

2005-6 Baseline Assessment for the CRTU Program: Reproductive Health and Family Planning in Kenya

April 2006



Graphic: USAID



Graphic: CIA World Factbook, 2005



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Executive Summary

Introduction

FHI was awarded the Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU) by USAID in 2005. The CRTU's goal is to expand the range and increase the use of safe, effective, acceptable, and affordable contraceptive methods and reproductive technologies, delivered through high-quality family planning and reproductive health services in developing countries. By concentrating its resources in a few carefully selected countries, the CRTU strives to maximize the public health impact of its work. FHI will identify and prioritize local research and program needs within these selected focus countries, develop and implement country work plans that address those needs, foster collaborative partnerships with local groups, and facilitate the translation of research into practice. For many reasons, including FHI's long and successful program there, Kenya was quickly identified as one of the CRTU's focus countries.

This report provides the first baseline assessment of a focus country. It is intended to serve two primary purposes: 1) as a resource for CRTU staff and colleagues who are working together on research, research utilization, and other reproductive health activities in Kenya under the CRTU; and 2) as a tool to assess and document changes in Kenya over the course of the five-year CRTU program.

The assessment compiles information from key resource documents and synthesizes the most recent qualitative and quantitative data on family planning and reproductive health in Kenya, with special attention paid to the integration of HIV and family planning services. In addition, this report summarizes on-going work under the CRTU, as well as results of the first CRTU stakeholders' meeting, in which the Ministry of Health (MOH), partner cooperating agencies (CAs), and health providers identified areas for the CRTU to address. These priority areas, coupled with the CRTU's own goals and outcomes and shaped by partnerships and funding realities, will inform and influence the future course of work in Kenya under the CRTU.

Highlights of Current Family Planning and HIV/AIDS Trends and Issues in Kenya

- Between 1998 and 2003, contraceptive use increased only slightly among married women in Kenya, from 39 to 41 percent. This was in contrast to the trend seen between 1984- 1993 when use of modern methods rose from 10 to 32 percent among married women.
- Currently, 45 percent of the population is under 14 years of age. This means that a large cohort will soon reach reproductive age, when people are most in need of family planning, HIV prevention, and reproductive health services.
- Knowledge of contraception is very high; approximately 95 percent of currently married Kenyan women know of at least one modern family planning method.
- The current national family planning method mix is heavily weighted toward short-term contraceptive methods, despite systematic difficulties with their procurement and distribution. Meanwhile, a shortage of service providers and inadequate attention and resources devoted to developing providers' skills diminish the quality of care.
- DMPA is the most widely used method by in-union women and is also the method with the greatest increase in use between the 1998 and 2003 DHSs. A new implant, Jadelle, is now available on a very limited basis. The IUD is the focus of renewed attention, and FHI and the MOH continue their efforts to improve knowledge of and access to this long-acting method.
- The Kenya MOH's national [Family Planning Guidelines for Service Providers](#) were last revised in March 2005. To a large extent they mirror the *WHO Medical Eligibility Criteria Guidelines*, although some exceptions are noted in this report.

- The number of NGOs and community-based distribution programs offering a range of family planning services has declined recently due, at least in part, to additional funding restrictions by donors.
- In March 2003, the POLICY Project conducted a [Country Analysis of Family Planning and HIV/AIDS: Kenya](#), which concluded that there has been an apparent and deliberate shift toward HIV/AIDS on all program levels, at the expense of family planning programs. Family planning, they reported, has fallen off the national agenda.
- As of December 2005, there were 12 different subprojects in Kenya affiliated with the CRTU. Of these, five were supported with USAID “core” funds, four with PEPFAR funds, and three with field support funds. Information about these and other Institute of Family Health subprojects is contained in Table 2 of this report.

Integration of HIV/AIDS and Family Planning Services

- Women are disproportionately affected by Kenya’s HIV epidemic. Of the 1,100,000 adults currently living with HIV in Kenya, 720,000 of them are women, and HIV prevalence among women (8.7 percent) is nearly twice the prevalence among men (4.5 percent).
- A deteriorating health care system limits access to both family planning and HIV/AIDS services and compromises the quality of both services. Integrating family planning and HIV/AIDS services offers an opportunity to make the best use of available financial and human resources to provide comprehensive, convenient health care.
- Kenya is on the forefront of research on and efforts to further integrate of HIV/AIDS and family planning services. Despite this, family planning services are not currently available through most PMTCT services nor are antiretroviral treatment services. Most integration efforts have centered on incorporating family planning messages in counseling and testing services.

Adolescent Reproductive Health

- Given that adolescents – or even more broadly, youth up to the age of 24 – are such a significant proportion of Kenya’s population, research and reproductive programs need to include special consideration for this group. Numerous national policies that pertain to youth are in place.
- A [YouthNet assessment](#) on reproductive health and HIV/AIDS programs for youth in Kenya provides an excellent and more detailed reference.

USAID and Other Key Organizations in Kenya

- USAID Mission funds for HIV/AIDS, population, and health dropped from US \$34.9 million in 2004 to US \$12.6 million in 2005. The goals of its population and health activities relate to “HIV/AIDS prevention, care, and support; family planning and child survival; health sector reform and health care financing.” Its activities are focused in the Western and Coast provinces. Links to several key USAID planning documents are contained in this report.
- Over the past five years, FHI’s Institute for Family Health has worked with several other CAs and local reproductive health organizations in Kenya, including the Population Council, JHPEIGO, IntraHealth, and the University of Nairobi’s Department of Medicine. In addition, FHI has collaborated with a number of nontraditional partners on YouthNet and CRTU projects.
- Numerous government entities play a role in the conduct of reproductive health work in Kenya. These include, but are not limited to, the Division of Reproductive Health at the Ministry of Health; the National AIDS Control Council, Office of the President; and the National Coordinating Agency for Population and Development. FHI’s Kenya office houses employees from both of FHI’s Institutes. Coordinating travel and CRTU activities with the Kenya office is

not only essential but also beneficial to projects given the experience and expertise of the in-country staff.

Priority Setting

Previous family planning and HIV/AIDS assessments concur with the current CRTU's stakeholders' opinions about improving political, financial, and programmatic support for family planning. These reports include call for:

- effectively integrating HIV/AIDS and family planning services
- addressing the shortage of trained health personnel with additional training and supervision and reviving the community-based distribution (CBD) program
- developing strategies to make reproductive health services more friendly and accessible to youth and further involving men in family planning
- encouraging stakeholder and private sector involvement in strategic planning and policy-making
- developing strategic plans to supervise, monitor, and evaluate service delivery points
- further implementing national health guidelines
- strengthening contraceptive procurement and distribution mechanisms

CRTU priorities, as identified by the stakeholders and the Program's own goals and objectives, are generally more sharply focused than the above recommendations. For example, while noting the need for training, stakeholders at the first CRTU meeting specified the need to improve providers' attitudes, skills and confidence to provide long-acting methods as well as hormonal contraception. They also suggested expanding the type of providers who could provide long-acting and permanent methods. Additional priorities identified at the first CRTU stakeholders meeting in Kenya are listed at the end of this report.

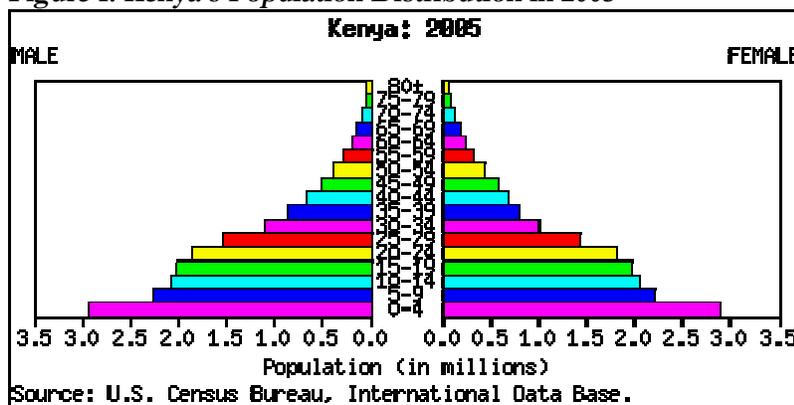
Ultimately, it is necessary to marry the realities of limited resources – human and financial – with both the priorities identified by all stakeholders, and with the outcomes which the CRTU is striving to achieve. It is intended that this document will serve as resource to those developing and implementing CRTU activities in Kenya, in addition to providing a “baseline” against which to measure changes over time. To the extent it is used to inform the difficult task of prioritizing future activities, then it will have served an even further purpose.

Land and Population

Kenya is an East African country situated between Tanzania and Somalia on the Indian Ocean, occupying a total land area of 569,250 square kilometers¹. Its population totals 33.8 million². Kenya has a considerably higher population density (59 people per square kilometer) than that of its neighbors, Tanzania (42) and Somalia (14), though it has less than half the population density of Uganda (137), its neighbor to the west.

Kenya has a very young population (see Figure 1), with the largest age stratum belonging to the group of people under 5 years old. According to the [UNFPA's Kenya profile](#)³, life expectancy has decreased from 58 years in 1990 to 49 years in 2005, largely due to the HIV/AIDS pandemic.

Figure 1: Kenya's Population Distribution in 2005



Most Kenyans reside in the country's rural areas and subsist by means of farming and animal herding. According to the World Bank, poverty in Kenya has risen from 49 percent of the population in 1990 to more than 56 percent in 2003. In 2004, the average annual income was US\$ 480 per person⁴.

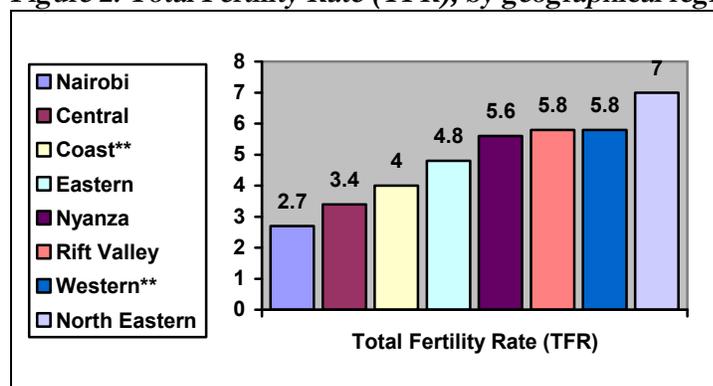
The majority (98 percent) of Kenya's citizens are affiliated with the country's 32 major indigenous ethnic groups. The five largest – Kikuyu, Luo, Luhya, Kamba and Kalenjin – account for 70 percent⁵.

Reproductive Health Demographics

Women of reproductive age (age 15-49 years) currently make up 51 percent (17.24 million⁶) of Kenya's total population. Among 15-19 year old girls, 17.5 percent of those living in urban areas and 21.8 percent of those in rural areas have already begun childbearing⁷.

Kenya has seen great improvements in reproductive health in the last 25 years. The Total Fertility Rate (TFR) in Kenya fell by 40 percent since 1980, from eight lifetime births per woman to its current five⁸. High rates of fertility continue to occur among women with the lowest educational levels and those living in rural areas, particularly in the Rift Valley, Western and North Eastern regions of the country. (See Figure 2). Note that the USAID Mission in Kenya focuses its activities in the Western and Coast provinces.

Figure 2: Total Fertility Rate (TFR), by geographical region. Kenya, 2003



Source: Kenya Demographic and Health Survey, 2003

** Province where USAID/Kenya focuses its activities.

The mean birth interval among Kenyan women is 32.6 months, with 40.6 percent of births spaced at least three years apart⁹.

Despite its achievements in reproductive health, the country will face population-related challenges given the extremely large cohort of young people that will soon reach reproductive age. Currently, 45 percent of the population is under the age of 14 years¹⁰. Meanwhile, national family planning services, contraceptive supplies and reproductive health education continue to inadequately meet the country's needs.

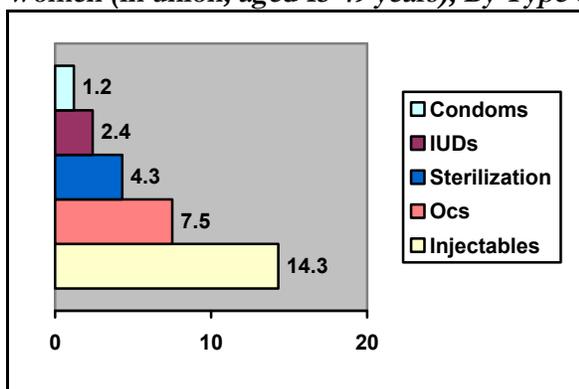
For more information on Kenya's reproductive health demographics and fertility trends, refer to Chapters 4 and 5 of the [Kenya Demographic and Health Survey](#).

Family Planning Use

Knowledge and Use

Knowledge of at least one modern family planning method is high (95.3 percent) among currently married Kenyan women¹¹. In general, Kenyan women know more about modern methods than traditional methods¹². The three most widely known methods among married women include injectables (93.5 percent), oral contraceptive pills (93.1 percent) and male condoms (91.6 percent). Yet only 31.5 percent of married Kenyan women aged 15-49 currently use any modern family planning method¹³. Of all contraceptives, injectables are the most widely used method by in-union women, at 14.3 percent. (See Figure 3.)

Figure 3: Percent Distribution of Current Use of Modern Family Planning Methods by Kenyan Women (in union, aged 15-49 years), By Type of Family Planning Method.

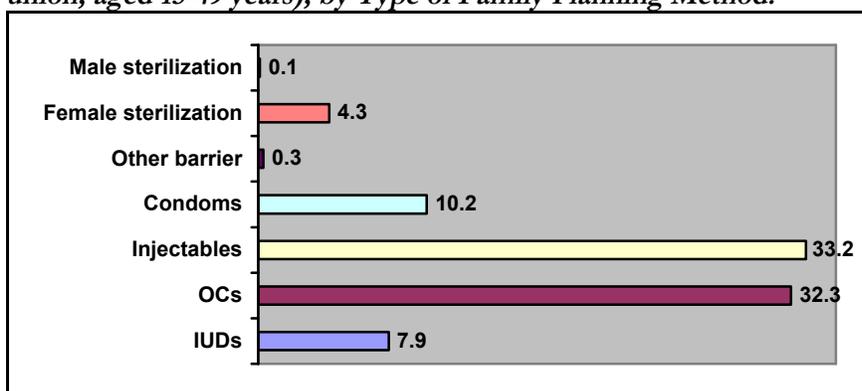


Source: Kenya Demographic and Health Survey, 2003.

Over half of the currently married female population (55.1 percent)¹⁴ has ever used a modern family planning method. Oral contraceptives and injectables are by far the most widely used methods among this group. (See Figure 4.) The popularity of the pill is declining, while for use of injectables is on the rise¹⁵.

With respect to method mix, one of the most significant trends has been the increase in the percentage of Kenyan women using injectables, from 7 to 15 percent between 1993 and 2003¹⁶. Injectable use is associated with low educational levels, residence in rural areas and partner disapproval of family planning¹⁷.

Figure 4: Percent Distribution of Ever Use of Family Planning Methods by Kenyan Women (in union, aged 15-49 years), by Type of Family Planning Method.



Source: Kenya Demographic and Health Survey, 2003.

Method Discontinuation

Family planning method discontinuation rates in Kenya are very high. Over one third (37.6 percent) of all family planning users in Kenya discontinue using within the first twelve months of beginning a method¹⁸. The methods with the highest discontinuation rates include male condoms (59.4 percent), oral contraceptives (46.2), periodic abstinence (33.3 percent) and injectables (31.8).

The most commonly reported reasons for discontinuation of any method in the five years preceding the 2003 survey were side effects (25.4 percent), wanting to become pregnant (23.3), becoming pregnant while using (15.7), and infrequent sex/husband away (7.5).

Informed choice is also an issue likely related to method discontinuation. Data from the 2003 KDHS suggest that less than half of family planning clients in Kenya are informed by health care providers about the side effects of family planning methods.

Barriers to Contraceptive Use

While contraceptive prevalence increased from 27 percent in 1989 to 39 percent in 1998, it rose only slightly to 41 percent in 2003.¹⁹

Women in Kenya continue to face barriers to accessing the family planning and medical services they need. According to the [2003 Kenya DHS](#), one quarter of Kenyan women have an unmet need for family planning, including 14 percent who would like to space their next birth and 10 percent who would like to limit births.

A 1996 study conducted by FHI in one urban slum area and one rural area in Kenya²⁰ found that common barriers to contraceptive use included:

...lack of agreement on contraceptive use and on reproductive intentions (within couples); husband's attitude on his role as a decision maker; perceived undesirable side effects; distribution and infant mortality; negative traditional practices and desires such as naming relatives; and preference for sons as security in old age.

Service provider practices such as menstruation requirements, which have no scientific justification, have also been barriers to contraceptive use in Kenya²¹. The next section discusses potential medial barriers found within Kenya's national family planning guidelines.

For more information on family planning use in Kenya, refer to Chapter 5 of the [Kenya Demographic and Health Survey](#).

Family Planning Program and Guidelines

Kenya was the first sub-Saharan African country to adopt a National Family Planning Program in 1967²². Since then, the country has benefited from a number of family planning successes, including a significant rise in contraceptive prevalence.

Kenya's Ministry of Health published the country's first family planning guidelines in 1997. The current national [Family Planning Guidelines for Service Providers](#) were last revised in March 2005 and are currently being disseminated to service providers throughout Kenya.

It is likely to be some time before use or impact of the current guidelines will be evaluated. However, a 2001 FHI study conducted among 177 health care providers from randomly selected health centers in Kenya found that only 45 percent of the providers had ever seen the national guidelines at that time, and only 29 percent had ever read them²³. Furthermore, only 25 percent of providers use the guidelines as a reference, while 20 percent refer to them sometimes or frequently.

Similarly, in October 2004, an FHI and Ministry of Health team conducted an assessment entitled [Family Planning Needs in the Context of the HIV Epidemic](#) and found that, in general, national

family planning guidelines in Kenya are neither distributed to nor carried out by health service providers. Current weakness in policy dissemination was attributed to high turnover among health professionals; poor communication and supervision; and reduced training opportunities for service providers.

A major challenge faced by the Kenya Ministry of Health is implementing an effective support and supervision system to ensure the delivery of quality family planning services. According to FHI staff in Kenya, national-level staff and resource shortages, as well as lack of provider training, are factors that contribute to this inadequacy. The Ministry is taking steps to ameliorate the situation and to ensure that routine assessments of the quality of care in family planning services are conducted. FHI Kenya staff report that as of March 2006, two rounds of training have been completed at the national level to train health service providers on how to assess the quality of service provision; however, the results have not been encouraging.

Comparison of National Guidelines to WHO Medical Eligibility Criteria (MEC)

Table 1 displays a comparison of Kenya's national contraceptive guidelines with the [WHO's Medical Eligibility Criteria for Contraceptive Use \(MEC\)](#).

FHI Medical Director Irina Yacobson confirms that Kenya's national family planning guidelines correspond very closely to the WHO's MEC, with the exception of one aspect: the Category 2* conditions. (The WHO defines Category 2 conditions as those where the advantages of using the method generally outweigh the theoretical or proven risks.) Compared to the Kenya guidelines, the MEC are lenient toward providers who may wish to initiate contraceptive methods under Category 2 conditions – allowing initiation while recommending follow-up. However, the Kenya guidelines consistently advise investigative or evaluative actions *prior* to provision of methods to clients with Category 2 conditions.

Additionally, under Kenya's current guidelines, provision of family planning methods to patients with Category 2 conditions is restricted to trained clinicians only. This rule limits the ability of community based distribution (CBD) agents and other non-clinicians to provide methods to women who wish to use family planning but who have Category 2 conditions. In these cases, non-clinicians can only provide referrals. While the repercussions of these stricter Category 2 guidelines have not yet been assessed, they clearly have the potential to create medical barriers for patients with Category 2 conditions.

* The WHO's criteria classify contraindications to contraceptives using four categories: Category 1 - a condition for which there is no restriction for the use of the contraceptive method; Category 2 - a condition where the advantages of using the method generally outweigh the theoretical or proven risks; Category 3 - a condition where the theoretical or proven risks usually outweigh the advantages of using the method; and Category 4 - a condition which represents an unacceptable health risk if the contraceptive method is used.

Table 1: Summary of Key Facts About Contraceptive Methods in Kenya’s National Family Planning Guidelines and Comparison with Current WHO Guidelines.

Methods	Kenya age guidelines	Other limitations	Comparison to WHO guidelines
Intrauterine Devices (IUDs)	The guidelines state that “women of reproductive age” can use IUDs.	<p><u>Women cannot use IUDs (Category 4) if they:</u> are between 48 hrs and 4 weeks postpartum ; have puerperal sepsis or are recovering from a post-septic abortion; have pelvic cancer, pelvic TB, PID, anatomical abnormalities of the uterus, fibroids or a high individual likelihood of Chlamydia or Gonorrhea exposure.</p> <p><u>Providers should proceed with caution (Category 2) if woman:</u> is <20 years of age and nulliparous; postpartum <48 hrs; following 2nd trimester abortion; has a past PID without subsequent pregnancy; is at increased risk for STIs/HIV; has a partner at increased risk for STIs/HIV; HIV infection or AIDS and is not doing well on ARVs; women who have heavy and prolonged vaginal bleeding, anemia, sickle-cell disease, endometriosis or valvular heart disease.</p> <p><i>Various evaluative actions are recommended before providers can initiate family planning method among women with these conditions.</i></p>	<p>Fibroids by themselves are not a Category 4 condition. Fibroids without distortion of the uterine cavity are a Category 2 condition. Fibroids with distortion of the uterine cavity which are incompatible with IUD insertion are a Category 4 condition.</p> <p><i>Either < 20 years of age or nulliparity is a Category 2 condition.</i></p> <p>Providers may initiate IUD method among women with Category 2 conditions, though follow-up is recommended. (Category 2 conditions here include postpartum <48 hrs; following 2nd trimester abortion; history of past PID without subsequent pregnancy; increased risk for STIs/HIV; partner at increased risk for STIs/HIV; HIV infection or AIDS and is not doing well on ARVs; heavy and prolonged vaginal bleeding, anemia, sickle-cell disease, endometriosis or valvular heart disease.)</p>

Oral Contraceptives (OCs)

The guidelines state that “sexually active women of reproductive age” can use OCs. The exception is that if the woman smokes and is over the age of 35 she should not use OCs because of health risks.

Women cannot use OCs (Category 4) if they: are breastfeeding mothers < 6 months postpartum; have history of blood clotting disorders; have ischemic heart disease, breast cancer, gall bladder disease, liver disease, diabetes or hypertension; are > age 35 and smoke; **or are receiving treatment with drugs that affect liver enzymes such as Rifampicin, epilepsy drugs and certain ARV drugs, which are known to reduce the efficacy of hormonal contraceptives.**

Providers should proceed with caution (Category 2) if the woman: is over 40 years of age; has unexplained vaginal bleeding; has non-aura migraines and is <35 years old; suffers from obesity, gall-bladder disease, breast lumps or sickle cell disease; smokes and is <35 years old; has uncomplicated diabetes or superficial venous thrombosis. *Various evaluative actions are recommended before providers can initiate family planning method among women with these conditions.*

Providers may initiate OCs among women with Category 2 conditions, though follow-up is recommended. (Category 2 conditions here include >40 years of age; unexplained vaginal bleeding; non-aura migraines and is <35 years old; obesity, gall-bladder disease, breast lumps or sickle cell disease; smokes and is <35 years old; uncomplicated diabetes or superficial venous thrombosis.)

Injectables

The guidelines state that “women of reproductive age” can use injectables.

Women cannot use injectables (Category 4) if they: are breastfeeding mothers < 6 months postpartum; have liver disease, cirrhosis, liver tumors, abnormal vaginal bleeding, multiple risk factors for cardiovascular disease, diabetes, ischemic heart disease, high blood pressure, history of stroke, current DVT or pulmonary embolism. **Certain drugs that treat epilepsy, fungal infection, tuberculosis and AIDS are known to reduce the efficacy of hormonal contraceptives.**

Providers should proceed with caution (Category 2) if the woman: is aged <18 years or >45 years; has heavy or irregular vaginal bleeding; has CIN or cervical cancer awaiting treatment; has undiagnosed breast lumps, migraines without auras, or a history of DVT or pulmonary embolism; **is on treatment with Rifampicin, anticonvulsants or certain ARVs;** has a history of hypertension or controlled BP; **has AIDS but is doing well on ARVs;** has gallbladder disease, uncomplicated diabetes, or mild cirrhosis of the liver; or is at risk of STIs. *Various evaluative actions are recommended before providers can initiate family planning method among women with these conditions.*

Providers may initiate injectables among women with Category 2 conditions, though follow-up is recommended. (Category 2 conditions here include <18 years or >45 years of age; heavy or irregular vaginal bleeding; CIN or cervical cancer awaiting treatment; undiagnosed breast lumps, migraines without auras, history of DVT or pulmonary embolism; **treatment with Rifampicin, anticonvulsants or certain ARVs;** history of hypertension or controlled BP; **AIDS but is doing well on ARVs;** gallbladder disease, uncomplicated diabetes, mild cirrhosis of the liver; or risk of STIs.)

Male Condoms	No age limits.	The guidelines state that “couples who want highly effective protection against pregnancy” need to consider more reliable methods.	Allergy to latex is a Category 3 condition.
Female Condoms	The guidelines state that “women of reproductive age” can use female condoms.	The guidelines state that “couples who want highly effective protection against pregnancy” need to consider more reliable methods.	Allergy to latex is a Category 3 condition.
Emergency Contraceptive Pills (ECPs)	No age limits.	The guidelines state that two 50-microgram oestrogen ECPs must be taken within 120 hours of intercourse, with a repeated dose 12 hours later. <i>For 30-microgram oestrogen ECPs or progestin-only ECP dosage, please refer to the guidelines.</i> ECPs should not be used in place of regular family planning methods and should not be given to women who are known to be pregnant. Certain drugs that treat epilepsy, fungal infection, tuberculosis and AIDS are known to reduce the efficacy of hormonal contraceptives.	No discrepancies.
Male Sterilization	The guidelines state that “men of reproductive age” can use the sterilization method.	Clients who are uncertain of their desire for future fertility or who do not give voluntary informed consent should not use the sterilization method.	No discrepancies.
Female Sterilization	The guidelines state that “women of reproductive age” can use the sterilization method.	Clients who are uncertain of their desire for future fertility, who cannot withstand surgery or who do not give voluntary informed consent should not use the sterilization method.	No discrepancies.

Sources: [Kenya Family Planning Guidelines for Service Providers, 2005](#) and [WHO’s Medical Eligibility Criteria for Contraceptive Use, 2004 edition](#)²⁴. Comparison provided by Dr. Roberto Rivera, Director of the Protection of Human Subjects Committee and Dr. Irina Yacobson, Assistant Medical Director at FHI, 2006.

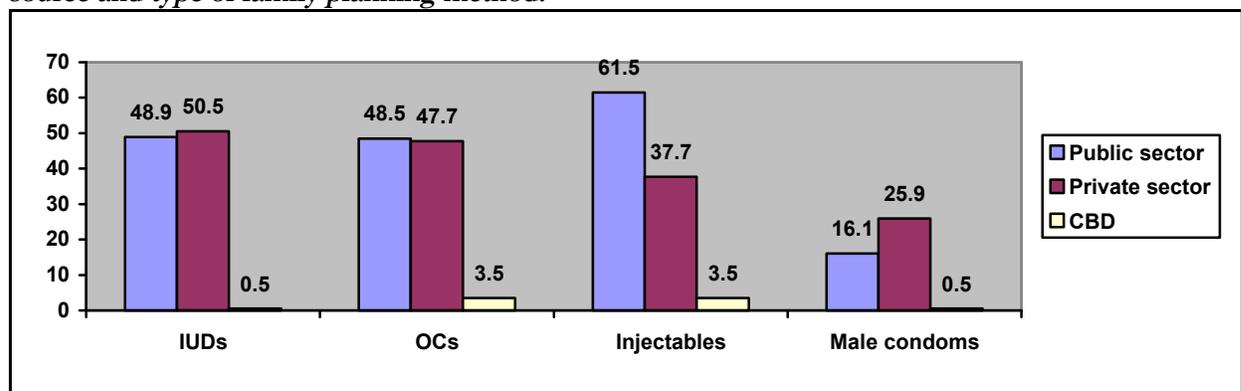
Sources of Contraceptives

The proportion of Kenyan women acquiring contraceptives from public sources has declined from 68 percent in 1993 to 53 percent in 2003. During same time period, the proportion of women getting methods from private medical sources has substantially increased, from 25 percent to 41 percent (KDHS 1993 and 2003). Nevertheless, public sector sources hold a marginal lead over private sector sources in providing oral contraceptives to Kenyan women and a substantially larger lead over the private sector in providing injectables (61.5 percent)²⁵.

The private sector, which includes mission clinics and hospitals, [Family Health Options Kenya \(FHOK\)](#) clinics – formerly known as Family Planning Association of Kenya (FPAK), pharmacies, friends/relatives and other private hospitals and clinics, provided Kenyan women with 25.9 percent of all condoms and just over half of all IUDs in 2003.

Overall, the proportion of facilities offering any modern method of family planning has declined from 88 percent to 75 percent from 1998 to 2003²⁶.

Figure 5: Percent distribution of source of modern family planning methods in Kenya, by source and type of family planning method.



Source: Kenya Demographic and Health Survey, 2003.

Method Mix

Based on the information provided in the [2004 Kenya Service Provision Assessment \(SPA\)](#), governmental programs in Kenya provide OCs (both combination and progestin-only); injectables (combined and progestin-only); implants; IUDs; voluntary surgical methods (vasectomies and tubal ligation); barrier methods such as male and female condoms; and natural family planning methods. FHI's Kenya staff confirm that pills, injectables, Jadelle implants, IUDs and condoms are currently the methods most commonly provided by government programs.

Vasectomies are provided at provincial and district health facilities, though this method's acceptability and use among Kenyan men is very low, accounting for less than 1% of all contraceptive use, as reported in the 2003 DHS. According to the [2004 Kenya Service Provision Assessment \(SPA\)](#), sterilization methods in general are offered at only 5 percent of health facilities in Kenya, including 46 percent of hospitals.

FHI's Kenya staff report that natural family planning methods are offered mainly through Catholic-run facilities, while the SPA reports that rhythm method counseling is provided at 51 per cent of family planning facilities in the country²⁷.

Diaphragms and cervical caps are neither actively promoted during general family planning counseling in Kenya nor available through the national procurement system. However, they are available in a limited number of pharmacies to those who are able to pay for them.

The non-governmental [Family Health Options Kenya \(FHOK\)](#) clinics offer OCs, IUDs, diaphragms, condoms, spermicides, vasectomies, tubal ligation, Jadelle and emergency contraceptive pills (ECPs)²⁸.

Changes to the Method Mix

In 2002, the Kenya Ministry of Health established a task force to develop a strategy for rehabilitating the IUD, a method which had nearly disappeared from the mix since the mid 1980s²⁹. In February of 2003, the MOH and its partners developed a joint work plan to launch this initiative, which is coordinated by FHI. The initiative's activities include distributing IUD kits and advocacy briefs, such as [A New Look at IUDs](#); establishing a training system for IUD service providers; conducting an IEC campaign; and making improvements to the IUD monitoring and evaluation system³⁰. For more information about IUDs in Kenya, refer to FHI's Reproductive Health Research Brief entitled [IUD Reintroduction in Kenya](#).

In 2005, the government of Kenya purchased supplies of *Postinor 2* for the public sector, an emergency contraceptive (EC) pill previously available only in urban pharmacies. During an April 2005 workshop involving key EC stakeholders, a national strategy to roll out *Postinor 2* was developed, including "ways to address the challenges of product distribution on a national scale, the need to monitor uptake and consumption levels, the challenges of providing technical updates to providers, and the importance of increasing public awareness of EC."³¹ As a result, clients of Kenyan public health facilities, youth centers, and sexual assault and rape clinics now have access to *Postinor 2*. Plans are also being developed to make it available in private health facilities.

Jadelle is the brand of implant currently available through the Ministry of Health's national procurement system, while Norplant is being phased out and has been out of stock for the last year. USAID, UNFPA, KfW and DFID assist the MOH with the procurement of Jadelle, however, the Kenyan government is now considering procurement of less expensive implant brands made in China³².

According to the [2004 Service Provision Assessment \(SPA\)](#), the proportion of facilities offering implants has increased slightly, from 8 percent in 1999 to 13 percent in 2004. However, as in 1999, supply remains a problem: only half of the facilities offering implants actually had them available on the day of the survey.

Trends in Family Planning

In March 2003, the POLICY Project conducted a [Country Analysis of Family Planning and HIV/AIDS: Kenya](#), concluding that there has been an apparent and deliberate shift toward

HIV/AIDS on all program levels, at the expense of family planning programs. Family planning, they reported, has fallen off the national agenda.

Key informants from FHI's October 2004 [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#) assessment confirmed that the private sector health organizations, due to shifts in donor funding priorities, have moved toward programs that focus on HIV/AIDS-related activities, leaving the public sector as the main source of family planning services.

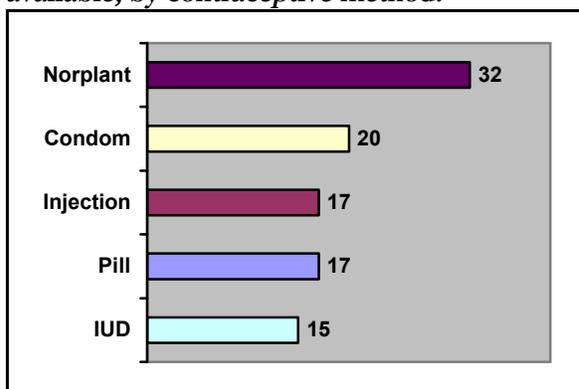
According to the [2003 Kenya DHS](#), the most common single source of contraceptives was private hospitals and clinics, which supplied one quarter of all users of modern methods. However, due to more recent donor restrictions on funding for contraceptive services, Kenyan women's access to injectables, implants, sterilization and IUDs via the private sector has been reduced³³. Specifically, the funding restrictions of the Mexico City Policy – reinstated by the U.S. Bush administration in 2001 – have caused non-governmental clinics such as those of MSI Kenya and FHOK to close facilities, reduce staff and scale back services³⁴.

Contraceptive Supply and Costs

The [1999 Service Provision Assessment](#) (SPA) found that approximately one quarter of facilities providing family planning services did not have on hand an adequate stock of at least one of the contraceptive methods that they offered. The most common stockouts were of Norplant, with 32 percent of facilities surveyed offering fewer than two unexpired units, and condoms, with 20 percent of facilities having less than adequate stock. (See Figure 6.)

As noted above, Norplant has since been phased out from national procurement plans, to be replaced by the brand Jadelle. According to the [2004 Service Provision Assessment](#), the proportion of facilities offering the implant method has increased slightly, from 8 percent in 1999 to 13 percent in 2004. As in 1999, however, supply remains a problem; only half of the facilities offering implants actually had them available on the day of the survey.

Figure 6: Percentage of facilities offering method with fewer than 2 unexpired units available, by contraceptive method.



Source: 1999 Kenya SPA facility inventory

Data from the [2004 Service Provision Assessment](#) suggest that the system for stock monitoring of contraceptives is weakest in Nairobi province (35 percent) and strongest in

the Coast province (87 percent). Management of stock contraceptives seems relatively good nationwide, as more than 70 percent of facilities store contraceptive commodities by expiration date. However, maintenance of an up-to-date inventory for medicines is sub-standard at 45 percent of all facilities.

A 2001 assessment of the contraceptive supply chain conducted by John Snow, Inc. (JSI) describes that, in an effort to increase health sector efficiency, the Government of Kenya recently decided to overhaul its central and regional medical supply store system. It was transformed into a system that implemented private sector management techniques to supply the public health system³⁵. An assessment of this new system found that inventory control procedures are not respected at the service delivery point level and that a lack of procedures results in frequent overstocks of IUDs and condoms. For more information, refer to the JSI report entitled [Kenya: Assessment of the Health Commodity Supply Chains and the Role of the Kenya Medical Supplies Agency \(KEMSA\)](#). Currently, JSI works on the [Global Fund Consortium to Improve Procurement and Supply Chain Management](#).

[Population Action International](#) reports that severe contraceptive supply shortages in Kenya have occurred as a result of decreased donor support for supplies, as well as logistical and distribution problems³⁶. A spokesperson for [EngenderHealth](#) blames 2004 stockouts of Depo-Provera, Norplant, female condoms and oral contraceptive pills on corruption related to procurement deals in the public sector³⁷.

The Ministry of Health's [Contraceptive Commodities Procurement Plan 2003-2006](#) (February 2003) states that “for the next four to five years, Kenya will continue to be heavily dependent on donor funds for the procurement of contraceptives.” However, the Plan reveals that financial commitments from the Government of Kenya and its development partners for contraceptive commodities through 2006 fall short by about US\$ 26 million.

The cost-effectiveness of loan mechanisms to help the Kenyan private sector provide family planning methods was explored by researchers in a 2003 study³⁸. The study concluded that financing can be used to motivate and assist the private sector in achieving public health outcomes like provision of family planning methods at low cost.

According to government policy, there should be no charge for any government-supplied contraceptive method administered, whether in government or private facilities³⁹. Currently, contraceptive methods are provided free of charge to all family planning clients, however, a minimal registration card fee (20-50 Kenyan shillings – equivalent to approximately US\$.27-.69) must be paid by clients at nearly all governmental and most non-governmental facilities⁴⁰. FHI Kenya staff say it is unlikely that this situation will change in the near future.

For more information on national contraceptive supply and costs to clients, refer to Chapter 3 of the [2004 Service Provision Assessment \(SPA\)](#).

For more information about donor support for contraceptive commodities, refer to the 2003 PATH report, [Ensuring Contraceptive Supply Security](#).

Community-Based Distribution

Kenya began a CBD program in 1982 through the Family Planning Association of Kenya (FPAK), now Family Health Options of Kenya (FHOK). Since then, nearly every approach to CBD has been attempted in Kenya⁴¹. In 1990, Kenya's Division of Family Health and the National Council for Population and Development (NCPD), now the designated coordinator for all CBD programs in Kenya, developed a set of policy guidelines for such programs. The [2005 Family Planning Guidelines for Service Providers](#) now include policies about CBD programs, which state that CBD agents can provide oral contraceptives (both COCs and POPs) and male condoms.

From 1991-1994, the Kenya Client-Provider Information, Education and Communication (IEC) campaign, a CBD program, was implemented by Johns Hopkins University and FPAK to improve the quality of family planning counseling by training trainers of community-based distribution agents.

A 1991 inventory of community-based distribution in Kenya found 25 CBD program agencies with over 10,000 CBD agents in eight provinces.⁴² Forty-eight percent of [1993 Kenya DHS survey](#) respondents reported living in regions served by CBD agents. However, according to the more recent 2003 Kenya DHS survey, community-based distributors supply only 1.1 percent of contraceptive users. (Refer to Figure 5.)

A CBD Performance Report from the Ministry of Health/GTZ Reproductive Health Project shows a clear downward trend in the number of CBD workers from 2002 to early 2005. FHI's Kenya staff affirm that past community-based distribution programs were primarily donor supported with little contribution from the Ministry of Health. Several donors that had backed CBD programs in Kenya through NGOs, including USAID and DFID, later withdrew funding because they thought that the family planning program in Kenya had reached a stable level and that users had sufficient access to services at facilities. Currently, CBD programs in Kenya are sponsored by GTZ, USAID, AMKENI and the [Maendeleo Ya Wanawake Organization](#) (MYWO), however, GTZ is the only donor supporting CBD programs through the MOH.

For more information about CBD programs in Kenya, refer to:

- an article in FHI's 1999 issue of *Network* entitled [Gender Norms Affect Community Distribution](#),
- an [IRIN PlusNews article](#) outlining 2001 research on Kenya's CBD programs, and
- [Family Planning and Reproductive Health Commodities in Kenya](#) (2000), which contains historical information about CBDs in Kenya.

Provider Knowledge of Family Planning Methods

The [1999 Service Provision Assessment](#) reported that 26 percent of health workers who delivered family planning services had attended at least one in-service course covering family planning since 1995.

All of the five provinces investigated during the [October 2004 assessment](#) (Coast, Eastern, North Eastern, Nyanza and Nairobi) reported suffering from a shortage of trained health care staff as a result of government restrictions on hiring within the civil service. The

availability and quality of training are reportedly limited due to reductions in training funds. Many public providers felt that their knowledge of contraceptive methods was not up to date and that they could not serve HIV-positive clients due to their own lack of skills.

A 2002 study to evaluate an initiative to introduce emergency contraception (EC) in Kenya compared its survey data with 1996 baseline data and found that in 2002 “more women and providers had heard of EC and more providers were distributing it.”⁴³

A 2003 FHI study was conducted to examine provider attitudes about advance provision of oral contraceptive pills to clients who are awaiting their menses. The study found “only 16 percent of providers thought it safe to give women oral contraceptives to be started at a later date.”⁴⁴ Since that time, the pregnancy checklist has been introduced nationally, but follow-up research has not been conducted yet to assess the potential impact of the checklist on providers’ beliefs and practices.

Family Planning in the Context of HIV

HIV in Kenya

Based on the [2004 Epidemiological Fact Sheet](#) from UNAIDS, the HIV prevalence rate among Kenyan adults aged 15 to 49 years is 6.7 percent. Women are disproportionately affected by Kenya’s HIV epidemic. Of the 1,100,000 adults currently living with HIV in Kenya, 720,000 of them are women, and HIV prevalence among women (8.7 percent) is nearly twice the prevalence among men (4.5 percent).

In 2003, an estimated 150,000 people died of AIDS, while the total number of orphans and vulnerable children living in Kenya numbered 650,000⁴⁵. The dominant mode of HIV transmission in Kenya is heterosexual intercourse.

For more information about HIV in Kenya, refer to the 2005 report by the National AIDS and STD Control Programme (NAS COP), [AIDS in Kenya: Trends, Interventions and Impact](#) (7th Edition).

National Integration Strategies

FHI’s October 2004 assessment entitled [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#), reported three key findings:

- A dramatic shift in priorities and resources to HIV/AIDS programs threatens to reverse the historic gains made over the past two decades by Kenya’s once strong family planning program.
- A deteriorating health care system limits access to family planning and HIV/AIDS services and compromises the quality of both services.
- Integrating family planning and HIV/AIDS services offers an opportunity to make the best use of available financial and human resources to provide comprehensive, convenient health care.

This assessment found no apparent conflict between Kenya’s HIV/AIDS and family planning policies. Some of Kenya’s national policies recognize the family planning needs of

HIV-affected people. One example is the country's voluntary counseling and testing (VCT) guidelines, which present family planning as a major component of VCT services.

Due in part to the assessment, Kenya's national [Family Planning Guidelines for Service Providers](#) were updated in March 2005 to include policies about linking family planning with HIV/AIDS services. Examples of these policies include an official list of anti-retroviral, anti-TB and anti-fungal drugs known to reduce the efficacy of hormonal contraceptives and a set of guidelines about family planning methods appropriate for HIV+ women.

Critical gaps were found in Kenya's family planning and reproductive health policies during the October 2004 assessment. These gaps included the lack of a comprehensive reproductive health policy; inadequate priority setting; vertically established policies that provide little support for or ability to integrate services at the district level where implementation often occurs; a poorly implemented monitoring and evaluation plan; and the lack of guidelines to address public-private partnerships. For more information about gaps in family planning and HIV policy in Kenya, please refer to the country assessment, [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#).

For additional information about HIV and family planning service integration in Kenya, refer to:

- the POLICY Project's 2003 [Country Analysis of HIV/AIDS and Family Planning in Kenya](#);
- the 2004 POLICY project report on [Provision and Use of Family Planning in the Context of HIV/AIDS in Kenya: Perspectives of Providers, Family Planning and Antenatal Care Clients, and HIV-Positive Women](#); and
- FHI's 2003 [Assessment of Voluntary Counseling and Testing Centers in Kenya](#), which explores the potential demand, acceptability, readiness and feasibility of integrating VCT with family planning services.

Target Areas For Improvement

At the November 2005 CRTU Stakeholder Committee meeting, key stakeholders from Kenya's reproductive health and HIV arenas reported that a shortage of qualified staff, attitudes of health workers and VCT providers, commodity stockouts, client load, inadequate training, cross cutting issues, and lack of knowledge and supervision are all barriers to integration⁴⁶.

The [2004 Family Planning and HIV assessment](#) also suggests areas where integration might be improved. In terms of services, the report suggests:

- Establish(ing) mechanisms for integrating components of family planning services into all HIV/AIDS programs, particularly those providing VCT, PMTCT, ARV therapy, anti-TB therapy, and HBC services.
- Integrat(ing) elements of HIV/AIDS prevention and care into family planning programs where appropriate and strengthening the capacity of family planning providers to address the reproductive health needs of HIV-infected women.
- Improv(ing) efficiency of service delivery through appropriate deployment of service providers in areas where their skills are most needed.
- ...reviving the CBD program....

- Strengthen(ing) mechanisms for commodity procurement and distribution to ensure contraceptive security.
- Develop(ing) strategies to make family planning and HIV/AIDS services more “youth friendly” and to promote involvement of men in reproductive health and HIV/AIDS prevention and care.

Also, the assessment called for affirmation by the Government of Kenya of “its commitment to existing policies on population and development by recognizing family planning as a crucial strategy for attaining development goals, allocating sufficient funds for family planning and establishing a line item for family planning”. (Importantly, since the assessment was conducted, a line item has been established for family planning in the national budget.)

Social Marketing

[Population Services International \(PSI\)](#) has marketed *Trust* condoms in Kenya since 1993, *Femiplan* oral contraceptives and injectable contraceptives since 2000 and *Trust* dotted condoms since 2004. PSI uses radio and TV broadcasts to disseminate HIV information and conducts advertising campaigns to reinforce abstinence and condom use. They also market voluntary counseling and testing services using BCC strategies such as celebrity television spots and billboards.

Sure brand condoms are currently marketed by the Ministry of Health in partnership with GTZ, while *Raba* brand condoms are promoted by Marie Stopes International. Socially marketed condoms like PSI’s *Trust* brand (US\$.14 for a pack of three) cost significantly less at the pharmacy than non-socially marketed condoms (US\$ 1.40 – 2.76 each)⁴⁷. FHI field staff also report that while emergency contraception is available in pharmacies and public health facilities, it is neither promoted nor socially marketed.

According to key stakeholders in Kenya, men currently receive HIV/STI infection messages about condoms, while women are targeted with family planning-focused messages. FHI’s Kenya staff confirm that condom marketing messages in Kenya are skewed toward HIV/STI prevention rather than contraception. Stakeholders view these mixed messages as a problem and recommend that social marketing programs reexamine the STI and family planning messages that they currently promote to include couple’s counseling and consistent messages.

Integration of Family Planning Through Other Services

Family Planning and PMTCT Services

Kenya’s [Family Planning Guidelines for Service Providers](#) emphasizes the role of family planning in PMTCT programs. According to the guidelines, providers should ensure that safe and affordable contraceptives are available to HIV-positive women to help them plan their childbearing. The guidelines include a list of contraceptive methods that may be used by HIV-infected women to prevent pregnancy.

According to 2005 data from Kenya's National AIDS and STI Control Programme (NASCO), 759 facilities are currently providing PMTCT services nationwide. Based on NASCO's latest figures, an estimated 39,000 women receive PMTCT services annually; however, uptake of family planning through PMTCT services is unknown.

For additional information about family planning and PMTCT services in Kenya, refer to:

- [Kenya's PMTCT National Training Program Curriculum](#),
- Population Council's 2004 article [Review of Field Experiences: Integration of Family Planning and PMTCT Programs](#),
- Pathfinder International's 2002-2005 report, [Preventing Mother-to-Child Transmission of HIV in Kenya](#), and
- the September 2005 *Studies in Family Planning* article, [Field Experiences Integrating Family Planning into Programs to Prevent Mother-to-Child Transmission of HIV](#).

Family Planning and AIDS Treatment Services

According to FHI's staff in Kenya, the National AIDS and STI Control Programme (NASCO) reports that 123 health care facilities are currently providing ARV drugs nationwide and that 54,093 people received ARV drugs in Kenya in 2005. Family planning is not currently available through anti-retroviral treatment (ART) services.

For more information about ART provision in Kenya, refer to the [2004 HIV/AIDS Service Provision Assessment Survey \(SPA\)](#).

Family Planning and Voluntary Counseling and Testing (VCT) Services

The [Family Planning Guidelines for Service Providers](#) discuss four levels of integration of family planning into VCT services, depending on the contraceptive methods available at the facility. The guidelines mandate that "where possible, FP services should be provided at the VCT site; otherwise, VCT clients should be referred for FP services."

Also, Kenya's [National Guidelines for Voluntary Counseling and Testing](#)⁴⁸ require that family planning information should be incorporated into VCT counseling sessions at the time of HIV diagnosis and during follow-up. However, according to an assessment conducted by FHI staff in 2003⁴⁹, this practice is not routinely taking place within the VCT centers in Kenya unless the staff have been specifically trained and encouraged to incorporate pregnancy risk assessment and family planning into their counseling.

The National AIDS and STI Control Programme (NASCO) estimates that 2 million people received VCT services in Kenya in 2005. Family planning, according to NASCO, is included at 62 of the 687 VCT service outlets in Kenya, although not all contraceptive methods are available at these 62 sites.

For more information about VCT services in Kenya, refer to:

- the [2004 HIV/AIDS Service Provision Assessment Survey \(SPA\)](#), and
- FHI's 2003 [Assessment of Voluntary Counseling and Testing Centers in Kenya](#), which explores the potential demand, acceptability, readiness and feasibility of integrating VCT with family planning services.

Family Planning and Post-Abortion Care (PAC) Services

According to a [1997 FHI Network article](#):

in Kenya, researchers were examining different ways of providing family planning to post-abortion clients in six hospitals. The Population Council collaborated with Ipas, Kenya Ministry of Health and the Family Planning Association of Kenya, to determine which model of family planning delivery is most effective: family planning services provided in the hospital ward by gynecology staff; services offered in the hospital but provided by staff from the hospital's family planning clinic; or services offered at the family planning clinic. At Nyeri Provincial Hospital, for example, staff escort patients from the gynecology ward to a family planning clinic, where they receive counseling and may choose a family planning method. A survey of patients and staff found both groups were satisfied⁵⁰.

The Population Council's 1999 study, [Creating Linkages Between Incomplete Abortion Treatment and Family Planning Services in Kenya](#) points out the feasibility and effectiveness of integrating the two services. The study also found that post-abortion and family planning counseling provided in the gynecology ward of the hospital by ward staff is the preferred and most effective counseling method in Kenya. After receiving post-abortion family planning services, 70 percent of women in the study who decided to begin using a method received contraceptives, as compared to 3 percent at baseline.

Since 1999, the Prime II project has trained 230 midwives in post-abortion care (PAC). The project emphasizes a comprehensive approach to services, including family planning and STI/HIV prevention. For more information, refer to the Prime II article, [Linking Family Planning with Post-Abortion Care](#).

The national [Family Planning Guidelines for Service Providers](#) include provision of family planning during postnatal care and as a component of post-abortion care services. The guidelines state that COCs, POPs and injectables are safe for post-abortion clients, recommending that oral contraceptives be started within seven days of the abortion for immediate effectiveness.

Adolescent Reproductive Health

Reproductive Health Statistics

According to the 2003 Kenya DHS, the median age at sexual debut is 18.1 years for females and 17.5 years for males. The mean age among women at first birth in Kenya is 20.1 years for women aged 25-29 years as of the 2003 survey, up slightly from the 19.6 year mean measured during the 1998 Kenya DHS⁵¹.

Condom use at first sex is low among Kenya's young people. Only 10 percent of men aged 15-19 at the time of the 2003 survey reported having used a condom at first sex, as compared to 12.5 percent of young women of the same age. Reported condom use at last sex was much higher: 24.7 percent among women aged 15-19 and 41.1 percent among young men of the same age⁵².

Among those aged 15-19 years, 3.9 percent of young women reported experiencing abnormal discharge, a genital sore/ulcer, or an STI in the 12 months prior to the 2003 DHS survey, compared to 2.2 percent of young men⁵³.

A [YouthNet assessment](#) conducted in Kenya in October of 2005⁵⁴ reports:

In particular, young women ages 15-24, young men ages 20-30, and out-of-school youth are at great risk for HIV. The HIV/AIDS epidemic, among other diseases, has continued to negatively impact the health of Kenya's youth. More than 75% of AIDS cases occur between the ages of 20-45, and approximately 33% of all AIDS cases reported are among the ages of 15-30. HIV prevalence among young people does appear to be headed downwards. Though there is no directly comparable prevalence data to the 2003 DHS, this survey found that 6% of women ages 15-24 were HIV positive, compared with slightly over 1% among men the same age. HIV is more prevalent in urban areas (10%) than in rural areas (5.6%).

HIV Knowledge and Behavior

The [YouthNet assessment](#) also discussed HIV/AIDS knowledge among youth:

Although general awareness about HIV/AIDS is widespread, i.e., greater than 97% among out-of-school youth, less than half of these young people are aware of HIV prevention methods and greater than 40% hold myths and misconceptions about HIV transmission, according to the 2002 Kenya HIV/AIDS and STIs Behavioral Surveillance Survey (BSS). Most Kenyans have heard of HIV/AIDS, but there is vast need for greater behavior change, especially among youth who are ill-equipped to protect themselves against unwanted and/or unprotected sex. Few youth seek HIV counseling and testing, and there are limited services designed specifically for youth, particularly in rural areas.

Youth-Centered Policies in Kenya

As excerpted from the [YouthNet assessment](#), the following national policies exist in Kenya and pertain to youth:

1) *Kenya National Youth Policy (2002)* – Developed by the Government of Kenya and other key stakeholders, this policy provides a broad framework within which the private and public sectors, civil society, and others can contribute to youth development. The policy aims to provide a comprehensive, multi-sectoral response with the objective of integrating youth into national development. The policy promotes youth participation in community and civic affairs.

2) *Adolescent Reproductive Health and Development Policy (2003)* – The goal of this policy is to contribute to improving the quality of life and wellbeing of Kenya's young people by integrating their health and development concerns into the national development process and enhancing their participation in that process. It examines the consequences of prevailing social, economic, cultural, and demographic issues in the context of adolescent RH. An accompanying *Plan of Action* is under development and aims to facilitate the operationalization of this policy through a multi-sectoral approach. The plan will promote the scaling-up of ongoing youth RH activities and strengthening coordination among key government ministries by clearly defining roles and responsibilities. The plan also outlines strategies for implementation, identifies priority

activities and major implementers, provides an avenue and basis for resource mobilization, and outlines a logical framework for implementation and monitoring and evaluation.

3) *The National Reproductive Health Strategy 1997-2010*⁵⁵ – This strategy is a national response to the Program of Action of the 1994 UN International Conference on Population and Development. It highlights the promotion of adolescent and youth health, and notes their RH needs and rights have received relatively little attention. This is demonstrated by lack of precise policies within the existing RH programs, user-unfriendly institutions, unfavorable service provider attitudes, and socioeconomic and cultural constraints.

4) *Kenya National HIV/AIDS Strategic Plan for 2000-2005* – Developed by the National AIDS Control Council in the Office of the President, this plan provides strategic leadership at national, provincial, district, and community levels. It outlines a framework to guide the implementation of activities at all levels and improve resource mobilization, management, and program coordination. In line with broader government policies, the plan aims to facilitate the realization of the principle objective of arresting the epidemic and reducing its impact on the society and the economy. Specifically, the plan calls for a national response in several priority areas: 1) prevention and advocacy; 2) treatment; 3) continuum of care and support; 4) mitigation of socioeconomic impact; 5) monitoring and evaluation and research; and 6) management and coordination.

5) *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan 2000-2005* – (Kenya's) Technical Sub-committee on Gender and HIV/AIDS developed this document to ensure that the gender dimension of the HIV/AIDS epidemic does not remain just an intellectual idea. The plan identifies strategies and acts as a practical tool for guiding policy decisions and programming for activities under the umbrella of the Kenya Association for the Promotion of Adolescent Health.

6) *Guidelines for Provision of Youth-Friendly Services in Kenya* – Led by the Ministry of Health/Division of RH, in collaboration with several other partners, these guidelines outline the minimal requirements for delivering youth-friendly services and describe different models for implementation at clinics, schools, and youth centers. The guidelines also aim to ensure national uniformity in the provision of services to youth.

7) *Post-Rape Management Guidelines* – Recently released by the Ministry of Health, these guidelines were developed to teach health workers how to conduct post-traumatic counseling and provide medical management to survivors of sexual assault. The guidelines also sensitize health workers to the importance of taking evidence following a rape and include information on emergency contraceptive pills (Postinor 2) and post-exposure prophylaxis for STIs, including HIV.

Youth-Friendly Health Services

The national [Family Planning Guidelines for Service Providers](#), updated in March 2005, mandate the provision of youth-friendly reproductive health services and efforts to address factors that affect accessibility and quality of care, including provider attitudes, privacy, confidentiality and hours of service.

The need for youth-friendly services was an issue raised consistently throughout the [YouthNet assessment](#).

Young people frequently laughed or scoffed at the idea when asked if they think youth-friendly services are available in their communities. Based on the 2004 [Kenya Service Provision Assessment Survey](#), which found that only 12% of all facilities provide youth-friendly services, one can easily understand why young people have the perceptions they do about the availability (and reality) of youth-friendly services...

While there are some examples of effective services, such as projects being run by Kenyatta National Hospital, the Family Planning Association of Kenya, and smaller NGOs such as Kibera Community Self-Help Program and the Kenya Association of Professional Counselors, the need to expand youth RH and HIV/AIDS services is widespread, especially in rural areas.

For more information about adolescent reproductive health and services in Kenya, refer to the October 2005 [YouthNet assessment](#).

Sexuality Education

[IRIN PlusNews](#) reports that Kenya's government policy on reproductive education "remains unclear". As excerpted from this article,

One education ministry official, who requested anonymity, told PlusNews there was no sex education at Kenyan schools; instead, the ministry had introduced the less controversial "moral education", which only touched on general aspects of reproductive issues and HIV/AIDS⁵⁶.

The moral education he's referring to is Kenya's Family Life Education (FLE) program. A UN Economic Commission for Africa report states that in Kenya, "youth in schools are reached through family life education (FLE), components of which are integrated in carrier subjects."⁵⁷ Integrating units of the FLE curriculum has been an attempt to educate adolescents about the consequences and responsibilities associated with sexual activity, however, the high rates of schoolgirl pregnancies suggest weaknesses in the program⁵⁸.

As excerpted from the [YouthNet assessment](#),

RH interventions targeted at adolescents started during the late 1970s and most of the programs are educational, delivered through youth centers, peers, the media and schools. There has always been discomfort with addressing the needs of unmarried sexually active adolescents; many policy makers still fear that discussing family life or sex education will encourage young people to experiment with sex and increase risky sexual behavior.

The assessment also reports that "the Ministry of Education, Science and Technology has established an AIDS unit to streamline HIV in the school curriculum and train teachers to handle the subject."

FHI's report [Reaching Kenyan Youth With HIV Messages in School: Snapshots from the Field](#) gives an overview of HIV prevention activities aimed at Kenyan youth in school under the Implementing of AIDS Prevention and Care Project (IMPACT). Program strategies

included stories in graphic novels, a newsletter written by and for youth, youth clubs and educational activities through the Kenyan Girl Guides Association (KGGA).

Youth-Focused Reproductive Health Programs

As excerpted from an August 2005 YouthNet report⁵⁹, the most common models of youth services in Kenya are:

1. Community-based
2. Health-facility based
3. School-based (including University – *I Choose Life*; Kenyatta University Peer Education and clinical services programs)
4. Mass media/youth centre interventions
5. Youth development or income generating activities

From the [PATH Web site](#): “Since 1995, PATH's Kenya office has worked with the Kenya Scouts Association (KSA) to provide reproductive health information to youth through scout clubs. The Kenya Scouts Association has 12,000 adult volunteers and over 175,000 scouts. Due to the program's success, the Ministry of Education asked the KSA to develop programs to reach out-of-school youth as well as provide a Family Life Education course in their programming.” (FHI also worked with the Kenyan Girl Scouts and Guides in a 1995 UNHCR-funded effort. That effort found it feasible and programmatically sound to implement reproductive health activities for adolescent refugees through the Girl Guide units.)

From the [Population Council Web site](#): “FRONTIERS and the Program for Appropriate Technology in Health (PATH) tested the effectiveness of community, school, and clinic interventions to improve young people’s knowledge of reproductive health, delay the onset of sexual activity, and increase young people’s access to adolescent-friendly reproductive health services. Over 100 teachers, 80 religious leaders, and 850 peer educators were trained as part of the project. The intervention, which was strongly endorsed by the community, led to increased discussion and knowledge about reproductive health, and encouraged safer sexual behavior among young people”.

From the [International Council Web site](#): the African Regional Youth Initiative (ARYI) “is a collaboration of youth and community-based projects and organizations in Africa working to fight HIV/AIDS. ARYI addresses HIV/AIDS in a comprehensive manner by engaging in activities that mobilize and empower communities, increase participation among women and youth, facilitate dialogue between organizations in different countries, and other activities that build capacity such as training in advocacy”.

The Kenya Youth Initiatives Project (KYIP), the Kenyan Association for the Promotion of Adolescent Health (KAPAH), and the [Nyeri Youth Health Project](#) are all locally-developed programs for youth in Kenya. They are evaluated on the [Advocates for Youth Web site](#).

For more information about youth-specific interventions in Kenya, refer to the 2003 meeting report by FHI’s YouthNet and the Population Council, [New Findings From Intervention Research: Youth Reproductive Health and HIV Prevention](#).

Youth-Focused Social Marketing Programs

Population Services International (PSI) continues to implement a social-marketing campaign that works toward reducing the HIV vulnerability of young girls due to cross-generational sex. To read more about this, refer to the 2005 PSI document, [The Sugar Daddy Syndrome](#).

For more information about social marketing programs in Kenya, view [PSI's Kenya page](#).

PEPFAR and USAID Funding Restrictions on Reproductive Health Activities

The Mexico City Policy – re-imposed in 2001 – “restricts foreign non-governmental organizations (NGOs) that receive USAID family planning funds from using their own, non-U.S. funds to provide legal abortion services, lobby their own governments for abortion law reform, or even provide accurate medical counseling or referrals regarding abortion⁶⁰.”

For information on how the Mexico City Policy has impacted Kenya’s reproductive health programs, refer to the [Kenya Case Study](#) by Population Action International.

The USAID’s anti-prostitution policy from the [Acquisition and Assistance Policy Directive](#) of 2005 prohibits USAID funds to be used “to promote the legalization or practice of prostitution or sex trafficking”, and requires that recipients adopt a policy “explicitly opposing prostitution and sex trafficking.” Further provisions advise recipients “to not endorse or utilize a multisectoral approach to combatting (sic) HIV/AIDS, or to not endorse, utilize or participate in a prevention method or treatment program to which the organization has a religious or moral objection.”

The President’s Emergency Plan for AIDS Relief (PEPFAR) emphasizes the provision of treatment and care for people with AIDS and mandates that 55 percent of its funds will be allocated toward those activities. PEPFAR does not fund condom education or distribution for the general public; instead, it funds such interventions only for certain designated high-risk groups⁶¹. Twenty percent of PEPFAR funds can go toward HIV prevention activities, however, one third of these prevention funds must support abstinence-only-until-marriage programs targeting young people.

Current Reproductive Health Activities

Table 2: FHI's current subprojects in Kenya, as of December 2005.

Subproject Title	Project/Award	FCO	Tech Monitor	Div	Total Approved Budget	Start Date	Projected End Date	Subproject Objective
AMKENI Project	Engender-Health	1761	TNutley	FITS	US\$ 907,762	01/01/01	6/30/06	To assist the AMKENI Project in the improvement and expansion of family planning, reproductive health and child survival services in Kenya.
Documenting PMTCT Best Practices	CRTU	9403	HReynolds	HSR	US\$ 236,000	01/21/04	8/31/06	To document the essential components of high-performing PMTCT services and to estimate the cost of replicating these services in other sites in South Africa and in Kenya.
Testing the ABC Approach among University Students	CRTU	9493	CJagermann	HSR	US\$ 494,511	09/10/04	8/31/06	To test an enhanced strategy for promoting ABC messages as a means of reducing risky sexual behaviors among university students in comparison with the existing program.
Site Assessment and Incidence Estimation for Three Sites in Kenya	Ireland Bilateral Aid Program, Int'l Partnerships on Microbicides	1815	MStalker	FITS	US\$ 524,682	06/10/05	8/31/06	1) To identify potential research locations for microbicide efficacy trials; 2) to conduct scouting activities for potential sites; and 3) to conduct screening activities to establish an estimate for HIV incidence, and community preparedness.

Kenya IUD Revitalization - Transition Phase and M & E	CRTU	113111	EMcGinn	FITS	US\$ 250,000	09/08/05	6/30/07	1) To develop and implement FHI's exit strategy from the Kenya IUD Revitalization Initiative (ongoing); 2) to provide technical assistance to the Kenya MoH and other partners during the leadership transition; 3) to support advocacy and outreach at the national level to program managers and professional associations in the dissemination of the new Kenya FP Guidelines and FHI's IUD Provider Checklist; and 4) to ensure ongoing monitoring and evaluation of the Kenya IUD Reintroduction experience.
Enhanced Country Program Implementation	CRTU	113122	TNutley	FITS	US\$ 8,706,661 between Kenya, South Africa and Uganda	09/08/05	4/28/10	1) To identify and prioritize local reproductive health research and program needs in five focus countries; and 2) to facilitate efficient, effective implementation and utilization of reproductive health research and programs in the focus countries.
Building Strategic Information Capacity within NASCOP	CRTU	153102	PNgom	FITS	US\$ 137,000	08/22/05	9/30/06	To build capacity for in-country operations research and strategic information activities, including monitoring and evaluation, within Kenya's National AIDS and STI Control Programme (NASCOP).

Improving Use of Family Planning in VCT	CRTU	153103	RWilcher	FITS	US\$ 52,900	09/08/05	6/30/07	1) To determine the effect of family planning provision in VCT on the uptake of contraceptive methods among VCT clients; 2) to develop and target messages to men in VCT programs and to assess whether these efforts strengthen family planning messages and services for men; and 3) to determine how to strengthen overall VCT providers' family planning messages and provision for both men and women.
Kenya PEPFAR Management	CRTU	153106	EMartin	FITS	US\$ 208,000	10/05/05	10/31/06	To support the management and administration of PEPFAR activities in Kenya.
Evaluation of the "Young Men as Equal Partners" Project	CRTU	114100	SThomsen	HSR	US\$ 492,000	8/23/2005	8/30/08	To measure change among young men 10-24 years of age after the implementation of the Young Men as Equal Partners project in the following indicators: 1) Sexual and reproductive health knowledge and attitudes; 2) Attitudes towards gender equity; and 3) Sexual and reproductive health behaviors.

PEPFAR: Risk of HIV & Feasibility Research Among House Girls in Nairobi	CRTU	154100	SThomsen	HSR	US\$ 182,000	7/22/2005	9/30/06	1) To map knowledge of HIV/AIDS, sexual experiences, behaviors and sexual networks of house girls; 2) to determine the feasibility of conducting an intervention study with house girls and/or their sexual partners; 3) to use the information gathered to develop an appropriate intervention to be implemented with the same population; and 4) to develop a protocol for an add-on intervention study, if one is deemed feasible.
Kenya Division of Reproductive Health Capacity Development: Follow-on Activity	CRTU	143103	CToroitich-Ruto	FITS	US\$ 212,499	12/08/05	7/31/07	1) To enhance the DRH staff capacity at all levels in research management skills and utilization of data for decision-making to ensure research utilization and evidence-based programming; 2) to provide a clear system and set of guidelines for conducting RH research in Kenya; 3) to provide efficient communications between the DRH (all levels) and partners as facilitated by establishing a DRH web site; and 4) to provide a platform for gathering strategic information and evaluating public health impact through the annotated bibliography on the web site and the existing resource center.

Evaluation of the uptake of a take-home infant dose of Nevirapine	CRTU	9518	HReynolds	HSR	US\$ 0	7/20/05	8/31/06	To examine whether offering the infant dose of nevirapine to take home increases uptake.
Kenya YRH Assessment	Non-CRTU	4211	JMasterson	Youth-Net	US\$ 38,000	8/16/05	1/31/06	In collaboration with IMPACT/FHI in Kenya, to conduct a two-phased youth RH and HIV programs assessment and make recommendations for improved programs for youth ages 10-24.
Assessing the Future Role of Implants	CRTU	112122	DHubacher	CRD	US\$ 220,000	9/28/05	6/30/07	1) To evaluate the Kenyan experience with implants; 2) to compare <i>Jadelle</i> with DMPA, oral contraceptives and IUDs in terms of costs to donors, programs, and users; and 3) to provide donors with information necessary to determine whether they should begin purchasing implants for their programs.

Source: Electronic Information System, FHI. Accessed December 2005

USAID's Family Planning, Reproductive Health and HIV Programs

USAID/Kenya funds for HIV/AIDS, Population and Health dropped from US\$ 34.9 in 2004 to US\$ 12.6 million in 2005. For more information, refer to [USAID's Integrated Strategic Plan for Kenya 2001-2005](#) and the [USAID's Kenya Program Budget Summary for 2005](#). For more information about PEPFAR-funded activities in Kenya, refer to [PEPFAR's 2005 Country Operational Plan](#).

The USAID Mission in Kenya focuses its activities in Western and Coast provinces. The goals of USAID/Kenya Population and Health activities relate to “HIV/AIDS prevention, care, and support; family planning and child survival; health sector reform and health care financing.” The USAID Mission has made a commitment to support Kenya's efforts in:

- The reintroduction of the intrauterine device (IUD)
- Family planning integration into other services such as MCH and HIV prevention
- Behavior Change Communication (BCC)
- Training and refresher training of health care providers
- Upgrading and strengthening of health facilities to provide RH services
- Contraceptive and condom social marketing
- Community-based distribution program

For the first year of the CRTU, FHI's Kenya portfolio included US\$ 1,060,000 in HIV/AIDS field support funding, PEPFAR funds, and Economic Support Funds (ESF), as well as US\$ 500,000 in population field support funding. CRTU core-funded activities in Kenya total more than US\$ 1.5 million. FHI's Institute for Family Health (IFH) portfolio in Kenya also includes non-CRTU funded projects through the International Partnership for Microbicides (IPM), YouthNet, Private Sector Partnerships (PSP) and AMKENI.

The Mission's continued and expanding financial support of FHI's work in Kenya, through PEPFAR and population field support funding, is evidence of USAID/Kenya's support of CRTU-related activities in country. These funds are currently supporting the following activities:

- Testing the ABC Approach Among Kenyan Youth in Institutions of Higher Learning
- Increasing PMTCT Program Effectiveness
- Risk of HIV and Feasibility Research Among House Girls in Nairobi
- Building Strategic Information Capacity with NASCOP and Kenyatta University
- Improving the Use of Family Planning in VCT
- Kenya Division of Reproductive Health (DRH) Capacity Development
- “What's New and Cool for Youth” Booklet
- Hormonal Contraception and HIV Information Management in Kenya

In order to remain responsive to the growing PEPFAR program in Kenya, FHI's Institute for Family Health has worked to develop research and programs that present a comprehensive reproductive health package including HIV as well as family planning

components. The Mission has been very supportive of this holistic approach to promoting reproductive health and HIV prevention.

Other Country Information

Table 3: Research organizations that FHI has worked with in the past 5 years

Research organization	Project title	FHI technical monitor
Population Council	Cluster randomized trial of two condom promotion strategies	Paul Feldblum
JHPIEGO	Do CTUs reduce medical barriers?	John Stanback
Family Planning Association of Kenya (FPAK)	Female condom community intervention trial: service delivery assessment	Paul Feldblum
IntraHealth International	Barriers to condom promotion among FP service providers	Lori Broomhall
University of Nairobi, Department of Medicine	Pregnancy checklist	John Stanback
KEMRI	International Partnership for Microbicides (IPM)	Michael Stalker
National Coordinating Agency for Population and Development (NCAPD)	“What’s New and Cool for Youth” booklet	Pierre Ngom

Source: FHI’s Kenya field staff, 2006.

FHI also partners with several organizations that do not traditionally focus on reproductive health and family planning. Table 4 provides a list of past and current subprojects implemented in partnership with these organizations.

Table 4: FHI's non-traditional partner organizations

Organization	Subproject Title
I Choose Life (ICL)	Testing the ABC Approach among University Students
Impact Research and Development	Evaluation of Involving Men in RH Decision Making
Matrix, Kenya Red Cross Society	Strengthening Blood Transfusion Services
Steadman Research Services	Behaviour Surveillance Survey
Kenya Girl Guide Association	Evaluation of MTV Staying Alive Campaign
Kibera Community Self-help Program (KICOSHEP)	Evaluation of MTV Staying Alive Campaign
Nation Media Group	Evaluation of MTV Staying Alive Campaign
Kenya Voluntary Women's Rehabilitation Center (K-VWRC)	Male and Female Condom Use Among Core Transmitters
Nairobi City Council	Pilot Study of Reversible Contraception and HIV Infection in Women
Coalition of Violence Against Women (COVAW)	Intimate Partner Violence and Its Relationship to Female Condom Use
Swedish Association for Sexuality Education (RFSU)	Evaluating the "Young Men as Equal Partners" Program

Source: FHI's Kenya field staff, 2006

See Table 5 for a list of other collaborative projects FHI has conducted in the last three years.

Table 5: Other collaborative projects in the last three years.

CA/NGO	Subproject title	Funding sources	Implementing agencies/project partners	Current status
IntraHealth International	Barriers to condom promotion among FP service providers	USAID	FHI/UON	Completed
JHPIEGO	Integration of FP and VCT Services	USAID	FHI	Ongoing

Source: FHI's Kenya field staff, 2006

Health First is involved in a USAID-funded research on female genital mutilation. According to FHI's Kenya field staff, FHI has not partnered with Health First in the past, but this is an organization that represents a potential future partnership opportunity.

Other Donor Priorities Relevant to the Scope of the CRTU

Table 6 provides a list of donor organizations that support reproductive health, infectious disease, HIV/AIDS and youth programs and research in Kenya.

Table 6: Potential donors supporting work in Kenya

Agency/Org.	Areas of Focus							G&A	Tier*
	Reproductive Health		Malaria Research	TB Research	HIV/AIDS Research	Youth			
	Research	Service Delivery				Research	Service Delivery		
USAID	Yes	Yes	Only service delivery	Only service delivery	Yes	No specific youth focus identified	No specific youth focus identified	Yes	1
DFID	Yes, area of high interest; research in Kenya	Yes	Yes – High interest, but only bilateral assistance identified	Yes - Area of high interest; no projects identified in Kenya	Yes - Area of high interest; no projects identified in Kenya	No specific youth focus identified	No specific youth focus identified	Yes	1
Rockefeller	Yes - Area of focus; no projects identified in Kenya	No	No	Yes - Area of focus; no projects identified in Kenya	Yes - Area of focus; no projects identified in Kenya	No	No	Yes – limited to 10% of budget	1
Ford	Yes - Area of focus; no projects identified in Kenya	Yes	No	No	Yes	Yes - research in other African Countries; no projects identified in Kenya	Yes	No, or limited	1
GTZ	No	Yes – Area of high interest	No	No	No	No	Yes – area of high interest; primarily related to HIV/RH	Yes	1
JICA	Yes	Yes	No	No	No	No	Yes	No, or limited	1

* Tier 1 represents highest likelihood of interest, as related to strengths of FHI.

Source: FHI Resource Development Division, December 2005. Information collected from donor Web sites.

There are also several potential private sector partners for FHI's work in Kenya. FHI's Institute for HIV/AIDS, informed by IMPACT's experience collaborating with Coca-Cola and Shell Oil Company, is currently investigating opportunities for such partnerships.

Government Entities Relevant to FHI's Work

As excerpted from FHI's draft Assessment of Youth HIV/AIDS and Reproductive Health Programs in Kenya.⁶²

Division of Reproductive Health (DRH), Ministry of Health

The Division of Reproductive Health (DRH) is a division within the Ministry of Health and is responsible for planning, implementing and monitoring reproductive health programs in Kenya. DRH is guided by the national reproductive health strategy, which is a national response to the Program of Action of the United Nations Conference on Population and Development (ICPD) which was endorsed by 179 countries. Its goal is to provide a comprehensive and integrated system of health care that offers a full range of services by the government, NGOs and the private sector.

National AIDS and STD Control Program (NASCOP), Ministry of Health (NASCOP)

It is a division within the Ministry of Health's Department of Preventive and Promotive Services and has the responsibility of leading and guiding the implementation of all HIV/AIDS and STD programs in the health sector. Under the leadership of the Director of Medical Services, NASCOP has been guiding the implementation of technical aspects of HIV/AIDS STIs and TB in the health sector and operates within the framework of the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005. During the last four years NASCOP has undergone major re-orientation to meet the increasing national demand for collective response to the National AIDS Disaster declared by the government in 1999. With the establishment of the National AIDS Control Council (NACC) the same year, implementation of activities to counter the spread and impact of HIV/AIDS have been scaled up and assumed accelerated pace with an increase in the number of actors dealing with health-related HIV/AIDS issues. In the early stages of its operations, NASCOP focused on HIV/AIDS surveillance, formulating guidelines for all programs and capacity building of providers. However, its role has since expanded to include technical advocacy, policy development, and resource mobilization for implementation activities.

National Coordinating Agency for Population and Development (NCAPD)

NCAPD is in the Ministry of Planning and National Development. Its mandate and role include analyzing population issues and developing policies relating to population; providing leadership and mobilizing support for population programs, implemented by different organizations; assessing the impact of population programs and making recommendations arising from such assessments; assisting other organizations in dealing with population issues; identifying and advising on population issues that may not be adequately or appropriately dealt with by the government; and advocating for political and other support to address population issues.

National AIDS Control Council (NACC), Office of the President

The corporate mission of the National AIDS Control Council, in the Office of the President, is to reduce the spread of HIV, improve the quality of life of those infected and affected and mitigate the socio-economic impact of the epidemic. Its main objectives are to: 1) reduce the number of HIV infections in both vulnerable groups and the general population, 2) improve the treatment and care, protection of rights

and access to effective services for infected and affected people, 3) adapt existing programs and develop innovative responses to reduce the impact of the epidemic on communities, social services and economic productivity.

FHI's Kenya field staff also add the following important government entities:

- Ministry of Local Government
- Ministry of Education, Science and Technology
- Ministry of Gender, Sports and Youth
- Ministry of National Heritage and Home Affairs
- Ministry of Information
- Ministry of Agriculture
- Ministry of Planning/National Development

Other public entities with whom FHI may collaborate, but that are not mentioned above, include:

- Kenya Medical Research Institute (KEMRI)
- Kenya Medical Training College (KEMTC)
- Kenya Bureau of Standards (KEBS)
- Central Bureau of Statistics (CBS)

The following are the key personnel from the Ministry of Health who currently work with FHI:

- Dr. Josephine Kibaru and Dr. Marsden Solomon from the Division of Reproductive Health (DRH), and
- Dr. Ibrahim Mohamed and Ms. Margaret Gitau from NASCOP. Within the specific divisions of NASCOP, FHI works with the M&E department (Godfrey Baltazar), the counseling and testing department (Carol Ngare) and the care and treatment department (Dr. Isaiah Tanui).
- Dr. Chakaya of the National Leprosy and TB program (NLTP).

For more information about organizations working in HIV and reproductive health in Kenya, refer to the [IRIN PlusNews list](#).

National Reproductive Health Strategies

Kenya's Ministry of Health has mapped out its approach to family planning and reproductive health in the National Reproductive Health Strategy 1997-2010⁶³. This strategy incorporates the following six main components: promotion of the concept of reproductive health, meeting unmet family planning needs, safe motherhood and child survival, the management of STDs and HIV, the promotion of adolescent and youth health, and the management of infertility.

FHI's Kenya field staff point out that one new program model currently being tested in Kenya is the utilization of community-oriented resource persons (CORPs) to provide reproductive health services, including DMPA provision, and retired midwives as skilled attendants at delivery.

For more information about Kenya's national reproductive health strategies, refer to:

- Kenya's [National Condom Policy and Strategy 2001-2005](#).
- Kenya Ministry of Health's June 2004 report, [Reproductive Health Research Agenda Setting in Kenya](#).
- Kenya Ministry of Health's October 2005 PowerPoint presentation [Overview of the National Reproductive Health Strategy and the Reproductive Health Decentralized System](#).

Ongoing Microbicide Research

As discussed in FHI's 2003 publication [Will Diaphragms Protect against STIs?](#),

some researchers think that diaphragms and microbicides may be most effective if used together. They hypothesize that a diaphragm, coated on both sides with a microbicide, could block STI pathogens from the cervix and help improve retention of the microbicide in both the cervix and the vagina. Principal investigators for a Kenyan diaphragm and STI study, funded by the CDC through an interagency agreement with USAID and CONRAD, are exploring the impact of the combined use of a diaphragm and a microbicide candidate on the acquisition of bacterial STIs. Dr. Craig Cohen of the University of Washington, USA, and Dr. Elizabeth Bukusi of the Centre for Microbiology Research at the Kenya Medical Research Institute are comparing one group of women who use only the microbicide candidate being tested, with a second group of women who use both diaphragms and the microbicide candidate.

Other organizations conducting trials on candidate microbicides in Kenya include the [Kenya Medical Research Institute \(KEMRI\)](#), funded by USAID, and the [International AIDS Vaccine Initiative \(IAVI\)/Kenya Chapter \(KAVI\)](#). IAVI is funded by the Bill and Melinda Gates Foundation, Rockefeller Foundation, Sloan and Starr Foundations, the Irish, Canadian and UK governments, PATH, European Union and USAID.

For more information on ongoing microbicide research, refer to the clinical trial registry at the [Alliance for Microbicide Development](#).

Research Ethics Requirements in Kenya

The National Council for Science and Technology (NCST) oversees research ethics in Kenya. According to David Borasky, manager of FHI's Protection of Human Subjects Committee (PHSC), there are four institutional review boards (IRBs) acceptable to the NCST which FHI uses to approve its research. These include the University of Nairobi, the Moi Teaching and Referral Hospital Ethical Review Committee based at Eldoret, the Kenyatta National Hospital, and the Kenya Medical Research Institute (KEMRI). Each of these IRBs intends to meet monthly; however, the approval process varies greatly in length, from two weeks to two months.

According to FHI's Kenya field staff, other government approvals required for clinical or social science research in Kenya include the pharmacy and poisons regulatory board, particularly in the case of seeking approval for a clinical research trial. Research clearance can also be granted through the Office of the President.

Point persons for the local IRBs include Professor Guantai, Secretary of the Kenyatta National Hospital Ethical Review Committee; George Segoo, Secretary of the Kenya Medical Ethical Review Committee; and Mr. Benard Adeyo, the Undersecretary for the Science and Technology Department. FHI staff should coordinate all local IRB requests with the FHI country office.

Local IRBs in Kenya typically require:

- a cover letter addressed to the relevant Research Ethics Committee secretary to accompany the research proposal/concept paper,
- the proposal signed by the principal investigators,
- the proposal submitted two weeks prior to the committee's next meeting,
- the submission of the protocol accompanied with the appropriate fees to the board,
- the protocol for submission composed of:
 - Summary
 - Introduction
 - Relevant literature review
 - Appropriate research methodology/methods
 - Authority references
 - Research's ethical considerations
 - Budget

Evidence of the Impact of FHI Research

As excerpted from FHI's Contraceptive Technology Research (CTR) Program Results Briefs⁶⁴, FHI research has had the following impact in recent years:

IUDs

FHI research in Kenya informed the (2002) initiative by the Kenya Ministry of Health to address barriers to IUD access and use, such as provider bias, myths about the method, stockouts, outdated service delivery guidelines and lack of provider training. National guidelines on the use of IUDs were also revised in Kenya because of FHI's work in country.

Male sterilization

On the basis of FHI research results, EngenderHealth is actively promoting fascial interposition techniques in Kenya through provider training and counseling.

Female condoms

FHI research on the female condom informed policy decisions made by USAID and the Ministry of Health in Kenya. While the United Nations Population Fund has procured the female condom for Kenya's Ministry of Health, its introduction has reportedly been more strategic as a result of FHI's research.

HIV/FP integration

Using results from the FHI-led feasibility research conducted in 2002, a task force established by the Kenyan Ministry of Health developed a national strategy to integrate family planning and VCT in Kenya.

Based on recommendations from FHI's assessment of family planning needs in the context of HIV/AIDS in Kenya, the national family planning guidelines in Kenya were revised to include a section on the provision of contraception to HIV-infected women and a section on integrating family planning and HIV/AIDS services.

Results of the evaluation conducted by FHI and Pathfinder International on the family planning and reproductive health needs of COPHIA home-based care clients in Kenya are being used to develop a reproductive health curriculum that will be incorporated into the Ministry of Health's national home-based care curriculum.

Since November 2003, when the national strategy aiming to integrate family planning into all VCT centers in Kenya was approved, the Kenyan Ministry of Health has been implementing the strategy. As of June 2005, more than 100 providers and nearly 40 trainers had been trained on integrating family planning and VCT. Supervised visits to 62 providers have also been conducted to support implementation of the integration strategy in facilities.

Research methodology

The FHI field guide on qualitative methods is being used in graduate program curricula in Kenya.

Other evidence of research utilization includes:

- FHI's efficiency and cost-effectiveness research, which resulted in the Kenya Ministry of Health's program to implement a decentralization program for the training of sexual and reproductive health service providers;
- FHI's involvement in the training of VCT service providers to provide basic FP services (counseling and provision of some methods) as part of the FP/VCT service integration;
- FHI's technical assistance to the Ministry of Health, especially the Division of Reproductive Health in its information management system, has been vital in improving the FP/RH health system performance in Kenya;
- FHI's research findings on the barriers to condom promotion among FP and STI service providers informed and supported retraining providers to promote condom use for FP.

Administrative and Technical Capacity

FHI's Kenya field staff is made up of employees of both FHI Institutes. As of September 2005, staff included three IFH support staff, eight IFH technical staff, and 17 staff shared between both Institutes, as well as a total of 30 employees from the Institute for HIV/AIDS, including five IT staff. FHI's Institute for Family Health technical staff in Kenya represent a wealth of reproductive health research and program experience with FHI and its partners as well as diverse educational backgrounds including doctoral degrees in medicine, nutrition and demography.

Dissemination

FHI Web activity

During the period of January 1 through March 31 of 2005, the FHI Web site received 349,936 visitors worldwide. Of those, 2,525 visitors were from Kenya⁶⁵.

Information-sharing networks

Table 7 provides a list of organizations, committees and groups, of which FHI is an active member, that share information about reproductive health projects and research results on a regular basis in Kenya.

Table 7: Information-sharing networks in Kenya.

Network/Group/Committee	Coordinating Organization/Agency	Members Include
Joint Interagency Coordinating Committee (JICC)	MOH	All local health stakeholders; chaired by the Minister for Health.
Reproductive Health Interagency Coordinating Committee (RH – ICC)	MOH (DRH)	DRH, FHI, JHPIEGO, PATH, LVCT, UNFPA, PPFA-I, JICA, JSI/DELIVER, GTZ, UNICEF, WHO, USAID, NCAPD, FCI, DFID, Population Council
Family Planning Working Group	MOH (DRH)	KOGS, NNAK, OCCO, KCOA, DRH, USAID, AMKENI, GTZ/MOH, JHPIEGO, CAFS, NCAPD, MYWO, CHAK, IntraHealth, APAC, Marie Stopes, JSI/DELIVER, WHO, UNFPA, POLICY Project, KFW, Family Health Options of Kenya, FCI, FHI, Population Council, KMA, KMWA, KMTC, NCK
FP/VCT Integration Subcommittee	MOH (DRH and NASCOP)	NASCOP, DRH, JHPIEGO, KICOSHEP, MOH/TB, CDC, KNH-VCT, AMKENI, FHI
USAID Family Planning Stakeholder Quarterly Meetings	USAID/Kenya	FHI, IntraHealth, JHPIEGO, POLICY Project, EngenderHealth, Population Council, AMKENI, MOH/DRH
NCAPD Reproductive Health Committee	NCAPD	MOH, MOEST, MOGSSS, KIE, KIMC, IPR, FPAK, POOS, MSK, CAFS, FHI, Population Media, NCAPD, MOH
NASCOP PMTCT Committee	MOH (NASCOP and DRH)	FHI, CDC, NARESA, UNICEF, KNH, UNAIDS, USAID, PATHFINDER International, AMREF, CMMB, IMC, Population Council, PSI, EGPAF, CHAK, KMTC, KEPI, Child Health, KEMSA, KOGS, DFID, JSI, IntraHealth, AMKENI, CRS, DRH, NASCOP, PATH, World Vision, GTZ/MOH, Moi University

Source: FHI's Kenya field staff, 2006

Other existing networks and strategies for sharing information among FP/RH stakeholders in Kenya include:

- Technical/consultative stakeholder meetings/forums,

- Monitoring and evaluation activities when stakeholders (implementing and CA) organize meetings to share and discuss emerging issues regarding initial project or research findings, and
- Project/research results dissemination at both the local and national level. Local dissemination meetings (in the community where the project or research was undertaken) mainly involve implementing or collaborating agencies and the participating community members/groups. At the national level, dissemination occurs among a wider audience including a variety of stakeholders.

FHI's Media Relations in Kenya

FHI's relationship with the media makes it possible to extend its research activities to youth, including:

- A YouthNet project, MTV Staying Alive 2002, was undertaken by FHI in collaboration with the Kenya Girl Guides Association, KICOSHEP and Mathare Youth Sports Association (MYSA) and launched with various television stations including the Nation television. The program was rights-free and available to all broadcasters free of charge. In turn, the media (e.g. Nation) worked closely to cover the program/campaign and developed a country forum targeting youth.
- Also, through other TV programs, the media has created forums targeting youth and other aspects of their lives including reproductive health, HIV/AIDS. One such forum was Nation television's "Eyes on the people." Staff from FHI, including Ndugga Maggwa Baker and Peter Mwarogo, participated to discuss, clarify and respond to questions and issues raised by the audience (primarily youth) or program presenters.
- FHI's relationship with the media also extends to the print media. Again, in reaching out to adolescents and young adults, FHI has partnered with Nation media group which helps print and distribute a magazine insert called "Straight Talk." This collaboration has allowed FHI to reach youth in large numbers regarding RH issues.
- FHI has also worked closely with the media and entertainment industry to mobilize, sensitize, educate and disseminate information through the ABC project with youth in institutions of higher learning. Organized at the University of Nairobi's main campus, FHI attracted media houses and freelance journalists to cover ABC events.
- Also, print media features (e.g. Daily Nation's Horizon) provide opportunities that FHI can utilize to communicate its various FP/RH/HIV/AIDS research findings, launch new contraceptives, disseminate prevention messages and also act as a communication channel for informing relevant policy makers.

Depending on the content and context of the program or project being undertaken, FHI also invites journalists and the media to cover events and research results. These contacts include journalists with expertise in various issues that are central to FHI's program activities. For instance, FHI could invite the *Daily Nation's Horizon* feature writer to cover and write about FP/RH research findings, *Saturday Nation's* buzz magazine to cover and write about youth RH information or programs, and youth/Y-FM radio journalists to cover youth-related activities.

Stakeholder Perspectives

Participants at the November 16-17, 2005 CRTU Stakeholder Committee meeting in Naivasha, Kenya⁶⁶ identified the following areas as priorities for the CRTU Program in Kenya:

1. Improve providers' attitudes, skills and confidence to provide LAPMs and HC,
2. Create demand (decrease myths, address side effects, improve image) for LAPMs,
3. Scale-up and evaluate community-based distribution of barrier methods through non-health networks (ex: via agriculture workers),
4. Target opinion leaders and policymakers with advocacy messages so they can support/lobby for family planning,
5. Involve men and youth (ex: mobile video units with messages targeted to these populations to increase demand) in family planning,
6. Generate strategic information to continue to refine models of HIV/FP integration,
7. Improve understanding of the relationship between contraception and HIV and informing policymakers with this information,
8. Improve provider skills to communicate messages on sexuality,
9. Promote best practices that increase provider efficiency (ex. Population Council's balanced counseling strategy),
10. Improve models of supervision and other programmatic inputs,
11. Increase access to hormonal methods through increasing service delivery points (CBD- for DMPA provision, pharmacists, etc.),
12. Expand types of providers that provide LAPMs (ex: nurse provision of mini-lap),
13. Harmonize and disseminate policies; ensure adherence.

Informed by this list of priority areas, a country matrix presenting an updated view of what areas FHI and Kenya are likely to focus on during the CRTU Program is currently being updated and revised. The document should soon be on FHI's SharePoint site under FITS' Kenya country page. It, as well as this document, should help FHI staff tailor their efforts so that work done under the CRTU is timely, relevant and helps to expand the range and support the use and availability of safe, effective, acceptable and affordable technologies for the prevention of unplanned pregnancy and sexually transmitted infections, including HIV, in Kenya.

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