

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

On the Ground with the Global Health Initiative

EXAMINING PROGRESS AND CHALLENGES IN KENYA

CSIS Delegation to Kenya

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Cover photo: U.S. Army medical researchers take part in World Malaria Day, 2010, Kisumu, Kenya, April 25, 2010; <http://www.flickr.com/photos/usarmyafrica/4553118035/>.

Center for Strategic and International Studies
1800 K Street, NW, Washington, DC 20006
Tel: (202) 887-0200
Fax: (202) 775-3199
Web: www.csis.org



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CSIS Delegation to Kenya¹

Key Findings

In December 2010, the Global Health Policy Center at the Center for Strategic and International Studies (CSIS) organized a trip to Kenya to examine progress in implementing the U.S. government's Global Health Initiative (GHI). This trip followed an earlier mission to Kenya in August 2009 that had helped inform the recommendations of the CSIS Commission on Smart Global Health Policy.² The December trip grew from a strong sense of the importance of examining how GHI was evolving on the ground in key partner countries, especially as debate sharpens in Washington around whether and how to preserve U.S. gains in global health, expand on them, and win continued support across partisan lines, from congressional and executive decisionmakers and from American citizens. These questions have intensified in the midst of a protracted U.S. economic downturn, acute budget pressures, and following the November 2010 elections, split power in government. It was our view that a close analysis of GHI's evolution since 2009, through the prism of how it is unfolding in Kenya, would be highly valuable and timely to broader discussions in Washington on GHI's future in this era of austerity.

¹ The CSIS Delegation included Suzanne C. Brundage, Lisa Carty, Janet Fleischman, and J. Stephen Morrison of the CSIS Global Health Policy Center and Christopher J. Elias of PATH. The authors wish to thank the U.S. embassy in Kenya for its guidance and insights, particularly the Global Health Initiative country team composed of the Office of the Global AIDS Coordinator, the U.S. Agency for International Development, and the Centers for Disease Control and Prevention. We are also grateful to the many Kenyan partners that hosted us during our visit. We benefited greatly from their expertise and advice.

² In 2009, the bipartisan CSIS Commission on Smart Global Health Policy brought together opinion leaders from Congress and the security, foreign policy, media, business, and public health communities to develop a long-term strategic approach for U.S. global health investments. In its final report, *A Healthier, Safer, and More Prosperous World*, the commission outlined a five-point agenda for global health: (1) Maintain our commitment to the fight against HIV/AIDS, malaria, and tuberculosis; (2) Prioritize women and children in U.S. global health efforts; (3) Strengthen prevention and health emergency response capabilities; (4) Ensure that the United States has the capacity to match our global health ambitions; (5) Make smart investments in multilateral institutions.

Discussion and debate about the merits of GHI's approach have unfolded over the course of 2009 and 2010. The CSIS delegation turned its attention outside Washington and sought to ascertain whether, in the Kenyan context, GHI really did represent a new way of doing business and whether this new model could have real and sustained impacts. In addition, the delegation hoped to identify key elements essential to GHI's long-term success, while also offering some reflections on what lessons GHI might have for the debate around foreign aid reform and implementation of the recommendations of the recently released Quadrennial Diplomacy and Development Review (QDDR). The group was also drawn to Kenya because of the opportunities and challenges that have emerged since its August 2010 constitutional referendum, which will have consequences not only on how U.S. health programs unfold but also on the broader bilateral relationship.

Early Progress

The group recognized at the outset that GHI implementation is still at an early stage and that the Kenyan experience may be exceptional in several respects. For that reason, care should be taken in drawing lessons for other GHI countries.

Kenya stands out as a state that matters significantly to U.S. interests, as evinced by repeated high-level Obama administration engagement. U.S. health investments in Kenya exceed \$500 million a year, major health gains have been achieved while significant health challenges persist, and U.S. engagement in health is bound together with a broader U.S. interest in Kenya in promoting stability, economic growth, and good governance that rests on democratic principles. U.S. interests are also tied to Kenya's pivotal influence over regional stability and economic growth. The U.S.-Kenya bilateral relationship is entering a tense and uncertain period as both sides look toward Kenya's 2012 national elections, knowing there is a considerable amount at stake for internal stability and U.S. interests. Further movement on constitutional reform and good governance will likely be stalled between now and the elections, with potential consequences for how U.S. health programs unfold during that period.

First and foremost, the delegation concluded that current U.S. health investments in Kenya are making a profound difference in individual lives and in the well-being of countless communities. Regardless of the status of GHI, that fact in and of itself is an important outcome that should be celebrated and not undervalued. The roots of these achievements lie in the George W. Bush era, when the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI) were launched, backed by considerable bipartisan support.

Second, in Kenya, GHI does appear to represent a significant change both in how the U.S. government does business internally and in how it engages with external partners. Meaningful work is being done in developing a new and more cohesive model of integrating U.S. government health programs and in prioritizing key approaches that could have significant public health impacts, but have been neglected in the past. For example, the U.S. interagency team has made a commitment to better align existing resources so they more effectively support work in maternal and child health (MCH), neglected tropical diseases (NTDs), and strengthening health systems.

Programs now focus more on improving integration, examining unit cost efficiencies, capturing impacts, collaborating with other donors, and leveraging higher commitments from the Kenyan government. These are all welcome and constructive changes that strengthen U.S. approaches to health and have broad applicability beyond Kenya.

Progress in Kenya³

- Rise in immunizations: Proportion of fully immunized children has increased from 57% in 2003 to 77% in 2009.
- Significant declines in child mortality since 2003: Under age-five mortality has declined from 115 to 74 deaths per 1,000 live births, while infant mortality has dropped from 77 to 52 deaths per 1,000 live births.
- Slight increase in percentage of women receiving antenatal care from a professional: From 88% in 2003 to 92% in 2009.
- Increase in insecticide-treated net (ITN) ownership to fight malaria: 56% of households had at least one ITN in 2008–2009, up from 6% in 2003.

Responsibility for these innovations and the achievement of greater unity of effort stems from leadership by the senior-most levels of the embassy, specifically the ambassador and deputy chief of mission. The extensive use of “chief of mission authority,” a key recommendation of the QDDR, is integral to success in Kenya and is an approach that needs to be replicated broadly if GHI is to succeed. Significantly, Kenyans and other donors alike have acknowledged this positive change: many remarked that the advent of GHI has been accompanied by a new willingness to have U.S. government-funded programs be more driven by country priorities and responsive to country needs than had been the case in the past. External partners also commented on the new willingness of the U.S. government to work collaboratively, as well as a new perceived “branding” of U.S. government health programs that reflect diminished interagency rivalries and a more cohesive, forward-looking U.S. approach.

Challenges Ahead

These are all smart, promising changes in the way the U.S. government goes about doing its business in health, changes that bridge the Bush and Obama administrations. Taken together,

³ Data taken from Kenya National Bureau of Statistics (KNBS) and ICF Macro, *Kenya Demographic and Health Survey 2008–09* (Calverton, Md.: KNBS and ICF Macro, June 2010), <http://www.measuredhs.com/pubs/pdf/FR229/FR229.pdf>.

they could have a lasting impact on how well U.S. government health aid dollars are used. But, real challenges remain.

First, there are significant questions as to whether GHI's new approaches can be brought to scale and sustained without additional resources. For example, while the new focus on more patient-friendly integrated services, with an emphasis on maternal and child health and improved access for women and girls, has been broadly applauded, it is unclear whether the United States has the means to execute meaningful results at scale and over time. GHI committed in 2009 to provide \$63 billion across all GHI countries over six years. However, to date little new money beyond what had already been budgeted has been provided in Kenya, and there is the very real possibility of budgetary cuts. In all GHI countries, this budgetary reality puts a premium on effectively leveraging existing U.S. government financial resources and on securing increasing funding from partner governments. This is a stated goal of GHI, but one that will be difficult to achieve in most GHI countries. This goal also suggests an imperative to work in much more direct collaboration with other donor entities, including the Global Fund to Fight AIDS, TB and Malaria, the World Bank, the private sector and nongovernmental organizations. Across the board, external partners and other observers in Kenya indicated that they have seen a greater willingness in principle by the United States to plan jointly and work within the framework of broader country and multilateral strategies. However, it is unclear whether this evolution in the U.S. approach will mature into more active joint working arrangements and whether it will be matched by a similar commitment from the government of Kenya to work in a more transparent, constructive, and accountable manner.

Second, there is a risk that the greater internal cohesion across U.S. government agencies, which has clearly been a driver of current GHI progress in Kenya, will fracture if budgets become even more constrained and difficult choices need to be made across agencies and programs. The outstanding question is: Can the environment in Washington—the array of executive agencies and congressional committees—support the consolidation of the early gains seen in Kenya? Despite the demonstrable progress toward a whole-of-government approach, there still linger significant questions regarding the division of labor across U.S. agencies. In the past it has been unclear who is in charge of overall GHI coordination. That problem hopefully will ease with the recent appointment of a GHI executive director with the potential to wield considerable authority in unifying U.S. approaches. It is also unclear whether GHI partners—PEPFAR, the Centers for Disease Control and Prevention (CDC), the U.S. Agency for International Development (USAID)—will be able to put aside individual institutional ambitions for the sake of greater efficiencies and improved outcomes across GHI as a whole. The QDDR attempts to clarify GHI's long-term organizational structure, but in fact only further muddies the waters; it lays out a complicated process through which non-PEPFAR components of GHI (e.g., maternal child health, family planning, neglected tropical diseases, etc.) migrate back to USAID for ongoing oversight, once USAID has met a series of management benchmarks.

Third, GHI continues to suffer from an identity crisis. Is it predominantly a set of operating principles and practices, or will it include new money dedicated to enlarging the scope of U.S.

programs, concentrated in maternal and child health, neglected tropical diseases, and investments in health systems? Despite efforts to dampen expectations of significant increases in funding and to explain that a major part of GHI's value-added is to promote a new way of using existing resources to achieve better outcomes, this message has not been well conveyed. Contradictory and ambiguous messages have created confusion about whether substantial new resources will be available to bring about new programs or whether planning should be based on no or very limited growth in resources, or worse. GHI needs a far better communications strategy both for a Washington and an international audience. This strategy needs to clearly articulate the more modest gains that can be expected within existing funding ceilings, the more ambitious achievements that are possible with more substantial additive funding, how budget reductions may be handled, and the longer-term plan for ensuring that even as PEPFAR continues to manage the lion's share of U.S. funding for health, it does so in a way that advances a range of health goals.

Ensuring Success

The delegation concluded that several elements will be essential for GHI's long-term success, certainly in Kenya, but elsewhere as well.

- *Active, engaged, senior leadership will be critical at every level.* In Washington, continued engagement from the White House, State Department, Congress, and GHI principals will be the *sine qua non* for keeping this initiative on track and keeping the U.S. bureaucracy focused on using a whole-of-government approach to achieve better impacts. Greater clarity is needed on who is in charge. Similarly, equally strong and visible leadership will be required in U.S. engagements with international leaders, particularly with senior political figures in GHI countries. The U.S. chief of mission will be pivotal to this effort and needs to be empowered to play this role. U.S. efforts should be focused on ensuring that partner countries are better developing their own internal capacities to address their national health challenges, including the ability to mobilize greater domestic financial resources.
- *Capturing results through rigorous measurement will be essential to demonstrate progress, overcome skepticism, and create a system of accountability and higher efficiency in the use of resources.* GHI's story has yet to be told: countries such as Kenya can in the near term begin to tell a compelling narrative that can shape perceptions in Washington—if impacts are well documented and effectively communicated to a broader audience.
- *Long-term strategic planning is essential for setting realistic benchmarks, preserving forward momentum, and defining an exit strategy.* It is essential to preserve the confidence of partners and see beyond near-term difficulties. GHI's current planning horizon stretches through 2014. Planning should begin now to look beyond that window to ensure that current investments will have maximum impact and to ensure that there is a plan for broader global burden sharing over the long term. Three ingredients will be essential: expanded and genuine partnerships with other donors and funding entities such as the Global Fund to better

leverage joint approaches; increased funding commitments from partner developing country governments; and a significantly intensified focus on disease prevention, both to minimize numbers of new patients requiring life-long treatment for HIV and to reduce the costs of preventable childhood and maternal deaths and disease.

- *It is critical to acknowledge that predictable financial resources are required to protect current investments and to achieve long-term success.* Future growth may be considerably less than the previous decade, but even modest growth will create the margin for innovation and the achievement of new important goals. GHI planning tools, particularly the focus on achieving maximum efficiencies, can play a critical role in achieving cost savings in an austere budget environment.

Finally, GHI is part of a broader set of transformations in U.S. foreign assistance programs, reflected in the recently released QDDR. In many respects, the early approaches taken by GHI foreshadowed a number of the QDDR's key recommendations focused on advancing a whole-of-government approach, promoting greater country ownership and burden sharing with partner countries, and measuring impacts through rigorous metrics. GHI's preliminary successes in applying some of these principles should be taken as an early indication that similar types of reforms could be made to work successfully in other U.S. foreign assistance programs. GHI is a signature initiative identified with the Obama administration. But it is much more than that. It builds on the Bush legacy and embodies a set of principles and aspirations that can play a critical role in driving forward a more effective approach to foreign aid.

GHI in Kenya: A Closer Look

In Kenya, GHI is unfolding in a complex political and economic environment where substantial health investments over several decades have helped set the stage for GHI implementation. The CSIS delegation recognized that in its brief visit it would only be possible to examine a part of the GHI story. The group chose to focus its attention on three key issues: (1) better understanding the impact Kenya's evolving politics might have on GHI's success; (2) examining practically how GHI and its learning agenda had evolved over the last 18 months; and (3) reviewing how GHI's gender-related objective, including expanding access to a broad range of maternal and child health services, could best be achieved. In addition, given the considerable investments by the United States in vaccine research in Kenya, and the potential for those investments to contribute significantly toward GHI's goal of reducing childhood deaths, the group also paid special attention to Kenya's malaria and tuberculosis vaccine trials and the introduction of the pneumococcal conjugate vaccine.

Kenya's Domestic Politics: An Impediment to Success?

The national atmosphere in Kenya remains highly uncertain. Since the last CSIS visit in August 2009, some initial optimism has emerged that Kenya may have escaped the alarming instability and violence that followed the December 2007 elections. A new constitutional reform process,

inaugurated by a peaceful August 2010 referendum, aims to build a more accountable and transparent government. Many are still skeptical, however, of the Kenyan leadership's commitment to full implementation of the most important reforms—a reduction in the power of the presidency, a devolution of administrative authority to 47 counties, a consolidation of redundant ministries, an increase in parliamentary authority, and an empowerment of a truly independent judiciary.

Caution is very much warranted, and drawing conclusions will be difficult before the next presidential and parliamentary elections in December 2012. Strong political and economic incentives, as well as deep fissures between constituencies, favor preservation of the status quo. Devolution without new structures of accountability risks simply transferring corruption to the county level. Real progress will require addressing the culture of impunity that characterizes Kenyan politics. It remains to be seen how Kenya handles the December 2010 International Criminal Court indictments of six senior members of the cabinet—in truth an indictment of the Kenyan political culture more broadly.

These challenges exert substantial stress on the bilateral relationship between Kenya and the United States. While reaching out to youth and civil groups pushing reform, the United States ambassador has adopted a public, confrontational posture toward the Kenyan political class. The consensus view at the White House and State Department, enacted by the U.S. embassy in Nairobi, is that wholesale reform must be Kenya's next item of business. The top U.S. priority in its current dealings with the Kenyan government is bringing maximal pressure to bear in favor of reform. Unsurprisingly, in the midst of this confrontation, only modest progress has been made winning agreement from the Kenyan government to assume greater responsibility for its country's own health needs and commitments.

Kenya and the Global Health Initiative

The United States has a long history of investing in the Kenyan health sector, including training a significant cadre of Kenyan scientists, clinicians, laboratory technicians, and field workers through robust research partnerships. The Walter Reed Army Institute of Research has been conducting research on parasitic and infectious diseases in Kenya since 1969; USAID began managing a robust and successful set of programs in family planning beginning in the 1970s; and CDC has partnered with the Kenyan Medical Research Institute (KEMRI) since 1979. The advent of PEPFAR in 2003 substantially deepened U.S. HIV support to Kenya, resulting in an influx of new HIV-related resources that dwarfed other U.S. investments. In 2010, \$529 million was targeted to HIV (up from \$176 million in 2006), \$5.5 million to MCH, and \$20.8 million to family planning.⁴

⁴ U.S. Department of State, "Kenya," ForeignAssistance.gov, <http://www.foreignassistance.gov/OU.aspx?OUID=173&FY=2010#ToggleYearAnchor>.

Despite a politically troubled environment, the United States' historically close relationship with Kenya has continued with the introduction of GHI. In May 2010, Kenya was named one of eight "GHI-plus" countries eligible for additional technical and management resources, as well as a small amount of financial resources, to quickly implement key aspects of the GHI approach. Deemed "learning labs," GHI-plus countries are supposed to provide early lessons on how to implement GHI principles in all countries with U.S. global health investments.

In many ways, the U.S. government's Kenya team was ahead of the curve. Kenya was chosen for its highly regarded U.S. embassy, which has a legacy of program innovation unseen in many other GHI countries. Most significantly, in 2005 the U.S. Kenya team decided to experiment with health service integration at the regional level. That decision resulted in a five-year legacy of interagency planning and service delivery, which has significantly advantaged the embassy in respect to GHI and given it the momentum to expand its existing interagency approach to new areas such as maternal and child health and neglected tropical diseases. Four agencies—USAID, CDC, the Office of the Global AIDS Coordinator (OGAC), and the Department of Defense (DOD)—form the core of the Kenya GHI interagency team. A focal person responsible for writing and ensuring implementation of the Kenya GHI strategy has been identified within each agency. USAID and CDC together have played primary coordinating roles; the lead planning responsibility will shift to OGAC in early 2011, with continued support from USAID and CDC.

The year 2010 saw intensive GHI planning for the U.S. Kenya team. The team has put an enormous amount of effort into reviewing the U.S. health portfolio, prioritizing areas where the United States can make a significant impact and where there is a high level of unmet need, drafting a country strategy that addresses GHI principles and beginning a dialogue with the Kenyan government and other development partners about how GHI represents a change in U.S. approach. The Kenya country strategy was approved in February 2011 and includes plans to align U.S., Kenyan, and other donor resources into integrated point-of-entry health platforms that reduce duplication, save costs, and result in demonstrable reductions in maternal, neonatal, and child mortality, as well as deaths from neglected tropical diseases. The team stresses that gains can be made in these two new priority areas without losing ground in HIV, TB, and malaria. Comprehensive implementation of GHI has not yet begun. Just prior to the delegation's visit, a stakeholders meeting was held in Kisumu, Kenya, to plan for the implementation of a "Learning Agenda," which will evaluate the impact of this strategy in select geographic areas.

The U.S. team in Kenya is cognizant that it must quickly demonstrate progress and results on the ground in order to sustain momentum for GHI. The U.S. team acknowledges that the six-month planning period has been arduous but necessary, especially for building consensus with the Kenyan government. After the initial April 2009 announcement of GHI, expectations were raised that the United States would commit additional funding for new global health priorities. As budget realities set in, the U.S. government attempted to clarify what new resources (if any) would be provided, but that message has not been clearly received. As a result, it has been difficult for country teams in many GHI-focus countries to shift attention away from the promise of additional funding when negotiating with partner countries. In Kenya, the U.S. team has

attempted to focus its conversations with the Kenyan government on the promise of greater U.S. cohesion and partner coordination as a way to improve delivery of health services. The team hopes this new level of coordination will become a model for the Kenyan Ministry of Health and for other GHI countries.

This planning process has also borne fruit internally. The CSIS team's visit revealed a high-functioning, energetic interagency team capable of brainstorming and planning together, as well as speaking with a unified voice. Whether this U.S. government cohesion will remain during the implementation stages of GHI, when agencies may have to forfeit territory or patients to other agencies, is yet to be seen. The deputy chief of mission has provided essential leadership, indicating the elevation of health and development as a priority within the embassy, and is looking to expand the whole-of-government approach outside the health sector. As a first priority this effort should look to achieving greater coordination with the Feed the Future Initiative. Notably, Kenya may also hold lessons for the QDDR goal of changing the culture in U.S. missions as GHI has already incentivized greater interagency coordination.

The GHI Learning Agenda

The GHI learning agenda, unique to GHI-plus countries, is an operational research agenda intended to evaluate the impact of applying GHI principles in settings with existing U.S. resources. For example, a country can choose to assess the value added of strengthening health systems, focusing on gender issues, or integrating health services in select geographic areas as a way to generate lessons for GHI more broadly. The late November stakeholder meeting in Kisumu narrowed the focus of the Kenya learning agenda to evaluating the impact of three GHI principles—health system strengthening, integrated service delivery, and demand creation—on maternal and child health and the management of neglected tropical diseases. The learning agenda will focus on implementing and evaluating a comprehensive package of services in five geographic areas in Kenya, combining Kenyan government maternal health resources with U.S. government programs. Implementation will begin by mid-2011 but may require additional resources, which were expected to come from GHI contingency funding but may not now be available.

Kenya is a particularly hospitable environment for the learning agenda because of its strong surveillance systems, which have been developed with considerable assistance from CDC. For more than 10 years, CDC has been conducting population-based surveys, nearly amounting to its own vital registration system. In Siaya, CDC surveys 220,000 people every four months, gathering data on a range of demographic and health issues. CDC is now proposing to use its surveillance system to capture a broader range of health services and measure cost-effectiveness. The goal is to determine the value of program integration, to focus on a few areas where integration might help improve health outcomes, and then to scale up those specific interventions.

The learning agenda represents a promising embrace of metrics and evaluation, and of MCH and NTDs as new priorities in the Kenyan context, but it is unclear how this model will be replicated in areas without preexisting, robust surveillance systems unless additional funding is provided.

GHI and Gender: Advancing Maternal and Child Health

While Kenya has seen progress over the last five years in advancing child health, improving the health of mothers continues to be a significant challenge. There are an estimated 488 maternal deaths per 100,000 live births,⁵ an unconscionably high figure that has largely been unchanged since the mid-1990s. In 2005, the U.S. government adopted an innovative approach to try to improve these outcomes by colocating maternal and child health services, which have been chronically underfunded, with HIV services. The resulting APHIA program (AIDS, Population and Health Integrated Assistance), which is cofunded by PEPFAR and USAID maternal/child health funding, is viewed as a model for moving away from stove-piped programs and toward integration, with an increased focus on the health of women and girls. As such, it holds important lessons for the implementation of GHI, both in Kenya and also in other GHI countries.

The value of integrated programming is being documented by APHIA*plus* in Western and Nyanza Provinces, where a consortium of U.S. nongovernmental partners led by PATH is using the maternal child health clinic as the entry point for women and their babies to receive a range of health services, including: antenatal and postnatal care; prevention of mother-to-child transmission (PMTCT) programs; HIV counseling, testing, and treatment; early infant diagnosis; childhood vaccinations; TB screening; malaria services; cervical cancer screening; and family planning services. By providing these services within the MCH clinic, as opposed to the HIV/AIDS clinic, the program seeks to create a more conducive and less stigmatizing environment for women to access appropriate HIV, reproductive health, and child health services.

The APHIA model faces challenges but is already showing important results. In some services, APHIA's MCH-focused model has led to a 30 to 40 percent increased uptake in services in the past six months.⁶ Under GHI, APHIA is slated to expand to additional regions where its impact on maternal health could be considerable.

Kenya as a Lab for Vaccine Development and Introduction

Vaccine development is a critical and distinguishing feature of Kenya's global health landscape. Although not a formal area of GHI implementation, and funded most often by non-U.S. government entities, vaccine development and delivery is critical for achieving a number of GHI's goals, including its vision of developing and introducing high-impact technologies in low- and

⁵ KNBS and ICF Macro, *Kenya Demographic and Health Survey 2008-09*, p. xxi.

⁶ For a more thorough discussion of APHIA lessons for GHI, see Janet Fleischman, *Lessons from Kenya for the Global Health Initiative* (Washington, D.C.: CSIS, February 2011).

middle-income countries. These types of innovations, whether vaccines or other critical health tools, will have a profound impact on how future U.S. global health investments unfold over time.

Developing vaccines is a complex and time-consuming process, but the potential impacts are profound: vaccines are cost-effective, relatively easy to administer, and provide blanket protection to vulnerable populations. Thanks to long-term partnerships among the U.S. government, the private sector, foundations, key multilateral agencies, and the Kenyan research community, Kenya has become a laboratory for the development and introduction of life-saving vaccines, particularly those that target malaria, tuberculosis, and pneumonia.

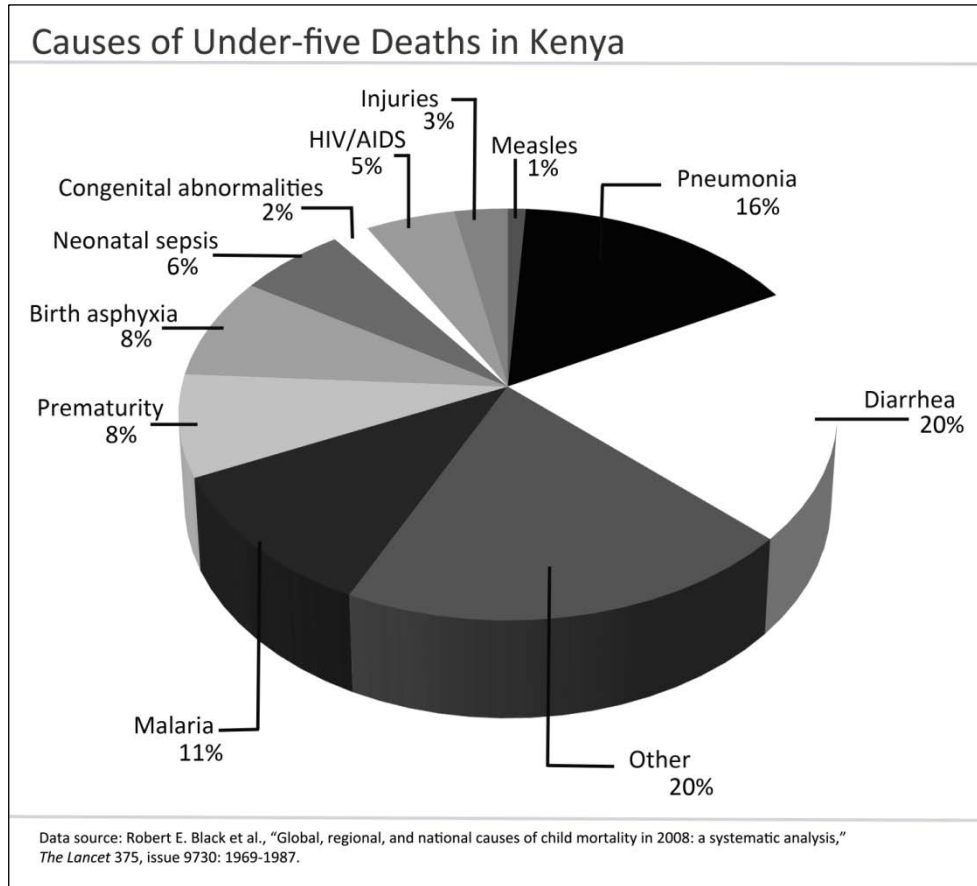
With an estimated 225 million malaria cases worldwide each year,⁷ malaria takes a significant toll on developing countries. Children under the age of five are especially vulnerable and account for most of the nearly 800,000 malarial deaths that occur annually. However, the development of the first pediatric malaria vaccine may be imminent. The most advanced candidate, the RTS,S vaccine, is currently in phase III testing (one of the last stages of development before the vaccine is submitted to regulatory authorities). This large-scale efficacy and safety trial, supported technically by a number of U.S. and international actors working with the PATH Malaria Vaccine Initiative (MVI) and GSK Biologicals, and with funding from the Bill & Melinda Gates Foundation to MVI, includes more than 15,000 infants and toddlers at 11 trial sites in seven sub-Saharan African countries. Kenya hosts three of the 11 trial sites, an arrangement that helps to build capacity among the next generation of Kenyan scientists and engages the communities that will benefit most from the vaccine. An early study published in *The Lancet Infectious Diseases* shows the RTS,S vaccine could offer young children (5 months to 17 months of age) 46 percent protection for 15 months.⁸ If these results hold, this new prevention tool, which may be available as early as 2015, has the potential to save hundreds of thousands of lives every year.

In the shadows of the closely watched malaria vaccine trials, Kenya kicked off in August 2010 the first African-based trials to develop a more effective tuberculosis vaccine. Supported in part by CDC, the trials aim to improve on the current Bacille Calmette-Guerin vaccine, which provides some protection for children but offers no protection in adults. TB killed more than 1.7 million people in 2009 and is the leading infectious cause of death among individuals with HIV/AIDS.⁹ Up to 2 billion people are estimated to be carriers of the disease. With the prevalence of drug-resistant forms of tuberculosis rising, a more effective TB vaccine would save countless lives and potentially avert a major global crisis.

⁷ World Health Organization, *World Malaria Report 2010* (Geneva: WHO, 2010), p. xv.

⁸ Ally Olotu et al., “Efficacy of RTS,S/AS01E malaria vaccine and exploratory analysis on anti-circumsporozoite antibody titres and protection in children aged 5–17 months in Kenya and Tanzania: a randomised controlled trial,” *The Lancet Infectious Diseases* 11, issue 2 (February 2011): 102–109.

⁹ World Health Organization, *Global Tuberculosis Control: WHO Report 2010* (Geneva: WHO, 2010).



Kenya is also playing a lead role in the early introduction of vaccines. In February 2011, Kenya became the third African country to introduce the pneumococcal conjugate vaccine. Pneumococcal disease kills 1.6 million people each year,¹⁰ half of whom are children under the age of five. Pneumonia, the most serious form of pneumococcus disease, is the leading cause of death among young children. Developing an affordable pneumococcal conjugate vaccine has been a collective effort bringing together the energies of the scientific and medical communities, as well as the private sector. In Kenya, the vaccine is being introduced with the assistance of the Global Alliance for Vaccines and Immunizations (GAVI), which launched an Advance Market Commitment financing mechanism to accelerate the development of the vaccine and has worked with the Kenyan government to secure affordable pricing and to build the health system required to get the vaccine to those most in need. All levels of the government—including President Mwai Kibaki—have been mobilized to ensure the vaccine is fully available in public hospitals. GAVI will

¹⁰ Global Alliance for Vaccines and Immunization, "GAVI Partners Fulfill Promise to Fight Pneumococcal Disease," http://www.gavialliance.org/media_centre/press_releases/2009_06_12_AMC_lecce_kick_off.php.

pay the costs for the first four years of vaccine introduction, at which point the Kenyan government will assume financial responsibility for the program.

Conclusion

Kenya's early progress in moving the Global Health Initiative forward is promising. By adopting the principles of GHI and harnessing its special assets—particularly a five-year legacy of experimenting with interagency planning and integrated health services at a regional level, recruiting top talent from across the U.S. government, and utilizing to the fullest extent possible its chief of mission authority—the U.S. embassy in Kenya has significantly changed the way it does business. Assuming this momentum carries through to the implementation stage, GHI will be a solid, smart strengthening of the way the United States advances global health. Especially heartening has been the U.S. government team's embrace of maternal and child health.

And yet, much work remains to be done. Almost two years since the announcement of the Global Health Initiative, and following an extensive one-year planning exercise, country plans are only now beginning to be implemented. For all the advances within the U.S. embassy, the larger political environment in Kenya and Washington has taken a continuing toll on the success and speed of GHI implementation across the country. It remains unclear whether Washington will provide the resources to move from planning to comprehensive implementation and to conduct the operational research agendas that could transform U.S. development agencies into more results-driven enterprises. It is also unclear whether the principal GHI decisionmakers in Washington will replicate the effective whole-of-government approach pioneered by the embassy in Kenya or whether interagency battles will ensue, particularly in the face of serious resource constraints. In Kenya, the U.S. embassy will have to continue to navigate a difficult political environment in the lead-up to the December 2012 national elections.

Despite these challenges, the GHI vision of making U.S. global health programs more impactful, coherent, and accountable is laudable. It is a goal worth pursuing, if it is coupled with the realization that progress will be slow, often hindered by debates in Washington and tough operating environments in partner countries. The key to future success is to harness the special talents of embassy teams, provide them with the modest resources they need, and encourage them to act as aggressively as possible to move GHI to the next stage.



1800 K Street, NW | Washington, DC 20006
Tel: (202) 887-0200 | Fax: (202) 775-3199
E-mail: books@csis.org | Web: www.csis.org