2006 UPDATES

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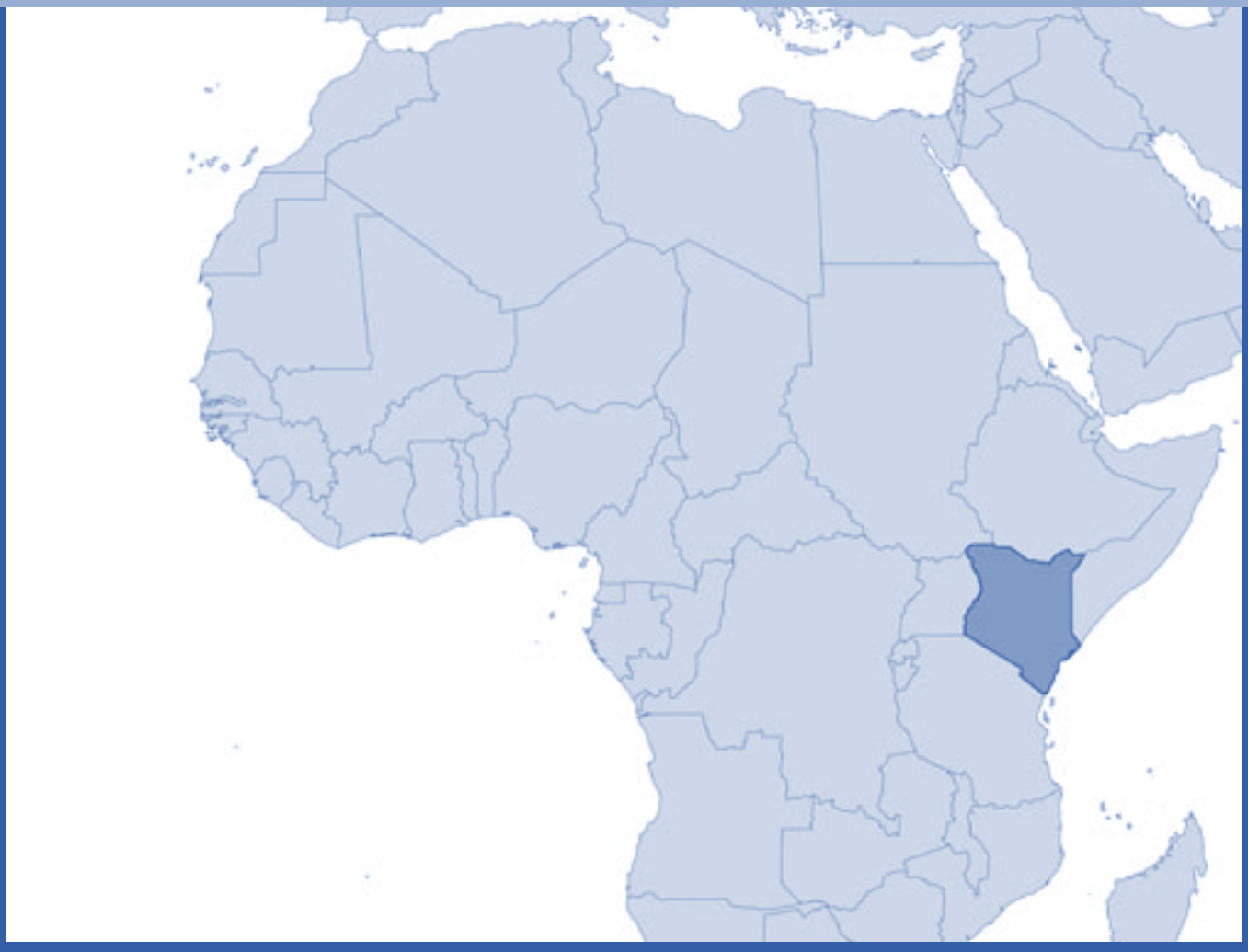
THE IMPACT OF THE GLOBAL GAG RULE IN KENYA



THE GAG RULE IS UNDERMINING KENYA'S REPRODUCTIVE HEALTH care system at a time when support for family planning and basic reproductive health care is more important than ever.

OVERVIEW

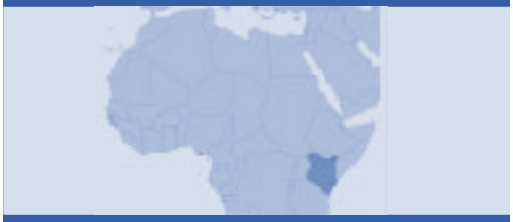
The effects of the Global Gag Rule, compounded by the global shift of funding from family planning to HIV/AIDS, are far-reaching in Kenya. The country's two leading reproductive health organizations – Marie Stopes International Kenya (MSI Kenya) and the Family Planning Association of Kenya (FPAK) – are important providers of reproductive health services, including prenatal and postnatal obstetric care and HIV/AIDS prevention efforts, especially in rural areas. In many underserved areas, their clinics are the only source of affordable primary health care. After refusing the terms of the gag rule in 2001, both organizations lost critical U.S. family planning funds.

MSI Kenya shuttered two clinics in 2002 and has only prevented the closure of further clinics by raising prices and laying off staff members. At the same time, FPAK's attempts to raise enough money to fill the void left by U.S. funds have failed. After initially closing three clinics in 2001 and 2002, the organization closed three more of its 12 remaining clinics in March 2005. These clinics provided critical services to poor and underserved populations in urban, peri-urban and rural areas; those services included: family planning (including the provision of emergency contraception), voluntary counseling and testing (VCT) for HIV/AIDS, management of sexually transmitted infections, pharmaceutical services, laboratory services, post-abortion care, maternal and child health services, Pap smear tests, minor surgery, and well–baby services. Following the closure of these clinics in 2005, at least 9,000 people – primarily women and children – were left with little or no access to health care.

CONSEQUENCES OF THE GLOBAL GAG RULE

- Kenya's leading reproductive health care providers have suffered serious budget cuts and were forced to close eight clinics, lay off large numbers of staff and scale back programs.
- In most cases, those shuttered clinics were the only source of health care for local communities.
- Community-based outreach services throughout Kenya's rural areas have been greatly curtailed as the country's primary family planning organizations cut back due to a lack of funds. Outreach services are often the only access rural men and women have to contraceptive supplies and education on HIV/AIDS.
- Kenya's leading family planning organizations have been forced to withdraw from a U.S.-funded project to provide comprehensive and holistic reproductive and child health care, as well as HIV/AIDS prevention and treatment, to vulnerable populations in Kenya; the project is consequently losing ground.

DEMOGRAPHICS



Population: **34.3 million (by 2005)**[1]

Percentage of women aged 15-49: **48.4%**[2]

Contraceptive prevalence (natural and modern methods): **39%**[3]

HIV prevalence in adults aged 15-49: **6.7%**[4]

Average births per woman: **5.0**[5]

Percentage of population aged 24 or younger: **65.7%**[6]

Life expectancy: **50.3 years**[7]

Abortion policy: **Abortion is permitted to save the life of a woman.**[8]

A HISTORY OF FAMILY PLANNING SERVICES IN KENYA

1950

1950s

Modern methods of contraception are available in Kenya.

1960

1962

The Family Planning Association of Kenya (FPAK) is established and affiliates with the International Planned Parenthood Federation (IPPF).

1963

Kenya gains independence from Great Britain.

Pathfinder International begins family planning and reproductive health programs in Kenya.

1965

The Government of Kenya formally accepts family planning as part of its national development strategy.

1967

Kenya is the first African country to establish a population policy and national family planning programs.

1970

1974

The Ministry of Health establishes a Family Planning Welfare Center to scale up government family planning efforts. This agency later becomes the Division of Primary Health Care (PHC) and evolves into the Division of Reproductive Health of the Ministry of Health.

> "The Global Gag Rule does not make sense. It is not applied to the United States. Instead, it is applied to countries that are the poorest…that have the highest rates of maternal mortality."
>
> *-Staff, Kenyan government agency*

COMMUNITY-BASED SERVICES HARMED

One of the major impacts of the gag rule in Kenya is the immense reduction of community outreach efforts to poor and vulnerable populations. FPAK and MSI Kenya were the country's leading providers of reproductive health care to people living in poor and rural communities. U.S. funds supported the work of FPAK community health volunteers, providing the contraceptive supplies that volunteers distributed in rural areas and covering the out-of-pocket expenses volunteers incurred, including transportation costs. Under the gag rule, this funding for volunteer activities stopped, and FPAK and MSI Kenya had to drastically reduce outreach activities.

Funding shortages have also led to a lack of regular contraceptive technology updates for community health workers. As a result, community health workers are uninformed of the types of family planning methods available to HIV-positive people. They avoid discussing condoms or reproductive health issues because their training has been restricted. Yet an emerging public health challenge involves those HIV-positive Kenyan women who are sexually active and desire pregnancy, but do not have the knowledge or tools to prevent transmission of the virus to their child.

PARTNERSHIPS DISRUPTED

In March 2001, USAID launched the AMKENI Project (AMKENI means "new awakening" in Kiswahili) to promote integrated reproductive health care. The Global Gag Rule took effect in the spring of 2001, just as AMKENI got under way. FPAK and MSI Kenya – both central to AMKENI's mission – refused the gag rule restrictions and, thus, had to withdraw from the project as they were no longer eligible for U.S. family planning funds. As a result of their withdrawal, AMKENI's effectiveness has been greatly reduced. At the time of this writing, no substitute partners had been found.

> "Losing MSI Kenya and FPAK from AMKENI was a huge blow. They were the ones meant to do outreach services. There is no replacement."
>
> *Staff, U.S. NGO*

FPAK's and MSI Kenya's departure forced AMKENI project leaders to turn to the public sector for outreach work, which has proven to be extremely difficult. Management systems within the public sector are weak, and there is little capacity to become involved in comprehensive reproductive health care, especially in the areas of long-term or permanent methods of contraception (which are FPAK's and MSI Kenya's strengths). Although training sessions were carried out for doctors working in the public sector on long-term or permanent family planning methods, these measures have been proven to be insufficient.

> "We're not reaching as many people as we need to. People are not getting access."
>
> *Staff, U.S. NGO*

AMKENI, however, is not the only partnership that has been negatively affected by the gag rule. Because FPAK and MSI Kenya play such central roles in the country's reproductive health and population sphere, any harm that comes to them has a ripple effect throughout Kenyan society. For example, the work of the National Coordinating Agency for Population and Development (NCPD)[9] has suffered. The NCPD has historically depended on partners, such as FPAK, to aid in the implementation of Kenya's population policy. Unfortunately, because of FPAK's budget deficit, it has been unable to assist the NCPD in this process.

REPRODUCTIVE HEALTH SERVICES CONSTRAINED

FPAK and MSI Kenya are the leading providers of long-term or permanent methods of contraception, and FPAK is the country's primary provider of Pap smear tests for cervical cancer – a major killer of women. These and other services were disrupted when the gag rule was reinstated. However, post-abortion care - an activity specifically allowed by the gag rule – has also been curtailed.

1982

FPAK becomes the first Kenyan non-governmental organization (NGO) to establish a community-based distribution program with support from the U.S. Agency for International Development (USAID).

EngenderHealth begins working in Kenya and helps to ensure access to safe and voluntary family planning.

1984

The first reported case of HIV/AIDS in Kenya occurs.

USAID's Private Sector Family Planning (PSFP I) project is established to provide a full range of managerial, programmatic and clinical assistance to private companies and industries to initiate and provide health and family planning services for their employees and surrounding communities. The second phase of this project, PSFP II, assists a select number of private health practitioners in initiating family planning services.

The Reagan administration announces the Mexico City Policy. At this point, FPAK is only receiving U.S. funds through the International Planned Parenthood Federation (IPPF). However, IPPF rejects the terms of the gag rule, loses U.S. funding and, consequently, reduces donations to FPAK. FPAK then turns to USAID/Kenya for direct assistance and reluctantly agrees to the terms of the gag rule. As a result, FPAK receives USAID funds directly for the first time.

1985

Marie Stopes International Kenya (MSI Kenya) begins providing services in the country.

Kenya hosts the World Conference on Women in Nairobi.

1990

1991

"Family Planning Policy Guidelines and Standards for Service Providers" is published by the Ministry of Health to help family planning workers assist Kenyan couples in making appropriate contraceptive choices.

1992

USAID's global Family Planning Services Project (FPSP) begins. Its overall goal is to meet growing demand for family planning and reproductive health services by building capacity to create and improve access to the fullest possible range of quality information and services.

1993

The Mexico City Policy is rescinded by President Clinton.

1995

EngenderHealth expands its focus to broader reproductive health care, including contraceptive services, maternity services, post-abortion care and infection prevention.

The Government of Kenya provides financial support through its National Coordinating Agency for Population and Development to expand FPAK facilities. This enables FPAK to open new clinics and build headquarters in Nairobi.

This disruption of services is particularly damaging in Kenya, where abortion is illegal and unsafe abortion is a major public health problem. A recent study estimates that as many as 300,000 abortions occur in Kenya annually.[10] Unsafe or failed abortions are the cause of an estimated one-third of maternal deaths in the country each year. AMKENI had been relying on FPAK and MSI Kenya to provide post-abortion care as an element of its integrated health care project. Unfortunately, the public sector has not fully replaced this gap in service provision.

> "There is no substitute for FPAK. No one has stepped in to fill the gap. If a woman used to go to one of their clinics that closed, there is a good chance that there will be no other clinic to go to in that area."
>
> *Staff, Kenyan government agency*

Other FPAK services that have been either cancelled or scaled back include child immunization and the training of nurses on family planning methods. The organization's diminishing ability to train nurses has had a direct effect on the quality of care. Plans to expand services are also on hold: FPAK is eager to integrate childhood disease management into its reproductive health services, but has been unable to fund the training of nurses required for this initiative.

Also due to the loss of funds, senior staff members are leaving FPAK to find better jobs elsewhere. New staff members have to be hired and trained in sexual and reproductive health, but there is little money to do this. Thus, the capacity and expertise of NGOs such as FPAK are continuously being eroded.

Despite its funding hardships, FPAK has felt pressure to introduce other vital services in its clinics. It has started providing antenatal and postnatal maternity services in two facilities and also now provides VCT services at most facilities, in addition to pharmaceutical services. In 2005, FPAK opened a maternity clinic in Nairobi.

MSI Kenya has similarly tried to make up for lost funds by diversifying its services. For example, the organization has continued to set up maternity delivery homes. However, staff members still cannot reach as many people as needed, and plans to scale up MSI Kenya's existing clinics to introduce HIV prevention and treatment programs, including prevention of mother-to-child transmission (PMTCT), in maternity delivery homes are currently on hold.

THE FIGHT AGAINST HIV/AIDS INHIBITED

> "HIV/AIDS is a disaster in Kenya. We needed resources here, but we never wanted our partners in reproductive health to drop what they were doing and turn to focus solely on HIV/AIDS. Reproductive health is equally important. No country will achieve the MDGs if family planning programs do not run well."
>
> *Staff, Kenyan government agency*

By crippling the country's primary reproductive health care providers, the gag rule has undermined HIV/AIDS prevention efforts in Kenya. Given that HIV/AIDS is primarily transmitted via heterosexual sex, a crucial link exists between HIV/AIDS and basic sexual and reproductive health care. Family planning providers, then, play a key role in HIV prevention. Unfortunately, because of the gag rule and an increasing focus on HIV/AIDS, donors and policymakers have sidelined their support of reproductive health care providers.

In Kenya, U.S. funds for HIV/AIDS activities heavily outweigh those available for family planning or basic reproductive health care. Most U.S.-based family planning and reproductive health NGOs in Kenya are now focused almost entirely on HIV/AIDS. Because of this shift, funds for comprehensive reproductive health or family planning efforts are scarce. When funds are available, the gag rule ensures they are not directed to Kenya's leading providers of family planning.

On the ground, reproductive health care providers in Kenya argue that they do not wish to take money away from HIV/AIDS activities; they simply wish to use funds more effectively and efficiently by integrating HIV/AIDS efforts with basic reproductive health care where possible. By disrupting partnerships, however, the gag rule makes such integration and coordination difficult, if not impossible.

One example can be seen in the AMKENI project. As part of its comprehensive integrated care project, AMKENI has received U.S. HIV/AIDS funds to provide HIV prevention, treatment and care at the community level. Unfortunately, such community-level activity cannot be carried out properly due to the absence of FPAK and MSI Kenya, the only two organizations with effective networks in the community. Therefore, not only has the gag rule disrupted AMKENI's reproductive health goals, but it has also prevented AMKENI from properly fulfilling the aims of U.S. HIV/AIDS assistance.

1997

"Reproductive Health/Family Planning Policy Guidelines and Standards for Service Providers" is published by the Ministry of Health (MoH) to provide the most current knowledge of contraceptive methods and other aspects of reproductive health.

The Kenyan MoH publishes the National Reproductive Health Strategy (1997-2010).

2000

USAID's global FPSP project ends.

2001

USAID lists Kenya as a "rapid scale-up" country for HIV/AIDS assistance.

President George W. Bush reinstates the Mexico City Policy, or Global Gag Rule as it is known by then.

The USAID-funded integrated health project - AMKENI - is launched.

IPPF refuses the terms of the gag rule and loses U.S. funds

FPAK refuses the terms of the gag rule and loses 58 percent of its budget through direct cuts from U.S. funds and indirect cuts from IPPF.

MSI Kenya also refuses the terms of the gag rule and loses 40 percent of its operating budget. The same year, MSI Kenya closes two clinics, lays off one-fifth of its staff, cuts salaries and increases client fees.

FPAK closes three clinics that collectively served about 1,560 women, men and children every month. Thirty percent of FPAK's staff is laid off.

2003

The Adolescent Reproductive Health & Development Policy is launched by the MoH with support from NGOs and the United Nations Population Fund (UNFPA). This holistic policy addresses poverty and socio-economic issues, reproductive health information and services, harmful practices, and gender issues.

2004

Preliminary results of the Kenya Demographic Health Survey are released, showing no increases in contraceptive use since 1998 and a reversal of the previous trend toward declining fertility.

The results of a national assessment on the magnitude of abortion complications in Kenya are published in BJOG: An International Journal of Obstetrics and Gynaecology. The study was conducted by the Kenya Medical Association, the Federation of Women Lawyers-Kenya and Ipas.

2005

FPAK opens a maternity unit in Nairobi to increase access to safe delivery and to offer permanent and long-term contraceptive methods.

Three more FPAK clinics are closed in Kakamega, Nkubu and Nyeri in March.

The ready availability of funds for HIV/AIDS programs has also led to increasing competition for jobs in this area. Many experts in family planning and reproductive health are moving to focus solely on HIV/AIDS. FPAK has lost almost all of its senior staff to well-funded HIV/AIDS programs.

"So even if we manage to keep our clinics open, we have no senior personnel to run them," said an FPAK representative.

CONTRACEPTIVE CRISIS DEEPENED

As is the case for many developing countries, Kenya depends heavily on donors for its supply of contraceptives. Major donors, such as UNFPA, have decreased donations to Kenya. UNFPA in particular decreased its donation of supplies at least partly in response to the budget difficulties Kenyan NGOs faced after the U.S. government refused to fund them. General procurement and logistic problems compound the situation, and reproductive health providers in Kenya now face constant stock-outs and shortages of supplies.

The donor-driven focus on HIV/AIDS has not helped. According to reproductive health NGOs, it is simply getting more and more difficult to maintain donor interest in contraceptive security.

> "The whole donor-driven contraceptive supplies system broke down in 2000 when we made the shift toward focusing on HIV/AIDS instead of family planning."
>
> *Staff, international NGO*

At a time when demand for contraception is increasing, family planning providers in Kenya are suffering from shortages in all commodities, especially contraceptive implants.

Supplies for HIV/AIDS activities are also particularly difficult to obtain, even though funds for HIV/AIDS efforts have increased. Many providers face a lack of Nevirapine, an anti-retroviral (ARV) drug that is specifically used in PMTCT efforts, as well as a serious shortage of HIV test kits.

CONCLUSION

The gag rule is undermining Kenya's reproductive health care system at a time when support for family planning and basic reproductive health care is more important than ever. The preliminary report of the 2003 Kenya Demographic Health Survey (KDHS) is ominous. The deterioration of reproductive health care in the country has undoubtedly contributed to a startling reversal in trends of earlier years. Fertility has increased (from 4.7 in 1998 to 4.9 in 2003), and contraceptive prevalence has

stagnated: at 39 percent, it is the same rate today as in 1998. Antenatal care from health professionals rose between 1989 and 1993, but consistently declined thereafter. The percentage of medically-assisted births fell from 50 percent in 1993 to 42 percent in 2003.

Unsafe abortion remains a major public health threat, disproportionately affecting women under the age of 25 and contributing to high maternal mortality rates.

A multitude of factors are to blame for these poor indicators. Health standards have been in decline for over a decade in Kenya, while donor attention to sexual and reproductive health in the country has been waning for some time. Although the gag rule does not solely account for this decline in reproductive health standards, it exacerbates an already deteriorating situation. Primary reproductive health care providers are being de-funded in a country where fertility rates are increasing, HIV/AIDS is ravaging the country, and fewer women are receiving pregnancy care.

NOTES

1 United Nations Population Division, World Population Prospects, the 2004 Revision. Available at: http://esa.un.org/unpp/ (accessed Dec. 13, 2005).

2 Id.

3 United Nations Population Division, Dept. of Economic & Social Affairs, World Contraceptive Use 2003 Wall Chart, ST/ESA/SER.A/227, 2004.

4 UNAIDS 2004 Report on the Global AIDS Epidemic. Available at: http://www.unaids.org/bangkok2004/report_pdf.html (accessed Nov. 15, 2004).

5 United Nations Population Division, World Population Prospects, the 2004 Revision. Available at: http://esa.un.org/unpp/ (accessed Dec. 13, 2005).

6 Id.

7 Id.

8 Center for Reproductive Rights, The World's Abortion Laws, June 2004. Available at: http://www.reproductiverights.org/pub_fac_abortion_laws.html (accessed Nov. 15, 2004).

9 The acronym NCPD previously stood for the National Council for Population and Development until October 23, 2004 when a presidential order from H.E. Mwai Kibaki, changed it to the National Coordinating Agency for Population and Development.

10 See Gebreselassie et al., "The Magnitude of Abortion Complications in Kenya." British Journal of Obstetrics and Gynecology 111 (2004): 1-7.

THE GLOBAL GAG RULE IMPACT PROJECT

is a collaborative research effort led by Population Action International in partnership with Ipas and Planned Parenthood Federation of America and with assistance in gathering the evidence of impact in the field from EngenderHealth and Pathfinder International. Recognizing the historic leadership role of the United States in supporting voluntary family planning and related health care internationally, the Project's objective is to document the effects of the Global Gag Rule on the availability of life-saving family planning services, as well as on efforts to address other major threats to public health, including HIV/AIDS and maternal deaths due to unsafe abortion. The project received its funding solely from private sources.

The Global Gag Rule Impact Project gratefully acknowledges the research and writing of Dina Bogecho of Population Action International.

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