEPFAR resources in Kenya dwarf the U.S. investments in family planning—in FY 2014, PEPFAR’s budget was \$371.68 million, family planning/reproductive health was \$27.4 million, and maternal, newborn, and child health (MNCH) was \$12.0 million.



**Ending Preventable Child and Maternal Deaths**

The USAID vision for ending preventable child and maternal deaths by 2035 is the signature USAID initiative on maternal, newborn, and child health (MNCH). USAID considers family planning to be one of the most impactful interventions to prevent maternal mortality in Kenya, second only to improved labor and delivery care. This underscores the need to address the demand for family planning, and to ensure that opportunities for integration of MNCH with other services are not missed, including family planning and immunizations. According to USAID’s June 2015 report, “Investment in voluntary family planning is linked to transformational benefits in health and development.”\*

\* USAID, “Acting on the Call: Ending Preventable Child and Maternal Deaths,” June 2015, <https://www.usaid.gov/sites/default/files/documents/1864/USAID-2015-Acting-on-the-Call.pdf>.

<sup>7</sup> The 15 PEPFAR focus countries are: Botswana, Côte d’Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Viet Nam, and Zambia.

## Lessons from U.S. Support for Integrated Platforms: The APHIAplus Example

Integration of family planning, maternal-child health, and HIV services under USAID's APHIA (AIDS, Population, and Health Integrated Assistance) program is widely seen as an important contributor to the rise in contraceptive prevalence rates in Kenya. APHIA<sup>8</sup> has been a hallmark of U.S. health investments in Kenya for the past decade, and has focused on using the PEPFAR platform to integrate HIV and family planning information and services to meet the needs of women living with HIV. As more women access antiretroviral treatment and live longer and healthier lives, HIV/AIDS services are an increasingly important source to help them decide whether and when to have children, and to help prevent mother-to-child transmission of HIV. PEPFAR described the impact of APHIA's approach as follows: "With no additional increase in family planning funding, geographic coverage of reproductive health services went from two to all eight provinces, couple-years of protection<sup>9</sup> using a modern family planning method increased exponentially, and HIV/AIDS programs were enriched because they began to focus on the 'whole patient' in the context of his or her family situation."<sup>10</sup>

Family planning commodities and most activities are funded separately under USAID's Office of Population and Reproductive Health,<sup>11</sup> although PEPFAR has developed guidance around how its funds can be used to support family planning as part of HIV prevention, care, or treatment, and has increased support for integrated program implementation.<sup>12</sup> Kenya's APHIA program has been a leader among PEPFAR focus countries in demonstrating the effective role that PEPFAR can play in

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<sup>8</sup> APHIA grew out of AMKENI (the first consortium) from 2001–2006, followed by APHIA bridging (in Western province only) from 2006 to June 2007; and APHIA 2 (2006–2010 in Nyanza province and July 2007–2010 in Western province), and then APHIAplus.

<sup>9</sup> Couple years of protection (CYP) is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. For more information, see USAID, "Couple Years of Protection (CYP)," April 9, 2014, <https://www.usaid.gov/what-we-do/global-health/family-planning/couple-years-protection-cyp>.

<sup>10</sup> PEPFAR, "Smart Investments: Making the Most of Every Dollar Invested," February 2011, <http://www.pepfar.gov/press/2011/155839.htm>.

<sup>11</sup> According to the COP Guidance for 2014, "As part of comprehensive care for HIV and AIDS, field teams are expected to prioritize opportunities to use PEPFAR funds to support voluntary family planning and reproductive health (FP/RH) services. These services must meet an HIV prevention, treatment, or care purpose and/or link PEPFAR-funded activities with FP/RH activities funded from separate U.S. government accounts or other non-U.S. government sources of funds. As in years past, PEPFAR funds may not be used to purchase family planning commodities; however, male and female condoms can be purchased using PEPFAR funds." See PEPFAR, "FY 2014 Country Operational Plan (COP) Guidance," November 8, 2013, 88, <http://www.pepfar.gov/documents/organization/217765.pdf>.

<sup>12</sup> PEPFAR outlines illustrative activities for integration, including family planning counseling in prevention of mother-to-child transmission (PMTCT) and HIV prevention, care, and treatment programs, and HIV counseling and testing in family planning programs. As with all U.S. support for family planning, the principles of voluntarism and informed choice are prerequisites that must be respected (PEPFAR, "FY 2014 COP Guidance"). In addition, PEPFAR and the USAID Office of Population launched a joint \$25 million initiative for family planning/HIV integration, targeting five countries (Zambia, Tanzania, Uganda, Nigeria, and Malawi). This is funded by PEPFAR out of money that was set aside for integration through the Global Health Initiative (GHI) strategy. The countries were selected because they have significant PEPFAR and USAID family planning platforms, high unmet need for family planning, and high burdens of HIV. Each country received \$5 million.

integrating family planning information and services. According to Dr. Irene Mukui of the National AIDS & STI Control Program, “one of the ways we have been very successful is that PEPFAR resources actually supported the integration. It was one of their deliverables.”<sup>13</sup>

The APHIA model of using the PEPFAR platform to also provide integrated family planning-HIV services was referred to as “a game changer”<sup>14</sup> by Kenya’s director of medical services, and “part and parcel of what we do” by the PEPFAR deputy coordinator.<sup>15</sup> Integration of services at the community and facility level is in line with Kenya’s overall health strategy; the Kenya Essential Package for Health, which is at the heart of the country’s Health Sector Strategic and Investment Plan (2013–2017), recommends “the integration of health programs into a single package.”<sup>16</sup> The current APHIA program, called APHIAplus, is implemented by various U.S. partners throughout Kenya.<sup>17</sup>

#### **APHIAplus Western**

APHIAplus Western supports service integration in 10 counties in what used to be called, before devolution, Western and Nyanza Provinces. At the Kakamega Provincial General Hospital, integration of care is bidirectional, meaning women can receive family planning services in the Comprehensive Care Center and HIV testing and treatment in the Maternal and Child Health clinic. The country has recently rolled out Option B+, meaning pregnant women found to be HIV positive are offered HIV treatment for life. But beyond typical PMTCT (prevention of mother-to-child transmission) programs, at this facility women can choose to stay to receive HIV services in the maternal-child health clinic until their child turns two, at which point they are transferred to the Comprehensive Care Center. We heard from one mother that it is “useful to have all the services in one place . . . you don’t have to move one place to another.” In the last year, over 7,700 women received integrated HIV and family planning services in the maternal-child health clinic at this site. APHIAplus Western has provided 580,000 couple-years of protections this past year, and through its services 167,000 unintended pregnancies have been averted since 2011.\*

\* CSIS interviews with Hudson Inyangala, technical adviser for RH/MNCH APHIAplus Western, Kakamega, September 7, 2015, and James Mukabi, chief of party APHIAplus Western, Nairobi, September 12, 2015.

However, integration of services is not without its challenges. In Kakamega, for instance, women remain reluctant to seek treatment in the Comprehensive Care

<sup>13</sup> CSIS interview with Irene Mukui, National AIDS and STI Control Programme (NAS COP), Nairobi, September 11, 2015.

<sup>14</sup> CSIS interview with Nicholas Muraguri, director of medical services, Ministry of Health, Nairobi, September 11, 2015.

<sup>15</sup> CSIS interview with Hannah Dagnachew, PEPFAR Kenya deputy coordinator, Nairobi, September 10, 2015.

<sup>16</sup> Ministry of Medical Services and Ministry of Public Health & Sanitation, “Transforming Health: Accelerating Attainment of Health Goals—The Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2013–June 2017,” [http://www.who.int/pmnch/media/events/2013/kenya\\_hssp.pdf](http://www.who.int/pmnch/media/events/2013/kenya_hssp.pdf).

<sup>17</sup> APHIAplus programs roughly corresponded with the former eight provinces: Kamili (Central + Eastern), Western (Western + Nyanza), Nuru ya Bonde (Rift Valley), Nairobi-Coast (Nairobi + Coast), and Imarisha (Northern counties of Turkana, Samburu, Isiolo, Marsabit, Mandera, Wajir, Garissa, Tana River). These programs have been implemented by Jhpiego, PATH, FHI360, Pathfinder, and Amref Health Africa, respectively.

Center because of lingering stigma surrounding HIV/AIDS. Another challenge identified by hospital staff was that in providing many services in a single appointment, these visits can become more time consuming. A shortage of providers trained in long-acting contraceptive methods is another clear challenge, which impacts the range of methods available to clients. How to best integrate services to meet the needs of women clients while addressing the demand it puts on healthcare workers is a question that the United States and its implementing partners, in conjunction with the Kenyan government, will need to address as the program continues to mature, and in anticipation of the changes in PEPFAR's strategy.

## Changes in PEPFAR's Approach: PEPFAR 3.0 and DREAMS

In late 2014, PEPFAR announced a shift in its approach—what many refer to as the PEPFAR pivot, or PEPFAR 3.0—which will allow PEPFAR to focus its resources on the areas of highest HIV burden. These changes reflect the tight U.S. budget environment and an effort to make better use of data to achieve greater impact and accountability. The new approach will focus on scaling up HIV services in high-burden subnational units in 20 of the 47 counties in Kenya—with particular emphasis on expanding HIV treatment, viral suppression, and retention. The remaining 27 counties will continue to receive PEPFAR support through commodities, but not site-specific activities. The pivot also means PEPFAR will disengage from low-yield sites, which means that PEPFAR partners will no longer provide support to those sites, including withdrawing from direct PMTCT programming support,<sup>18</sup> other than commodities for testing. According to PEPFAR, the pivot has enabled PEPFAR to provide \$110 million in additional funding over the past year to Kenya to expand treatment of children, increase voluntary medical male circumcision, increase HIV prevention in young women, and expand treatment access for men.<sup>19</sup>

In describing the new approach, PEPFAR documents state: “To reach the Joint United Nations Programme on HIV/AIDS’ (UNAIDS) ambitious 90-90-90 global goals: 90 percent of people with HIV diagnosed, 90 percent of them on ART [antiretroviral therapy] and 90 percent of them virally suppressed by 2020—we have to shift the way we do business. We can best control the epidemic by pivoting to a data-driven approach that strategically targets geographic areas and populations where we can achieve the most impact for our investments.”<sup>20</sup> Ambassador Deborah Birx refers to

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<sup>18</sup> Providing family planning services as part of PMTCT is essential so that women can make informed decisions about their future reproductive lives. According to WHO, prevention of unintended pregnancies in HIV-positive women is part of a comprehensive approach to PMTCT, referred to as the second prong of PMTCT. The four prongs are: 1) the primary prevention of HIV infection among women; 2) the prevention of unintended pregnancy among HIV-infected women; 3) the provision of specific interventions to reduce HIV transmission from mothers to their infants; and 4) the provision of HIV treatment, care, and support to HIV-infected mothers, their infants, and family. See WHO, Department of HIV/AIDS, “Prevention of Mother-to-Child Transmission of HIV (PMTCT): Briefing Note,” October 2007, 5, <http://www.who.int/hiv/pub/toolkits/PMTCT%20HIV%20Dept%20brief%20Oct%2007.pdf>.

<sup>19</sup> CSIS phone interview with Angeli Achrekar, chief of staff, Office of the U.S. Global AIDS Coordinator and Health Diplomacy, November 5, 2015.

<sup>20</sup> PEPFAR, “PEPFAR 3.0—Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation,” December 2014, <http://www.pepfar.gov/documents/organization/234744.pdf>

this as doing the right things (the core interventions<sup>21</sup>) in the right places (geographically focused and reaching the most vulnerable) at the right time (since an unending response to an ever expanding HIV epidemic is not financially sustainable).<sup>22</sup>

To accomplish this in Kenya, PEPFAR is refocusing its programing, using data to identify the areas of highest HIV burden, based on number of people living with HIV and HIV incidence. Despite PEPFAR's presence throughout Kenya, HIV prevalence varies considerably; some counties like Homa Bay in western Kenya have HIV prevalence as high as 27 percent, while prevalence in counties in the northeast is generally far lower, around 2 percent.<sup>23</sup> No one is claiming that this will be an easy task. As one PEPFAR official said, "We're . . . moving a big ship quickly."<sup>24</sup>

The PEPFAR pivot will likely impact its integrated model in Kenya. The APHIA approach for HIV services has included costs for clinic renovations, laboratories, vehicles, health management information systems, training of healthcare providers, and strengthening procurement systems. These improvements have benefited other services in health facilities, including family planning where integrated services are offered. A U.S. government official expressed the concern of many others in stating: "We will have to think creatively to maintain a similar effort on the RMNCH program."<sup>25</sup>

Some representatives of implementing organizations and the Kenyan government raised concerns that the pivot may mean dismantling integration in sites that no longer receive PEPFAR support. An official of the Ministry of Health expressed his "serious concern" that the important emphasis on integration—through PMTCT programs in maternal-child health clinics, and with the rollout of Option B+<sup>26</sup> across the country—may be negatively affected. When asked about the Kenyan government's response in the counties that won't be PEPFAR focus areas, he replied: "We'll fill some gaps, but not all the gaps."<sup>27</sup> Another U.S. official explained that while it makes sense

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<sup>21</sup> Core activities are essential to saving lives and preventing new infections; near-core are activities that directly support HIV/AIDS goals and that cannot yet be done well by other partners or the host government; non-core are activities that do not directly impact HIV/AIDS goals and can be taken on by other partners or the host government. See PEPFAR, "PEPFAR: 2015 Annual Report to Congress," 15, <http://www.pepfar.gov/documents/organization/239006.pdf>.

<sup>22</sup> Ambassador Deborah L. Birx, U.S. Global AIDS coordinator, "Delivering an AIDS-free Generation," Kaiser Family Foundation Town Hall Forum, June 23, 2014, <https://kaiserfamilyfoundation.files.wordpress.com/2014/06/birx-kaiser-town-hall-june-2014.pdf>.

<sup>23</sup> National AIDS Control Council of Kenya, "Kenya AIDS Response Progress Report," March 2014, [http://www.unaids.org/sites/default/files/country/documents/KEN\\_narrative\\_report\\_2014.pdf](http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf).

<sup>24</sup> CSIS interview with PEPFAR official, Nairobi, September 10, 2015.

<sup>25</sup> CSIS interview with U.S. government official, Nairobi, September 10, 2015.

<sup>26</sup> Option B+ as defined by the WHO is "providing lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count or clinical stage." See WHO, "Guideline on When to Start Antiretroviral Therapy and on Pre-exposure Prophylaxis for HIV," September 2015, [http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/186275/1/9789241509565_eng.pdf?ua=1).

<sup>27</sup> CSIS interview with Nicholas Muraguri, director of medical services, Ministry of Health, Nairobi, September 11, 2015.

for PEPFAR to redouble its focus on HIV, “we have to be careful not to throw out the benefits that have been accrued.”<sup>28</sup>

These concerns highlight a looming challenge about the longer-term sustainability and scale of these health programs as Kenya moves toward middle-income status.<sup>29</sup>

Whether the government of Kenya and the county governments will step up and fill the gaps left as PEPFAR refocuses remains to be seen.<sup>30</sup> The main impacts are expected to be on PMTCT services, which caused particular resistance from the Kenyan government, and PEPFAR consequently agreed to continue purchasing test kits for PMTCT. “We need to give the government time to adjust and define the impact of the shift, and to support them in adjusting the budget, managing services, equity and rights,” a U.S. official noted.<sup>31</sup>

Another U.S. official in Kenya expressed the uncertainty felt by many: “[E]verybody’s waiting—we don’t know what it will look like,” and conceded: “Integration will be more difficult. The focus on numbers on treatment doesn’t create space for family planning integration. . . . The flexibility in PEPFAR is no longer there.”<sup>32</sup>

## DREAMS

As PEPFAR is refocusing on high-burden areas, it is also launching the DREAMS partnership in Kenya, which stands for Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe. This is a public-private partnership aimed at reducing HIV incidence in adolescent girls and young women by 25 percent in two years, and 40 percent in three years. In addition to PEPFAR, the partnership includes the Bill & Melinda Gates Foundation and the Girl Effect (funded by the Nike Foundation). With an accumulated \$500 million in resources and highly ambitious goals, the DREAMS Partnership aims to address HIV risks for adolescent girls and young women in high-burden “hot spots” in 10 countries in southern and eastern Africa. To accomplish this,

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<sup>28</sup> CSIS interview with Kevin DeCock, country director, Division of Global HIV/AIDS, CDC Kenya, Nairobi, September 12, 2015.

<sup>29</sup> Kenya’s GNI (gross national income) per capita is \$1,290, just above the threshold for low-middle-income status. See World Bank, “GNI per capita, Atlas method (current US\$),” 2015, <http://data.worldbank.org/indicator/NY.GNP.PCAP.CD>.

<sup>30</sup> The part of the country that will be especially difficult includes the northern counties of Mandera, Wajir, Marsabit, and Turkana, which have the four highest maternal mortality rates and among the lowest contraceptive prevalence rate, as well as very low HIV prevalence. Mandera alone contributes to one-third of maternal deaths nationwide (2,136 of 6,623, according to UNFPA) and has a contraceptive prevalence rate of 1.9 percent, but adult HIV prevalence is under 2 percent. In some places the APHIA program, operated by Amref Health Africa, is the sole point of care for the broader family planning and maternal-child health needs of women and families. Given historically limited investments on the part of donors and the national government for a variety of political and security reasons, there may be serious implications in shifting health resources away from these areas. See UNFPA, “Counties with the Highest Burden of Maternal Mortality,” August 13, 2014, [http://countryoffice.unfpa.org/kenya/2014/08/13/10333/counties\\_with\\_the\\_highest\\_burden\\_of\\_maternal\\_mortality/](http://countryoffice.unfpa.org/kenya/2014/08/13/10333/counties_with_the_highest_burden_of_maternal_mortality/).

<sup>31</sup> CSIS interview with U.S. government official, Nairobi, September 10, 2015.

<sup>32</sup> CSIS interview with U.S. government official, Nairobi, September 10, 2015.

DREAMS aims to identify where these girls and young women are being infected, what is putting them at risk, and how to target programs accordingly.<sup>33</sup>

At this writing, DREAMS implementation has not yet begun in Kenya, but it is likely to be focused on four high-burden counties—Kisumu, Homa Bay, Siaya, and Nairobi. U.S. officials report that DREAMS in Kenya will have a \$30 million budget over two years, and will work through 10 implementing partners.<sup>34</sup> To measure impact, the program will assess how many teenage girls test HIV positive through PMTCT baseline exams in the target areas. In Kenya, USAID and CDC are working to coordinate this effort, and have defined two age cohorts (10- to 14-year-olds and 15- to 19-year-olds) that will receive different combinations of interventions, ranging from cash transfers to PrEP (pre-exposure prophylaxis).<sup>35</sup> One of the biggest challenges for DREAMS is sustainability: it is an admittedly expensive project with a short timeline. U.S. leadership is working to engage the Kenyan government from the onset, with the hope that they will buy in and continue these efforts once the program takes off. Another challenge will be to develop new and effective ways to reach adolescent girls and young women at risk of HIV, requiring PEPFAR’s current implementing partners to adopt new approaches.

## Political Landscape in Kenya: Family Planning Policies and Budgets

*“Using impact modeling, the National Council for Population and Development Kenya in 2015 estimated that increased use of family planning services to reach a Contraceptive Prevalence Rate (CPR) of 64.7% by 2020, Kenya would be able to save the lives of more than 20,000 mothers and 144,000 children, and avert more than 7.7 million unintended pregnancies and 1.4 million unsafe abortions.”*—Ministry of Health, Government of Kenya, “RMNCAH Investment Framework, Draft Version 17,” September 8, 2015.

### National Leadership/Policy Environment

Kenya’s recent rise in contraceptive prevalence rate is due to many factors, but national leadership and the development of enabling policies have been key contributors. Over the past 10 years, the government of Kenya (through the Ministry of Health and the Ministry of Planning) has also taken some steps to increase domestic investments and promote access to reproductive health services. Although family planning commodities had historically been completely donor-funded, a line item for family planning was added in the federal budget in the 2004–2005 fiscal year. This was a watershed moment that led to increased domestic mobilization for

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<sup>33</sup> Janet Fleischman and Katherine Peck, *Addressing HIV Risk in Adolescent Girls and Young Women*, Washington, DC: CSIS, 2015, [http://csis.org/files/publication/150410\\_Fleischman\\_HIVAdolescentGirls\\_Web.pdf](http://csis.org/files/publication/150410_Fleischman_HIVAdolescentGirls_Web.pdf).

<sup>34</sup> CSIS interview with U.S. government official, Nairobi, September 10, 2015.

<sup>35</sup> PrEP is part of the core package for DREAMS, but is not required. It will not be provided to girls under the age of 18.

commodities, reaching \$7 million in 2012–2013.<sup>36</sup> However, this commitment has fluctuated considerably, with the Kenyan government providing some 40 percent of the commodities in 2013, and then dropping to 2.9 percent in 2015, resulting from changes related to the decentralization of the health budget.

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### **Kenyan Government Polices on Family Planning**

In recent years Kenya has developed a number of family planning and reproductive health strategies, including the National Reproductive Health Policy (2007), National Reproductive Health Strategy (2009–2015), and Population Policy for National Development (2012–2030).<sup>37</sup> Supported by a coalition of partners, Kenya also developed a Costed Implementation Plan for Family Planning 2012–2016. This was a key act in establishing family planning as a national priority: the document laid out resource requirements in very clear terms, and set a national goal of increasing the contraceptive prevalence rate from 45 percent in 2009 to 56 percent in 2015. This goal was recently surpassed, according to the 2014 Kenyan Demographic and Health Survey.<sup>38</sup>

The Kenyan government has developed other policies that have raised the profile of women’s health. Based on data that showed high unmet need for family planning services among HIV-positive women (an average of 60 percent in 2007),<sup>39</sup> the government, again supported by international partners, developed a National Reproductive Health and HIV and AIDS Integration Strategy in 2009.<sup>40</sup> This strategy outlined a minimum package for HIV facilities to provide “information, a method of family planning, and refer clients for long term methods,”<sup>41</sup> which increased the focus on family planning-HIV integration in the public sector. In 2013, President Uhuru Kenyatta announced the abolishment of maternity fees at public hospitals, making good on a campaign promise to reduce maternal deaths by removing financial barriers to facility delivery.<sup>42</sup> Both the president and first lady have taken a special interest in maternal and child health: the first lady’s “Beyond Zero” campaign has led to a renewed focus on HIV and maternal and child survival.<sup>43</sup>

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<sup>36</sup> Until 2004–2005, donors purchased all of Kenya’s family planning commodities. According to FP2020, domestic funding for commodities increased to \$6.6m in 2012–2013, which left a funding gap of 60 percent supplied by donors. See FP2020, “Kenya,” 2015, <http://www.familyplanning2020.org/entities/77>.

<sup>37</sup> Population Reference Bureau, “PRB: A Committed Partner in Kenya,” August 2015, <http://www.prb.org/pdf15/idea-kenya-timeline.pdf>.

<sup>38</sup> Ministry of Health, “National Family Planning Costed Implementation Plan 2012–2016,” January 2012, <http://www.fhi360.org/sites/default/files/media/documents/kenya-costed-implementation.pdf>.

<sup>39</sup> National Council for Population and Development (NCPD) and PRB, “Kenya AIDS Indicator Survey (KAIS) 2007 Data Sheet,” July 2009, <http://www.prb.org/pdf09/kaiskenyadatasheet.pdf>.

<sup>40</sup> Ministry of Public Health and Sanitation and the Ministry of Medical Services, “National Reproductive Health and HIV and AIDS Integration Strategy,” August 2009, [http://www.healthpolicyinitiative.com/Publications/Documents/1279\\_1\\_BOOKLET\\_II\\_acc.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/1279_1_BOOKLET_II_acc.pdf).

<sup>41</sup> CSIS interview with Irene Mukui of NASCOP, Nairobi, September 11, 2015.

<sup>42</sup> According to the 2008–2009 Kenyan DHS, 90 percent of women receive antenatal care from a medical professional, but less than half of all births take place in a health facility. On June 1, 2013, President Uhuru Kenyatta announced that the government had abolished maternity charges in public health facilities to increase access to skilled care. See USAID Kenya, PEPFAR, and Health Policy Project, “Ministry of Health implements free maternity services nationwide,” [http://www.healthpolicyproject.com/ns/docs/MaternalNewbornHealthCare\\_Kenya\\_Oct2013.pdf](http://www.healthpolicyproject.com/ns/docs/MaternalNewbornHealthCare_Kenya_Oct2013.pdf).

<sup>43</sup> UNAIDS, “New ‘Beyond Zero Campaign’ to improve maternal and child health outcomes in Kenya,” January 30, 2014, <http://www.unaids.org/en/resources/presscentre/featurestories/2014/january/20140130beyondzerocampaign>.

Kenya's national leadership was particularly evident in the revised 2010 constitution, which makes direct reference to reproductive health in its expansive bill of rights. It reads: "Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care."<sup>44</sup> Significantly, no other health issue is singled out.

## Devolution: Challenges and Opportunities

Devolution is a sweeping, ambitious process of decentralization and political reform in Kenya, stemming from the 2010 constitutional referendum. The momentum behind devolution involved efforts to address grievances against the central government and unequal economic development, highlighted by the post-election ethnic violence in 2007–2008 that brought Kenya to the brink of civil war.<sup>45</sup> In the historic referendum, nearly two-thirds of the population voted in favor of a dramatic restructuring of Kenyan governance, with a centralized federal system and eight provinces giving way to 47 new and more autonomous counties. Devolution sought to improve accountability and reduce regional inequities by bringing government closer to communities, building new county-level structures, and establishing a revenue-sharing formula that takes into account county population size and poverty rate.<sup>46</sup>

Under devolution, healthcare delivery has been devolved to the counties, while the national government is responsible for capacity building, policy, and referral hospitals.<sup>47</sup> Devolution of health was meant to be a three-year phased process with careful deliberation about how functions were to be decentralized. However, the transition process was rushed due to "pull and push between the national government and governors," as one U.S. official put it.<sup>48</sup> With the counties wanting "total control of the health docket,"<sup>49</sup> devolution of health has been a hurried, complicated, and highly

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<sup>44</sup> National Council for Law Reporting, "The Constitution of Kenya, Revised Edition 2010," <https://www.kenyaembassy.com/pdfs/The%20Constitution%20of%20Kenya.pdf>.

<sup>45</sup> Violence erupted in Kenya following the disputed presidential victory of Mwai Kibaki over Raila Odinga in 2007. In a surge of targeted ethnic violence, more than 1,500 people were killed and over 300,000 were displaced. The crisis led to the formation of a coalition government, negotiated by former UN Secretary General Kofi Annan, which kept Kibaki as president and established a new office of prime minister, filled by Odinga. Future president Uhuru Kenyatta and his deputy William Ruto were among a group of high-level political leaders charged with crimes against humanity by the International Criminal Court (ICC) for their alleged role in inciting the post-election violence. They were elected in 2013 and the ICC charges were eventually dropped, citing lack of sufficient evidence to bring the case to trial. The ICC said that the Kenyan government obstructed the investigation and failed to protect witnesses from intimidation. See International Crisis Group, "Kenya After the Elections," May 15, 2013, <http://www.crisisgroup.org/en/regions/africa/horn-of-africa/kenya/b094-kenya-after-the-elections.aspx>.

<sup>46</sup> Kenya's 47 counties vary widely in both population size and poverty rates. Revenue-sharing among counties in Kenya is based on the following formula: 45 percent population, 20 percent poverty index; 8 percent land area; 25 percent basic equal share; 2 percent fiscal responsibility. The last two percentages are equal for all counties. For more information, see Mwangi S. Kimenyi, "Kenya Devolution and Resource Sharing Calculator," Brookings Institution, October 2013, <http://www.brookings.edu/research/interactives/2013/kenya-resource-sharing>.

<sup>47</sup> Katherine Barker et al., "Devolution of Healthcare in Kenya," Health Policy Project, July 2014, [http://www.healthpolicyproject.com/pubs/479\\_KenyaPETSCountyReadinessFINAL.pdf](http://www.healthpolicyproject.com/pubs/479_KenyaPETSCountyReadinessFINAL.pdf).

<sup>48</sup> CSIS interview with U.S. government official, Nairobi, September 10, 2015.

<sup>49</sup> CSIS interview with Samburu Wa-Shiko, Kenyan-based development consultant, Nairobi, September 12, 2015.

political endeavor. Limited preexisting capacity has meant that most counties have been unprepared to take on this responsibility, and have required extensive support on a range of activities from basic budgeting to supply chain management.

The process of decentralization began in earnest in March 2013 with the election of county governors and assemblies.<sup>50</sup> According to Wycliffe Oparanya, former minister of planning and now the governor of Kakamega County, “Kenya has a unique devolved system. [It] came through bloodshed, because of skewed development. We’ve spent 20 years fighting for equitable sharing of money.”<sup>51</sup> It should be noted that Kakamega is in western Kenya, an area associated with the political opposition, so the governor’s views on devolution also reflect broader political dynamics in Kenya and tensions between different parts of the country and the central government, under President Uhuru Kenyatta.

One of the biggest challenges has been keeping a focus on family planning in the midst of many competing priorities. As staff from one U.S. implementing partner described, though the counties clamored for a speedy handover of power, the new county leadership “is small and they have too much to do...therein lies the challenge.”<sup>52</sup> Only six counties have a budget for family planning, due largely to concerted advocacy efforts. The medium- and long-term effects that these enormous governance changes will have on access to family planning in Kenya remain to be seen.<sup>53</sup>

Despite all the challenges, many in Kenya express optimism about the potential benefits of devolution on family planning and health more broadly. The Kenyan national government had never come close to meeting the target of 15 percent for spending on health as outlined by the Abuja Declaration,<sup>54</sup> in recent years reaching about 6 percent, but the average county budget allocation for health is at 22 percent.<sup>55</sup> Bringing oversight of services down to the county level provides an opportunity for more responsive and accountable programming. It may also lead to improvements in equity, as counties that have been historically neglected for political reasons start to receive more funding.

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<sup>50</sup> World Bank, “Kenya’s Devolution,” 2015, <http://www.worldbank.org/en/country/kenya/brief/kenyas-devolution>.

<sup>51</sup> CSIS interview with Wycliffe Ambetsa Oparanya, governor of Kakamega, Nairobi, September 7, 2015.

<sup>52</sup> CSIS interview with U.S. implementing partner, Nairobi, September 9, 2015.

<sup>53</sup> To date, 7 of the 47 counties have developed costed implementation plans for family planning: Kakamega, Kitui, Siaya, Tharaka Nithi, Homa Bay, Nyeri, and Busia. See Advance Family Planning (AFP), “Four Kenyan Counties Develop Costed Family Planning Strategies Case Study,” January 2015, [http://advancefamilyplanning.org/sites/default/files/resources/kenya\\_EN.pdf](http://advancefamilyplanning.org/sites/default/files/resources/kenya_EN.pdf).

<sup>54</sup> In April 2001, African Union heads of state pledged to allocate at least 15 percent of their annual budgets to health. For more information, see WHO, “The Abuja Declaration, Ten Years On,” March 25, 2011, [http://www.who.int/healthsystems/publications/abuja\\_report\\_aug\\_2011.pdf?ua=1](http://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1).

<sup>55</sup> Ministry of Health, “2014/2015 National and County Health Budget Analysis Report,” July 2015, [http://www.healthpolicyproject.com/pubs/532\\_FINALNationalandCountyHealthBudgetAnlysis.pdf](http://www.healthpolicyproject.com/pubs/532_FINALNationalandCountyHealthBudgetAnlysis.pdf).

### **The Example of Kakamega County**

In the midst of devolution, Kakamega County has managed to maintain a focus on family planning. Through the leadership of Governor Wycliffe Oparanya (former minister of planning and Kenya's FP2020 representative at the London Summit in 2012) and the county Ministry of Health, 25 percent of the total budget has been allocated to health, and a modest budget line of 3 million Kenyan shillings (\$30,000) has been allocated to family planning and reproductive health. With the help of partners, Kakamega has developed a costed implementation plan for family planning spanning 2014–2018. In addition, 38 million Kenyan shillings (\$370,000) has been set aside to pay community health workers for this next fiscal year, 2015–2016.

With newfound resources and power, however, some governors have been more interested in building structures than buying commodities, with the bulk of health spending going to salaries and not services. Going forward, it will take heightened engagement, advocacy, and capacity building to prioritize family planning at the county level. Advocates, implementers, and donors have already started to reconfigure their approach, but priority setting remains a challenge.<sup>56</sup>

### **Community Health Volunteers and the Community Strategy<sup>57</sup>**

In reaching beyond facilities to address health needs at the community level, community health volunteers (CHVs) have become important in Kenya as well as in other countries. However, there are major challenges in building a sustainable model; in Kenya, with some 150,000 such volunteers, this is a pressing issue.

Developed by the Kenyan government in 2006 and revised for 2014–2019, the community strategy is meant to facilitate service delivery, build capacity, and strengthen linkages between the communities and the health facilities. This national policy divides Kenya's 47 counties into smaller "community units," representing the lowest administrative level of the health system. Each unit comprises 1,000 households, with a network of community health volunteers<sup>58</sup> providing basic information, services, and referrals to an assigned facility for more complicated issues. The criteria for these volunteers are that they have completed secondary

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<sup>56</sup> Advance Family Planning (AFP) is an advocacy initiative working to achieve the goals of FP2020, located at the Bill & Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health. It is supported by the Bill & Melinda Gates Foundation, the David & Lucille Packard Foundation, and the William and Flora Hewlett Foundation. In Kenya, the lead partner for AFP is Jhpiego.

<sup>57</sup> The program is currently in process of national scale-up. The overall target is to establish a community unit for every 5,000 persons with an associated dispensary, private clinic, health center, or maternity home. The overall goal is to establish 8,000 community units; at this point, there are roughly 2,500. The community strategy is integrated into Kenya's broader Health Sector Strategic and Investment Plan. See Ministry of Medical Services and Ministry of Public Health & Sanitation, "Health Sector Strategy and Investment Plan (KHSSP) July 2013–June 2017," [http://www.who.int/pmnch/media/events/2013/kenya\\_hssp.pdf](http://www.who.int/pmnch/media/events/2013/kenya_hssp.pdf).

<sup>58</sup> Advancing Partners & Communities, "Country Profile: Kenya Community Health Programs," 2013, [https://www.advancingpartners.org/sites/default/files/landscape/countries/profiles/country\\_profile\\_kenya\\_0.pdf](https://www.advancingpartners.org/sites/default/files/landscape/countries/profiles/country_profile_kenya_0.pdf).

school<sup>59</sup> and that they live in the community they serve. They undergo short training on a variety of health issues, including nutrition, HIV/AIDS, malaria, and family planning.

Community health volunteers whom we interviewed in Kakamega, Tharaka Nithi, and Kayole (on the outskirts of Nairobi) described their role in advancing access to family planning. Across these groups, the volunteers were tasked with providing information on the different family planning methods, providing condoms and oral contraceptives, and making referrals to facilities if a client chooses a long-acting method.

While the recent increase in contraceptive prevalence involved changes at multiple levels of the health system, demand creation and community acceptance have been key to ensuring last-mile access and delivery, which was largely credited to the work of the community health volunteers. In structuring services around a specific location, the volunteers have contributed to improved access to family planning (see text box).

#### **Task Shifting in Tharaka Nithi County**

In the rural county of Tharaka Nithi, the terrain is rough and sparsely populated. To demonstrate the feasibility of task shifting to community health volunteers, a group of volunteers were trained by Jhpiego, under a USAID-funded pilot, to provide injectable contraceptives (depo provera), by far the most popular family planning method in Kenya. This form of task shifting has been met with resistance within the medical community, who contend that medically untrained community health volunteers should not be permitted to provide injections. But in Tharaka Nithi, there have been no reported adverse effects associated with the community health volunteers administering injectable contraceptives, and the contraceptive prevalence rate has increased from just under 50 percent in 2012 to 67 percent in 2014 for modern methods, 9 percentage points higher than the national average. While the pilot program was very successful, it has only expanded to nearby Elgeyo Marakwet County, although advocacy efforts are underway to scale up to additional counties. At this writing, national policy has restricted the trainings to “hard to reach and underserved” counties.

However, it is clear that community health volunteers face major obstacles in their work, chief among them being that they are all technically volunteers. While in the past they were provided some remuneration through monthly stipends of 1,000–2,000 Kenyan shillings (roughly \$10–\$20)<sup>60</sup> or transport allowances, those funds have always come from implementing partners, and much of it has dried up over the last few years, especially those funded through PEPFAR. One community health volunteer in Nairobi mentioned that when it comes to working to put food on the table or volunteering your time in the community, many are compelled to work, which contributes to high turnover rates among volunteers.

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<sup>59</sup> Email communication with Jane Otai, Jhpiego senior program adviser, November 6, 2015.

<sup>60</sup> These numbers also reflect national recommendations for community health worker payment put out by the Ministry of Health.

Tensions exist for national and county-level officials between providing salaries for the community health volunteers and paying other facility-based healthcare workers. According to Dr. Muraguri, “For all intents and purposes, they are not health workers [as in] in Ethiopia.<sup>61</sup> It’s a different game . . . should my investment be CHVs or health workforce? That is a policy debate.” Given its impact, the community strategy’s reliance on volunteerism is a question that Kenya must address as it looks to consolidate and build on its recent family planning achievements.

## Youth and Adolescents

According to Dr. Josephine Kibaru of the National Council for Population and Development, adolescents are “the big elephant in the room” in discussions of family planning.<sup>62</sup> Young women in Kenya are particularly vulnerable to unintended pregnancies, unsafe abortion, child marriage, sexual violence, and HIV/AIDS. The statistics are startling: with nearly 25 percent of the population between 10 and 19 years of age, adolescent girls have the highest risk of unsafe abortion, the highest unmet family planning need, and contribute to nearly 30 percent of maternal mortality.<sup>63</sup> A female adolescent is on average three times more likely to contract HIV than her male counterpart,<sup>64</sup> and nearly half of teenage pregnancies are unintended.<sup>65</sup>

Despite impressive improvements in contraceptive use among 15- to 19-year-olds (an increase from 14 to 40 percent between 2008/9 and 2014), this rate is still much lower than other age cohorts, and nearly 40 percent of girls have given birth or become pregnant by the age of 19.<sup>66</sup> According to Harriet Birungi of the Population Council, a recent study in Western Kenya showed that early pregnancy is a leading cause of school dropout and a primary cause of early marriage.<sup>67</sup>

To reach adolescents with comprehensive sexuality education, many in Kenya recognize the value of a school-based approach.<sup>68</sup> Free primary education, instituted

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<sup>61</sup> Ethiopia’s Health Extension Program, launched by the government in 2003, is built on the widely used community health worker model, where members of the community work as volunteers and are provided some training to deliver basic health information and services. A key difference between Ethiopia and Kenya, however, is that in Ethiopia health extension workers are formally trained and paid as full-time government workers. See Janet Fleischman and Alisha Kramer, “Family Planning and Linkages with U.S. Health and Development Goals: A Trip Report of the CSIS Delegation to Ethiopia, February 2014,” [http://csis.org/files/publication/140417\\_Fleischman\\_FamilyPlanningEthiopia\\_Web.pdf](http://csis.org/files/publication/140417_Fleischman_FamilyPlanningEthiopia_Web.pdf).

<sup>62</sup> CSIS Interview in Nairobi, September 11, 2015.

<sup>63</sup> CSIS interview with Marsden Solomon, FHI360 project director, Nairobi, September 12, 2015.

<sup>64</sup> UNAIDS, “The Gap Report,” 2014, 33, [http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS\\_Gap\\_report\\_en.pdf](http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf).

<sup>65</sup> Ministry of Health, “National Adolescent Sexual and Reproductive Health Policy 2015,” 2015.

<sup>66</sup> Kenya National Bureau of Statistics, “Kenya Demographic and Health Survey: Key Indicators 2014,” 2015, <http://dhsprogram.com/pubs/pdf/PR55/PR55.pdf>; and Kenya National Bureau of Statistics, “Kenya Demographic and Health Survey 2008–09,” 2010, <http://dhsprogram.com/pubs/pdf/fr229/fr229.pdf>.

<sup>67</sup> CSIS interview with Harriet Birungi, Population Council senior associate and country director, Nairobi, September 9, 2015. The study in Bungoma County included 728 girls out of school aged 13–19. The study found that early pregnancy is a leading cause (67 percent) of school dropout; 93 percent of the pregnancies were unintended. Thirty-three percent (243) of the teens out of school were married and 92 percent reported that pregnancy triggered their early marriages.

<sup>68</sup> The importance of age-appropriate comprehensive sexuality education is mentioned in the 2015 National Adolescent Sexual and Reproductive Health Policy.

in January 2003, means that more Kenyan girls are enrolled in school than ever before. But implementing quality, age-appropriate programs has become “a big time controversy,”<sup>69</sup> with vocal opposition from teachers, parents, and the Catholic Church. In the same vein, reaching adolescents, especially young women, with sexual and reproductive health services remains a challenge. A young woman named Shiko, who lives in a slum area of Nairobi, told us that teenage girls do not feel comfortable going to health facilities to access HIV or family planning services with older women, and that there aren’t enough young community health volunteers to talk to. Boys are often drawn to youth-friendly centers because of the recreation provided to attract young people to the sites, but many of these centers are not necessarily safe spaces for young women.<sup>70</sup>

The Kenyan government recently launched the National Adolescent Sexual and Reproductive Health Strategy, which endeavors to mainstream these issues into national health and development agendas, and was cited by many as an important step forward, although no new resources were attached. The major issue, however, is not Kenya’s lack of supportive policies, but enacting change in classrooms and clinics that will improve indicators for this population, and the resources required to make this happen.

Debates over adolescent sexuality are certainly not unique to Kenya, but with two-thirds of the population under 30 years of age, Kenya has a lot to gain, or lose, in how it responds to the needs of this population. According to Dr. Kibaru, “One of the problems we have is the huge youth bulge: we have lots of young people. . . . We need to tap into the demographic dividend [and] see how we can gain from the momentum for socioeconomic [reasons] and for quality of life.” The demographic dividend, an emergent phenomenon in many sub-Saharan African countries, is a window of opportunity for accelerated economic growth that starts when fertility rates fall, leading to a larger population of working-age adults.<sup>71</sup> If Kenya can continue to expand access to family planning and reduce fertility rates while improving education and economic policies, this will advance prospects for youth employment and contribute to the nation’s overall economic and development goals. It is important to recognize that actions taken by the national and county governments to prioritize family planning and promote access to quality services contribute directly to Kenya’s prospects of achieving middle-income status.

## Toward Sustainable Financing in Family Planning

The rising interest in developing sustainable financing for family planning in Kenya involves not only resources from external donors, but also the financial investments

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<sup>69</sup> CSIS interview with Nicholas Muraguri, director of medical services, Ministry of Health, Nairobi, September 11, 2015.

<sup>70</sup> CSIS interview with Shiko, Nairobi, September 9, 2015.

<sup>71</sup> National Council for Population and Development and HPP, “Demographic Dividend Opportunities for Kenya: Results from the DemDiv Model,” July 2014, [http://www.healthpolicyproject.com/pubs/384\\_KenyaDemDivBrief.pdf](http://www.healthpolicyproject.com/pubs/384_KenyaDemDivBrief.pdf).

and political commitments by the Kenyan national and county governments, as well as the private sector.

## The Emerging Private Sector

The private sector and public-private partnerships represent a growing part of family planning services in Kenya and can help fill gaps in access and services, although there is still huge variability in quality. According to the Kenyan Ministry of Health, private-sector health providers account for 49 percent of health services in Kenya,<sup>72</sup> including private providers who charge fees for services and not-for-profit faith-based organizations (FBOs) that work in health. Those accessing private-sector services include people in Kenya's poorest and hard-to-reach communities, who often seek services at pharmacies or unofficial sites of questionable quality, as well as a growing percentage of the middle class willing to pay for quality services with shorter waiting times than in the public sector. In addition, a large percentage of adolescents and young people who do seek out family planning services do so in the private sector, often fearing that they would see their parents or their neighbors at a public clinic, or would encounter judgmental healthcare workers. Public-private partnerships in Kenya are also developing mobile health approaches to address issues of affordability and access for family planning and maternal-child health services.

The private-sector family planning services in Kenya include private pharmacists in urban and slum areas as well as social franchise clinics and social marketing programs, notably Marie Stopes Kenya and PS Kenya, not to mention the well-equipped private hospitals. The government provides contraceptives (most of which are supplied by donors) for free to the private sector, and in turn expects them to be distributed without charge, although there are fees charged for the services. According to Ministry of Health officials, 20–25 percent of family planning commodities go to the private sector and FBOs.<sup>73</sup> Siddharth Chatterjee, the UN Population Fund (UNFPA) representative in Kenya, characterized the wide range of private sector in Kenya: “What is private sector? Is it the large companies or the midwife who sets up her shop in the slum?”<sup>74</sup>

While the government provides family planning commodities free of charge, it still restricts private provision of family planning methods other than pills and condoms. For example, government regulations prevent pharmacists from providing injectables, the most popular contraceptive method in Kenya, based on the fact that it is not part of their training. The Ministry of Health is exploring a policy exemption that would allow trained pharmacists to provide injectable contraceptives and implants.

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<sup>72</sup> This includes 33 percent for profit and 16 percent not-for-profit health facilities. See Ministry of Health, “Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework,” Draft Version 17, 52, September 8, 2015.

<sup>73</sup> CSIS interview with Nicholas Muraguri and Kigen Bartilol, Nairobi, September 11, 2015.

<sup>74</sup> CSIS interview with UNFPA, Nairobi, September 11, 2015.

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## Social Franchises in Kenya

Marie Stopes Kenya has a presence throughout most of Kenya, currently operating in 42 of the 47 counties. MSK provides the full range of family planning services, including short, long-acting, and permanent methods, as well as HIV counseling and testing and cervical cancer screening. MSK services are available through 23 static clinics; 14 mobile outreach teams offering family planning in 600 public and private sites; and 406 members of the social franchise network, Amua. The social franchise network engages private providers in underserved areas to provide quality family planning, reproductive health, skilled delivery, and HIV services. These clinics charge fees for services, although family planning commodities are provided for free from the government. MSK aims for market segmentation, meaning that those who can pay for services will, including women from Kenya's emerging middle class, in order to get shorter waiting times and higher-quality services. If clients can't pay, services are subsidized. However, MSK recognizes the gap in addressing the needs of adolescents and youth, who often don't seek services at an MSK site due to perceived cost.<sup>75</sup>

PS Kenya, formerly part of Population Services International (PSI), is a social marketing organization focusing on building the capacity of private providers to offer quality family planning and reproductive health services. PS Kenya works with over 5,000 pharmacies that sell social-marketed contraceptive methods and has built their capacity to counsel and refer clients for family planning and other services. PS Kenya has also built the capacity of a network of private health providers to offer family planning and reproductive health services as well as HIV. The franchise network of health providers called Tunza was established in 2008 and currently there are around 330 providers in the network in 37 counties, all trained on family planning counseling and long-term methods (IUCDs and implants). PS Kenya provides supportive supervision for the family planning/reproductive health services as well as for the business skills.<sup>76</sup>

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Private-sector providers can play an important role in moving Kenya toward sustainability in family planning services. As private health insurance becomes more widely available in Kenya, women and families are increasingly able to use insurance to access private providers. These private health insurance companies and providers can also help health facilities to raise revenue without having to rely on international donor funding. The importance of new forms of health care financing in Kenya was emphasized by U.S. officials, who noted that attractive and viable insurance schemes covering family planning services could relieve the burden in public-sector health care.

## Commodity Security

Commodity security involves a person's ability to choose, obtain, and use a contraceptive method, which is dependent on effective supply chains, resources,

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<sup>75</sup> Marie Stopes Kenya, "Our Vision: When Every Birth Is Wanted," PowerPoint presentation 2015, and CSIS interview with Faustina Fynn-Nyame, MSK country director, Nairobi, September 13, 2015.

<sup>76</sup> Email communication with Lucy Maikweki, director, Sexual & Reproductive Health, September 23, 2015; and CSIS interview with Lucy Maikweki, director, Sexual & Reproductive Health, Nairobi, September 11, 2015.

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## Tupange

Tupange (which means “Let’s Plan” in Swahili) is part of the Urban Reproductive Health Initiative, funded by the Bill & Melinda Gates Foundation.<sup>77</sup> The \$26 million Tupange project ran from 2010–2015 and focused on increasing modern contraceptive rates by 20 percent among the urban poor in five Kenyan cities—Nairobi, Mombasa, Kisumu, Machakos, and Kakamega. Tupange was implemented by a consortium led by Jhpiego, working with the county governments and other partners, as well as the National Council for Population and Development and Ministry of Health.<sup>78</sup> Discussions are currently underway about a possible follow-on phase to Tupange, including a challenge fund to incentivize governments in the region to replicate family planning programs for the urban poor.

The Bill & Melinda Gates Foundation’s focus on urban areas grows out of data showing that future population growth will be concentrated among the urban poor in low-income countries and poor women living in urban and peri-urban slums have significantly lower rates of contraceptive use and higher unmet need for contraceptives compared to non-poor urban women. Tupange integrated family planning with maternal and newborn health services and improved quality of family planning services, especially in high-volume public-sector sites. This was accomplished by increasing access to family planning using public-private partnerships; creating demand for family planning among the urban poor, through community health workers and community leaders, including faith-based leaders; and ensuring access to family planning supplies and services. Tupange’s overall results were impressive, showing a marked increase in contraceptive prevalence rate in all sites.<sup>79</sup>

One of Tupange’s objectives was to support women to use more effective methods of contraceptives, including long-acting and reversible methods of contraception (LARCs), such as implants and IUCDs, as well as permanent methods such as vasectomy and bilateral tubal ligation.<sup>80</sup> These efforts contributed both to the increase in new family planning users, and to an increase in long-acting methods—for example, Machakos and Kakamega saw a 10 percent increase in the number of women using implants.<sup>81</sup> To address the perennial problem of stock outs of contraceptive commodities, Tupange developed an SMS Commodity Tracking System, using mobile technology to strengthen family planning programs. This program enabled Tupange to identify sites with shortages or overstocks of commodities and to redistribute the commodities based on the need and the SMS data.<sup>82</sup>

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<sup>77</sup> In addition to Kenya, the other countries involved in the Urban Reproductive Health Initiative are Nigeria, Senegal, and India.

<sup>78</sup> CSIS interview with Jhpiego Kenya country team, Nairobi, September 9, 2015.

<sup>79</sup> The results of Tupange were: an increase of 11 percentage points in contraceptive prevalence rate in Nairobi (from 44 percent to 55 percent); an increase of 15 percentage points in Mombasa (from 29 percent to 44 percent); an increase of 15 percentage points in Kisumu (from 44 percent to 59 percent); an increase of 9 percentage points in Kakamega (from 46 percent to 54 percent); and an increase of 13 percentage point in Machakos (from 45 percent to 58 percent). See Measurement, Learning & Evaluation (MLE) Project, “Measurement, Learning & Evaluation of the Kenya Urban Reproductive Health Initiative (Tupange): Kenya, Endline Household Survey 2014,” Chapel Hill, NC: Measurement, Learning & Evaluation Project, 2015, [https://www.urbanreproductivehealth.org/sites/mle/files/twp\\_3\\_2015\\_kenya\\_endline\\_household\\_survey\\_report.pdf](https://www.urbanreproductivehealth.org/sites/mle/files/twp_3_2015_kenya_endline_household_survey_report.pdf).

<sup>80</sup> In addition to working with Marie Stopes Kenya, which worked with Tupange to provide LARCs, Tupange (through Jhpiego) trained public-sector health workers to deliver these methods, and trained community health worker to increase demand for family planning in the communities.

<sup>81</sup> MLE Project, “Kenya Urban Reproductive Health Initiative (Tupange): Kenya, Endline Household Survey 2014.”

<sup>82</sup> Kenya Urban Reproductive Health Initiative, “Commodity Tracking System Featured at mHealth Conference,” 2011, <http://www.tupange.or.ke/content/commodity-tracking-system-featured-mhealth-conference>.

policies, and political commitment.<sup>83</sup> Addressing commodity security prior to devolution was considered a pillar of Kenya’s success in expanding access to family planning. But according to Dr. Muraguri, with devolution, the “structure we built over the years collapsed.”<sup>84</sup> One of the most direct and damaging impacts of the political transition on family planning was that the budget line item for commodities that had been carefully cultivated at the national level “just got lost.”<sup>85</sup> In the process of devolving funds to the county level, family planning resources were combined with other health-related resources in large block grants. Consequently, what should have been dedicated to procuring commodities was spent in other ways.

A scramble ensued in 2014 to procure family planning commodities through KEMSA (Kenya Medical Supplies Authority). Donors, including USAID, the United Kingdom, Germany, and UNFPA, had to step in and fully fund commodities, a reversion to the early 2000s when Kenya was entirely dependent on donors for family planning commodities. Many contend that this power of procurement should never have been devolved in the first place, given the inherent complications and limited bargaining power of the 47 individual counties, and that procurement of other essential commodities, including ARVs and vaccines, were not devolved.<sup>86</sup> While the line item has been reestablished in the federal budget at a very modest \$500,000, confusion at the county level and disagreement over whether or not this responsibility should be restored to the national government remains a topic of debate. While Kenya’s donors, including USAID, stepped up to fill this year’s funding gap for commodities, it is already clear that there will be gaps in the coming years. In addition, continuing supply chain problems through KEMSA result in barriers to access.

## Donor Landscape

USAID has historically worked with other donors—notably the UK’s Department for International Development (DFID), UNFPA, and Germany’s KfW—to coordinate family planning investments and support national objectives. The majority of family planning commodities are supported by USAID (approximately 34 percent), UNFPA (26 percent), KfW (19 percent), and DFID (16.7 percent), with the government of Kenya contributing a small amount (2.9 percent).<sup>87</sup> After USAID, DFID has the next-largest bilateral program on family planning and is also the FP2020 donor focal point in Kenya, along with UNFPA. It remains to be seen how the PEPFAR transition will affect other donor funding, including the Global Fund for AIDS, Tuberculosis and Malaria.

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<sup>83</sup> K4Health, “What Is Commodity Security?,” <https://www.k4health.org/toolkits/contraceptive-security-committees/what-commodity-security>.

<sup>84</sup> CSIS interview with Nicholas Muraguri, director of medical services, Ministry of Health, Nairobi, September 11, 2015.

<sup>85</sup> CSIS interview with Josephine Kibaru, NCPD director, Nairobi, September 11, 2015.

<sup>86</sup> In fact, ARVs and vaccines were supposed to be devolved as well, but the governors agreed to have the national government support this component.

<sup>87</sup> CSIS interview with UNFPA, Nairobi, September 15, 2015. Before devolution took effect in 2013, the Kenyan government was supplying close to 40 percent of the family planning commodities.

## FP2020

FP2020 is a global partnership that was launched at the 2012 London Summit on Family Planning. Kenya was among more than 20 governments that made commitments to address the various barriers to women accessing family planning information and services. It adopted a target to increase contraceptive prevalence from 46 percent in 2009 to 56 percent in 2015 and 70 percent in 2030, goals that were reflected in its subsequent National Costed Implementation Plan. A number of FP2020 partners, including Advance Family Planning (led by Jhpiego) and Health Policy Project (led by Palladium), are very active in Kenya, working to increase the capacity of Kenyans to develop and carry out advocacy strategies that advance the importance of family planning to national and local leadership.\* They also engage with policymakers at the national and county level to ensure political commitment and increased investment in family planning.

\* See FP2020, <http://www.familyplanning2020.org/>.

The biggest new development in financing for family planning and maternal-child health is the Global Financing Facility (GFF), launched at the Financing for Development Conference in Addis Ababa, Ethiopia, in July 2015. This initiative was designed to finance the UN secretary general’s “Every Woman Every Child” initiative and to close the estimated \$33 billion annual funding gap globally.<sup>88</sup> At the launch, the GFF announced that it had aligned \$12 billion in resources—domestic and international, public and private—for the four “front runner” or first-round countries, including Kenya,<sup>89</sup> although the ultimate goal is to assist 62 high-burden countries.<sup>90</sup>

The GFF concept note recognizes the importance of family planning: “Ensuring the availability of certain services—such as family planning, prenatal care, skilled care at birth, reproductive health care after delivery and a range of services for adolescents—is key to preventing maternal deaths and improving the quality of life for woman and children.”<sup>91</sup> The GFF is being coordinated by the World Bank, and is expected to combine external support, domestic financing, and innovative sources for resource mobilization (including the private sector), to focus on “smart financing” of proven, high-impact interventions, including family planning.

According to the World Bank, in low-income countries transitioning to middle-income

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<sup>88</sup> World Bank, “Global Financing Facility in Support of Every Woman, Every Child,” <http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/GFFExecutiveSummaryFINAL.pdf>.

<sup>89</sup> Donors including the Bill & Melinda Gates Foundation, Canada, Japan, and the United States announced new financing commitments of \$214 million, in addition to previous commitments by Norway of \$600 million and Canada of \$200 million. See World Bank, “Global Financing Facility Launched with Billions Already Mobilized to End Maternal and Child Mortality by 2030,” July 13, 2015, <http://www.worldbank.org/en/news/press-release/2015/07/13/global-financing-facility-launched-with-billions-already-mobilized-to-end-maternal-and-child-mortality-by-2030>.

<sup>90</sup> The next group of countries eligible to benefit from the global trust fund will be Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal, and Uganda. See Ariel Pablos Mendez, “Sustainable Finance Key to Health Equity,” USAID, July 16, 2015, <https://blog.usaid.gov/2015/07/sustainable-finance-key-to-health-equity/>.

<sup>91</sup> World Bank, “Concept Note: A Financing Facility in Support of Every Woman Every Child,” September 2014, <http://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/ConceptNote-AGlobalFinancingFacilitySupportEveryWomanEveryChild.pdf>.

status, such as Kenya, the GFF will encourage domestic resource mobilization for family planning and maternal-child health in preparation for the decline of external assistance. This will also involve transitioning from donor grants to International Development Association (IDA) credits and the International Bank for Reconstruction and Development (IBRD) loans.<sup>92</sup> A GFF Trust Fund has been established, funded by Canada, Norway, and the Bill & Melinda Gates Foundation. The World Bank expects that every \$1.00 in Trust Fund grants will leverage \$4.00 in IDA financing, so as to avoid displacing domestic resources.<sup>93</sup>

Some U.S. officials in Kenya indicated that the push to shift IDA credits to family planning and maternal-child health issues may leave gaps in resources for other sectors, although that is a negotiated process between the World Bank and the Kenyan government. “It’s a work in progress still,” one U.S. official told us.<sup>94</sup> USAID is expected to contribute \$50 million into “the financing platform” in the four front-runner countries, by aligning funding to country investment cases.<sup>95</sup> The United States is not contributing directly to the GFF Trust Fund and the financing modalities for GFF in Kenya have not yet been defined. However, the U.S. contributions are likely to be in the form of direct grants through country-specific trust funds, designed to complement the global Trust Fund. According to U.S. officials, this is to ensure that U.S. funds are controlled by USAID missions for country-specific results. The \$50 million is not necessarily “new” money; the funds are drawn from a combination of core and country-specific health budgets for family planning and maternal-child health, and directed toward specific components of the countries’ investment case. Supported activities may include capacity building, technical support, and results-based financing programs in the health sector.<sup>96</sup>

Kenya has developed a draft GFF strategy that, after advocacy from stakeholders and civil society, includes a focus on family planning as part of its investment case. However, as one Kenyan family planning advocate put it, “The big question is what [the GFF] will bring, and how much it will bring to family planning.”<sup>97</sup> As the Kenyan government builds its investment strategy and puts forth a projected budget for family planning services, ongoing transparency will be key to ensuring that family planning remains a priority area.<sup>98</sup> Country-level advocates questioned how the GFF might adversely impact bilateral funding for family planning.

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<sup>92</sup> Ibid.

<sup>93</sup> Tim Evans, “The Global Financing Facility: A Pathfinder for Post-2015 Financing for Development,” Summer 2015,

[http://onlinedigeditions.com/article/The\\_Global\\_Financing\\_Facility%3A\\_A\\_Pathfinder\\_For\\_Post-2015\\_Financing\\_For\\_Development/2018391/260337/article.html](http://onlinedigeditions.com/article/The_Global_Financing_Facility%3A_A_Pathfinder_For_Post-2015_Financing_For_Development/2018391/260337/article.html).

<sup>94</sup> CSIS interview with U.S. government official, Nairobi, September 14, 2015.

<sup>95</sup> Ariel Pablos-Mendez, “Sustainable Finance Key to Health Equity.”

<sup>96</sup> Email communication with USAID, October 30, 2015.

<sup>97</sup> CSIS interview with family planning advocate, Nairobi, September 9, 2015.

<sup>98</sup> Ministry of Health, Government of Kenya, “Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework,” 48, June 18, 2015. It is important to note that the Kenyan government projections for the resources required for family planning services were reduced significantly between its draft strategies from June and September, which some attribute to a change in

Advocates in Kenya, as well as the National Council for Population and Development, worked hard to make the case to the Ministry of Health to include family planning in the country's GFF strategy: originally, it just covered maternal health, essential obstetric and emergency care, and newborn care. Key advocates within the government included Dr. Kibaru, who said, "I had to talk myself dry" to make sure family planning was included.<sup>99</sup> Ministry of Health officials noted that the GFF covers all family planning and maternal-child health issues and nutrition, and said that "family planning is still a pillar of anything maternal health."<sup>100</sup>

## Conclusion and Recommendations for U.S. Policy

This is a critical time for U.S. support for family planning and maternal-child health in Kenya. Important successes are potentially put at risk by the dual impacts of devolution of health services and shifts in U.S. funding for integrated services through PEPFAR. As long as the United States relies so heavily on PEPFAR to support countries' efforts to reach their broader health goals, it will be vulnerable to the kinds of changes underway in PEPFAR strategy that alter the playing field significantly. Careful oversight will be key to ensure that the United States continues to support important innovations that expand access to quality, integrated family planning and maternal-child health services, with the aim of establishing more ample, secure, and dedicated U.S. funding to achieve these goals.

At the same time, the United States will need to heighten its engagement with the national and county governments of Kenya, and its support for civil society groups focused on accountability for health, to ensure that Kenya mobilizes domestic resources for family planning and maternal-child health in an informed and accountable manner.

To support the viability and sustainability of Kenya's family planning program, the United States should consider the following policy options:

- **Mitigate the impact of the PEPFAR pivot on integrated family planning-maternal and child health-HIV services in Kenya.**

The United States faces a complicated problem in addressing the impact of changes in PEPFAR strategy on family planning and maternal-child health services, with implications not only for Kenya but for other PEPFAR priority countries as well. U.S. agencies will have to engage in careful deliberations and planning at two levels: first, at the country level, to allocate short-term transition resources to avoid the collapse of these services while directly engaging with the Kenyan national and county governments to increase their mobilization of domestic resources for family planning, including in areas affected by PEPFAR's pivot. Second, a higher-level clarification of

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how the commodities are calculated. Whatever the explanation, the apparent shifts in the draft investment case highlight the importance of ongoing scrutiny and accountability.

<sup>99</sup> CSIS interview with Josephine Kibaru, Nairobi, September 11, 2015.

<sup>100</sup> CSIS interview with Kigen Bartilol, Nairobi, September 11, 2015.

U.S. policy involving the White House, PEPFAR, and USAID as to how the United States can mitigate the impact of PEPFAR’s refocus will help to ensure the viability of family planning and maternal-child health programs in PEPFAR-focus countries.

- **Support more sustainable family planning programs by building county-level capacity, with particular focus on ensuring access for vulnerable populations.**

The United States has an important role to play in assisting Kenya to build county-level capacity to manage the new health landscape under devolution, including budgeting, training healthcare workers to provide the full range of family planning methods (including long-acting methods), and building accountability for quality services. This will be especially critical to address the unmet need for family planning among vulnerable populations, such as adolescent girls and young women and the urban and rural poor, and to strengthen the community health workforce.

- **Address longer-term financing for family planning and maternal-child health by strengthening accountability around mobilizing domestic resources, and expanding quality, private-sector services for family planning and maternal-child health.**

In this rapidly changing environment around financing for family planning and maternal-child health, the United States should be clear about where its support can be most effective and yield the biggest impact. This means working with Kenya to ensure that family planning is included at every level of Kenya’s GFF strategy as part of broader investments in maternal and child health. Financing for family planning in Kenya should incorporate lessons emerging from the growing private sector and from public-private partnerships. The United States should heighten its global health diplomacy with the Kenyan government and with other public and private donors to address long-term financing for family planning and for integrated family planning-maternal and child health-HIV programming. This includes providing targeted support to Kenya—through the national and county governments, implementing partners, and civil society—to strengthen support for the mobilization and expenditure of domestic resources for family planning and maternal-child health.



Much is at stake in Kenya to improve access to family planning information and services, to scale up quality, integrated programs, and to transition to more sustainable financing. Given the importance of the U.S.-Kenyan bilateral relationship in health, development, and security, the future trajectory of U.S. support will have implications throughout the region and for other priority countries in family planning, maternal-child health, and PEPFAR.





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