

Kenya Trip Report

CSIS/CARE Joint Delegation to Kenya

August 10-12
2009



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CSIS Commission on Smart Global Health Policy

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Summary

Members of the CSIS Commission on Smart Global Health Policy traveled to Kenya from August 8–12 to get a snapshot of multiple U.S. health investments on the ground and gather perspectives on the core questions of impact, measurement, integration, and sustainability of current efforts. Overarching conclusions include:

- Combined U.S. investments in health have had dramatic impact—in HIV treatment and prevention, in moving the gender agenda forward, and in building incipient indigenous capacities. The U.S. mission in Kenya has a strong, integrated team that has been innovative and opportunistic in building partnerships and seeking new models to coordinate and integrate U.S. investments for maximum impact, coverage, and efficiency.
- There is a broadening of approach beyond HIV/AIDS, despite the heavy preponderance of HIV assistance in U.S. resource flows. Integration of efforts has had demonstrable effects in bolstering non-HIV services, particularly family planning and tuberculosis. But long-term management and expansion of integration efforts remain uncertain.
- U.S. partnerships and training have contributed to a growing cadre of technical and health professionals, but retention of health personnel, incentives, and adequate remuneration remain problematic.
- U.S. partnerships have also created a growing surveillance network and base of epidemiological analysis that will be critical to health responses and to measuring impacts. But measurement of outcomes and impacts remains an enduring challenge that warrants far greater attention and investment.
- Governance issues pose among the most challenging obstacles to mounting an effective national response. Health planning and expenditures, systems of procurement and oversight, political spillover into the health sector, and anemic country ownership of health programs all underscore the uncertainty around sustainability of current U.S. investments.
- Of particular concern in sustainability of investments is the growing “HIV mortgage” that increasing demand, access, and cost of HIV first- and second-line antiretroviral (ARV) therapy will entail. Currently the donor community shoulders 98 percent of this burden.
- The Kenyan government faces multiple human security challenges that affect health outcomes, including severe food insecurity, chronic water scarcity in parts of the country, spillover from regional conflicts, and a growing humanitarian crisis among refugees.

The CSIS Delegation

Members of the CSIS Commission on Smart Global Health Policy, led by commission cochair Helene Gayle (president and CEO of CARE) and Admiral William Fallon (USN ret.), traveled to Kenya for a three-day mission, in partnership with CARE, from August 8–12, 2009. The delegation focused on a core set of questions, ultimately intended to inform commission recommendations to U.S. policymakers in forging a long-term, strategic, and sustainable approach to global health investments in the developing world. Among the principal objectives were:

- To better understand impacts on the ground of multiple U.S. investments in health;
- To explore possibilities for greater integration across the various strands of U.S. support to maximize impact;
- To better grasp the obstacles and opportunities for improving maternal/child health, which in Kenya, as elsewhere, has remained an enduring and often neglected health challenge; and
- To hear from U.S. implementers and Kenyan partners how best to plan for long-term sustainability and impact of current efforts.

In the course of the visit, the delegation met with a broad range of players, including U.S. officials, Kenyan government officials and public health workers, nongovernmental and community-based organizations, and individual beneficiaries of U.S. assistance. Members spent the first day in Nairobi in a series of briefings and site visits to urban-based health facilities and interventions. On the second day, the delegation broke into three groups, travelling to Mombasa and environs in Coast Province, Kisumu and environs, and later Muhuru Bay in Nyanza Province, and Eldoret in Rift Valley Province, getting a broad sense of U.S.-Kenya partnerships and interventions at the provincial and community level. Given the compressed time frame of the visit, the mission was not intended as a comprehensive assessment of U.S. assistance, but rather an effort to garner, from a diverse set of actors on the ground, perspectives on the core questions of impact, measurement, integration, and sustainability.

The Kenyan Context

Kenya has yet to recover from the crisis that followed the December 2007 election. A coalition government, forced on the parties in the aftermath of the crisis, remains fragile and stalemated on a core set of key reforms. This standoff preoccupies the country's leadership and has further politicized a number of important sectors, including public health. In expanding the cabinet to accommodate political stalwarts from both parties, the Ministry of Health was divided into a Ministry of Public Health and Sanitation and a Ministry of Medical Services, creating additional costs and considerable bureaucratic confusion.

Kenya has been a reliable long-time partner of the United States—in security cooperation, in serving as regional conduit for humanitarian assistance, in taking the lead on a number of conflict mediation efforts, and since the al Qaeda attack on the U.S. embassy in Nairobi, as a

partner on counterterrorism in the Horn of Africa. More recently, the relationship has become more tense, with the Obama administration threatening to impose travel sanctions on a number of key political leaders accused of stalling on reforms. The overall U.S.-Kenya relationship is sufficiently complex and robust that it will likely withstand the current contretemps, but progress on reforms, reconciliation, and fundamental change in Kenyan's political culture remains highly uncertain.

Kenya is unusual in U.S. health engagement—in the breadth of its investments and the longevity of the partnership. The Walter Reed Army Institute of Research, through the U.S. Army Medical Research Unit–Kenya (AMRU-K), has had a presence in the country since 1969, initially focused on trypanosomiasis and now encompassing much broader cooperation with the Kenyan Medical Research Institute (KEMRI) on a range of parasitic and infectious diseases. The U.S. Agency for International Development (USAID) managed a robust and successful set of programs in family planning beginning in the 1970s. The U.S. Centers for Disease Control (CDC) has partnered with the KEMRI since 1979, conducting research on Kenya's major health challenges and training a significant cadre of scientists, clinicians, laboratory technicians, and field workers. Today Kenya boasts the largest CDC operation outside of Atlanta, with some 1,300 Kenyan employees. The advent of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in 2004 resulted in an exponential expansion in U.S. HIV support to Kenya, which increased from \$34 million in 2003 to \$534 million in 2009. This infusion dramatically shifted the focus of U.S. assistance, with investments in HIV dwarfing other programming. In 2008, \$534 million was targeted to HIV, \$3.4 million to material and child health (MCH), and \$13 million to family planning (which increased to \$17 million in 2009). The overwhelming focus on HIV, the delegation was told by several Kenyans, has eclipsed much needed attention to family planning, which traditionally was a major focus of U.S. support, and MCH, which has remained chronically underfunded.

This multiplicity of efforts generated early interest among implementers on the ground to integrate and coordinate efforts for greater impact, and thus Kenya offers an interesting case study on the challenges and potential of integration and the comparative advantage of various forms of U.S. investment.

The APHIA project (AIDS, Population, and Health Integrated Assistance), now in its second phase in Kenya, was initially intended in the 1990s to build into U.S. investments in family planning greater attention and capacities on HIV/AIDS. With the advent of PEPFAR, the balance shifted, and the APHIA II project seeks to build, through PEPFAR funding, an expanded platform into which TB, malaria, MCH, and family planning services can be integrated. The intent is for this approach to build economies of scale, facilitate referrals from one service to another, and strengthen both physical and human health infrastructure. A second component of APHIA II is to better link communities and individuals to HIV-prevention services and to expanded facilities by investing in community networks and private or faith-based organizations.

Key Findings in Brief

Impact and Integration

Measuring long-term impacts of U.S. investments in health in a comprehensive way remains an enduring challenge. Nonetheless, the infusion of PEPFAR funding has had clear impact on individuals' lives.

Some 190,000 Kenyans now receive antiretroviral therapy supported by PEPFAR, and the program has established 700 treatment sites and over 2,000 counseling and testing sites throughout the country. Coverage with prevention of mother-to-child transmission (PMTCT) is near universal. Prevention services have also expanded dramatically. In Nyanza Province, there has been a dramatic uptake of adult male circumcision. U.S. funding has established 120 sites performing the procedure, which to date over 20,000 men have opted for. In Nyanza and Coast Province, the delegation met with several groups of people living with HIV, who with U.S.-supported treatment are living productive working lives, caring for their children, and active in their communities as health workers combating stigma, encouraging HIV counseling and testing, and providing information on a range of health services, and linking communities with health care facilities and services.

PEPFAR support goes beyond treatment and preventions services. Increasingly the program provides wraparound services, technical support and training, commodity procurement, and health infrastructure rehabilitation.

Daunting challenges remain. Currently more than 110,000 people living with HIV are in need of antiretroviral therapy, and there remains a significant treatment-prevention gap. Increasing demand for ARV treatment, costly second-line therapies, and new research that indicates that HIV-positive individuals should start treatment earlier in their disease, all contribute to a costly “HIV treatment mortgage” that will continue to grow.

Prevention efforts among most-at-risk groups remain problematic. Injecting drug use (IDU), a growing problem in Coast Province, is illegal and highly stigmatized, and both needle exchange and replacement therapy are prohibited. Staff at an IDU outreach and recovery center in Mombasa outlined the difficulties in getting attention, resources, or cooperation from authorities on this issue. Homosexual sex remains illegal, highly stigmatized, and secretive; in Coast Province, the delegation heard, one outreach center was shut down by local religious leaders because it offered educational materials targeting men who have sex with men (MSM). It is estimated that up 80 percent of all HIV-positive persons in Kenya remain unaware of their status.

Given the imbalance in U.S. funding flows, U.S. institutions on the ground—PEPFAR, CDC, USAID, AMRU-Kenya—have made a concerted effort to better rationalize efforts and integrate services where possible through the APHIA program. Said one CSIS commissioner, “the relationships among [these agencies] may not be perfect, but they are as good as I have ever seen elsewhere.”

The delegation visited APHIA II in Coast Province, which provides integrated services for HIV/AIDS, sexually transmitted infections, MCH, family planning, TB, and malaria. The program has worked with the World Food Program to provide food supplements to vulnerable HIV-infected families. At Mariakani District Hospital in Coast Province, family planning services uptake has increased by 25 percent, which hospital administrators attribute to integration of services. The integration of family planning into APHIA sites has doubled the number of U.S.-supported family planning sites country wide. However, there is a substantial unmet need for family planning throughout the country, estimated at 60 percent among HIV-positive women.

Overall, there is a strong impression that APHIA is making a difference: in building economies of scale—sharing laboratories, procurement systems, and communication; in improving referrals, particularly in family planning and in TB; in better using scarce personnel; and in streamlining U.S. investments in a way that makes it easier for local health officials to track and manage. Said one commissioner, “This is how the new PEPFAR should be shaped.” The Kenyan integration model is still very much in its early state, and it remains to be seen how these models will be managed effectively and brought to scale.

Beyond the immediate health impacts, there is evidence of overall capacity impact in training, in building surveillance systems, and in creating a baseline of data that can ultimately be used to better measure impact of health interventions.

The longstanding partnerships between CDC and KEMRI and AMRU-K in Nyanza have built a remarkable cadre of lab technicians and epidemiologists, able, through extensive surveillance networks, to better inform national policy on health trends and disease patterns. These partnerships are credited with significantly improving reporting and response time to the 2006–2007 outbreak of Rift Valley fever, which in previous episodes had had devastating human and economic impact. Such surveillance capacity will be critical in tracking emerging infections, and already there is greater confidence in Kenya’s ability to track and control the H1N1 (“swine flu”) virus. In Nairobi, through Carolina for Kibera’s Tabitha Clinic, CDC aggregates data collected by the clinic and a cadre of health workers going door to door, data that will be invaluable in understanding health trends among the urban poor and in better targeting interventions.

AMPATH—Academic Model Providing Access to Care—in Eldoret, provides an alternative model for integrating programs, based on a consortium of Kenyan institutions. Moi University Teaching and Referral Hospital, together with Moi University School of Medicine and the Kenyan Ministry of Health, provides clinical care, training, research, and capacity building within neighboring communities. Originally established to prevent and treat HIV/AIDS, the partnership, with significant external funding, now works to address associated challenges of disease, hunger, and poverty through agriculture and rural development projects, supplemental feeding, and economic development training. This partnership provides training for medical doctors and health professionals from across Kenya. AMPATH leadership has fostered partnerships with U.S. universities, corporations, and private foundations.

Sustainability: Country Ownership

The sustainability of U.S. investments remains a major uncertainty, tied both to the growing “HIV mortgage” and to questions of governance and increasing Kenyan government ownership. The delegation visited a number of highly successful global health projects—Tabitha Clinic in Kibera, AMPATH in Eldoret, the KEMRI partnerships—which clearly have important immediate and spin-off impacts, but remain largely dependent on external assistance in resourcing, management, and technical assistance.

The networks of community health and outreach workers are impressive in their energy, commitment, and impact, but most of these workers receive minimal support and maintain full-time jobs to support themselves and their families. Health sector employees need to be incentivized, remunerated, and offered career development opportunities that build the desired competencies and work products. Trained hospital administrators are in short supply—most often a medical doctor has taken on the role and learned on the job, and there are currently no degree programs in health management available in Kenya. A number of the very successful sites visited by the delegation were the result of one group or individual’s commitment and compassion. While laudable, ultimately developing an accountability and reward structure that provides incentives to improve care is essential for long-term success. The role of civil society and community-based organizations will remain critical to the overall success and sustainability of the effort. Only by tapping into the insights and skills of such groups can the United States and other donors be assured that their programs will be well targeted and of benefit to the intended population.

Investments in the health sector will have diminishing marginal returns if other critical sectors are not adequately addressed. During the delegation’s visit, Kenya was in the midst of a water emergency—due to failure of rains and environmental degradation—and a food crisis. “In my district,” said one parliamentarian, “the most basic and most needed health intervention is access to water.” Another Kenyan analyst emphasized women’s education, as “an intervention that unlocks a whole range of improvements in health and health access.”

Ultimately, the sustainability of current and future efforts will depend on the Kenyan governance context. The split of the Health Ministry—a split that divides health administration down to the district level—was done for political rather than pragmatic reasons. The split has increased costs, confused local health officials as to distinct roles and responsibilities, and lessened accountability by both ministries.

The Kenyan procurement institution, KEMSA, is deeply dysfunctional, and a number of sites visited by the delegation were experiencing stock-outs in critical supplies. The Ministry of Health in previous years has returned some 35 to 40 percent of its annual budget unspent, and there is a sense in certain areas, especially in ARV provision (currently 98 percent dependent on donors), that the government sees donor support as a continuing given.

Many of these governance issues go well beyond the health sector. Isolated U.S. health assistance to Kenya, even if better integrated and expanded, will not alone be sufficient to reverse the impact of poor governance and policy failures. U.S. engagement that prioritizes competent and accountable governance, service delivery, greater planning capacity, and system reform should undergird a more robust and strategic approach to global health investments.

The Gender Lens

Gender equity and women's empowerment has gained greater attention within the Kenyan health agenda. Women are increasingly accessing HIV services: 42 percent of Kenyan women have been tested for HIV versus 28 percent of men. Gender indicators are now part of the national HIV/AIDS plan, and the National AIDS Coordination Council has a gender task force that operates at the national level. There is a much clearer focus on prevention for women in the national plan and recognition of the need to improve "life skills" through education and training to empower negotiation of sexual relations. The delegation visited a range of projects addressing different aspects of women's vulnerabilities. These included savings and loan cooperatives in Kibera and Siaya District in Nyanza, targeting caretakers of orphans and vulnerable children; income-generating activities for at-risk women and former commercial sex workers through the Lifeworks program in Mariakani, Coast Province; and the WISER project in Muhuru Bay, Nyanza, which seeks to provide a safe and secure learning environment for very low-income young women and girls.

U.S. funding for family planning has seen a slight increase, and integration with other services has had an important impact, but again and again the delegation heard that access to family planning is a key to women's health and empowerment and warrants far greater attention than it currently attracts.

The incidence of sexual violence against women remains high, after a spike during the postelection violence of 2008. The Kenya Sexual Offences Act, was passed in July 2006 but remains unevenly and half-heartedly implemented. The delegation visited the Sexual Based Violence Center at the private Nairobi Women's Hospital, which offers free counseling and health services for survivors of sexual violence. The center, which is on the high end of the health scale, provides extensive long-term psychosocial support and comprehensive care, including PEPFAR-supported ARV treatment and post-exposure prophylaxis. The center is heavily dependent on donor funding and may not be replicable on a national scale. Nonetheless, the center's collection of data on incidences of sexual violence helped drive the sexual offences legislation; center staff work with local police forces on handling incidents, on tracking "hot spots" in Nairobi, and on processing evidence; and the center trains health workers at other facilities in counseling and treating survivors. There are currently 19 post-rape treatment centers country wide. Scaling up in an effective and sustainable way is critical, but equally important are addressing cultural norms, government response, and implementation of existing legislation.

Dadaab: Health and Security Impacts of a Regionalized Conflict

Kenya sits within a highly volatile and unstable region, and regional insecurity—in Sudan, Uganda, Ethiopia, and Somalia—has at various times threatened Kenya’s own security. The conflict-driven insecurity in Somalia is the most recent threat, with massive humanitarian displacement and a powerful Islamist insurgency, both of intense concern to Kenyan security officials. Commissioner Keith Ellison visited Dadaab refugee camp, which offers a stark illustration of the security and health challenges that regional instability is having on already fragile communities, ecosystems and health systems, and water resources in northeastern Kenya. The Dadaab camps, initially built to house 90,000 refugees, are now home to 300,000, with some 3,000 to 6,000 new arrivals each month. The problem of water scarcity, food insecurity, overburdened health facilities, diseases borne of overcrowding and poor sanitation, the vulnerability of women, and cultural barriers to health access are distilled in this bleak, arid, and remote setting within Kenya. Sensitivities and resentment among local communities and serious security worries by Kenyan authorities add to the difficulties of effectively addressing the immediate problems and challenges of the camps’ 300,000 inhabitants. Ultimately, Dadaab is a manifestation of regionalized challenge whose ultimate solution rests with the internal stability of Somalia itself.

The camp is beyond its capacity, and stresses are most immediately evident in health—with periodic cholera outbreaks and a current tally of 46 measles cases. Overcrowding and poor sanitation and waste disposal facilities add to the risk. With the closure of the border, the main border transit center has shut down and with it medical screening for incoming refugees, who might otherwise receive treatment prior to integrating within the camp. Insecurity at the camp, particularly spousal abuse and sexual assault, has increased. Maternal/child health remains a stubborn challenge, despite some improvements. Dr. Ibtisam Salim, the dynamic doctor-in-charge at Ifo Hospital talked about the cultural norms and fears that keep many women from accessing antenatal care, coming to hospital for delivery, or waiting until it is too late. In many instances, women in labor are pressured by family members not to allow caesarian sections. One mother, whose wheezing newborn was suffering from pneumonia, would not allow her child to receive oxygen, fearful that it would do more harm than good. Hospital and UN Refugee Agency staffs are valiant in their efforts to serve inhabitants of Dadaab camp as best they can, but the sheer numbers of those they serve is overwhelming.