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The contribution of USA international organizations to capacity building on healthcare service delivery in Kenya

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Abstract: *International organizations of the government of the United States of America have for a long time established an interstate partnership with Kenya's state and non-state agencies in the delivery of public healthcare services in different parts of the Kenya, especially the informal settlements. However, public health delivery services being dependent on international support have not had the desired impact due to deficiencies in specific attributes of public health diplomacy between the two states. Challenges still persist in the delivery of public health services including family planning and HIV/AIDS in the informal settlements in major urban areas. This study examined the contribution of USA international organizations to capacity building on healthcare service delivery in Kenya with a focus on Kibra informal settlement. The study used qualitative research design and descriptive survey research methods to collect data and analyze data. It employed questionnaires and interview guides to collect data. A sample size of 100 respondents was determined using purposive, census and stratified random sampling procedures. Quantitative data was analyzed using descriptive statistics while qualitative data responses were thermalized. It was found out that 100% of the respondents indicated that USA state agencies partnered with them in productive health care. The findings showed that USA public diplomacy is mostly advanced by known global organizations such as USAID. The study findings indicated that there was timely delivery of services as indicated by 62% of the respondents, a 52.2% indicated that patients were well taken care of by the staff due to the established capacity building programs, while 38.0% of the respondents that capacity building programs ensured availability of funds and 64.1% agreed that capacity building programs ensured staff motivation. The study concluded that capacity building is limited to NGOs and this leaves out sensitization of health programs to residents of Kibra. It further concludes that public diplomacy has gaps when left to sending state and where the role of local community is not clearly defined. The study recommends creation of awareness of the existence of these health programs to locals in Kibra which means community participation is important alongside NGOs health workers.*

Key words: *USA international organization, public health diplomacy, healthcare service delivery, and Kibra, Kenya.*

I. Introduction

Public health is increasingly becoming a diplomacy and international relations theme. The global health activities have been on the rise, with increase in international assistance for health, especially with focus on HIV and Ebola epidemic (Leslie, Sun & Kruk, 2017) including COVID 19. They argue that globally, Low and Middle- Income Countries (LMICs) experience a lack of adequate infrastructure and health worker shortages necessary for delivery of primary healthcare services. For example, Sub-Sahara Africa has 3% of the global workforce and an estimated 1.5 million more health workers are needed to provide basic health services. This is an indication that developing states lack required work force or capacity to meet health demands of their populations.

Therefore, the evolution of public health diplomacy has seen a substantial number of agreements between national governments and international health NGOs not through traditional diplomatic channels. The focus of public health diplomacy has been between international organizations and local NGOs or state parastatal (Abbott, 2005). For example, divisions of the U.S. Agency for International Development (USAID) and the U.S.

Centers for Disease Control and Prevention (CDC) may do enter into separate agreements with a particular country's ministry of health, health NGOs etc. These agreements can take various forms, such as a memorandum of understanding (MOU) or a cooperative agreement, based on institutional culture and program goals.

Kenya has been a beneficiary of USA health initiatives whereby Center for Disease Control and prevention (CDC), the President's Emergency Plan for Aids Relief (PEPFAR), the President's Malaria Initiative (PMI) and USAID partner with Kenyan health parastatal and NGOs on matters of health. For example, USAID (2015)reports indicates that Kenya is a focus country in the US President's Malaria Initiative (PMI) and the National Malaria Control Programme intended to reduce and eventually eradicate malaria. The same report, however, indicates that cases of malaria and other diseases continue to undermine human health in Kenya. Rather, reproductive health, including family planning and HIV/AIDS, depends entirely upon the support of donors, including USAID among other USA international health organizations.

Background

A majority of USA international health organizations partner with private sector organizations in Kenya to realize capacity building towards delivery of public health services. For example, for 40 years, the Centers for Disease Control and Prevention (CDC)-Kenya has helped strengthen public health and laboratory systems in Kenya, creating an integrated research and program center. This model ties together multiple program areas, leveraging technical skills and a strong partnership with the Government of Kenya to build sustainable public health capacity. CDC Kenya saves lives by conducting research on the effectiveness of new interventions and by preventing disease, reducing death and disability, and implementing evidence-based public health programs (CDC/Kenya, 2004).A good example is where USAID worked with the Ministry of Health Services and other partners to put in place a competency-based emergency obstetric and newborn care training curriculum. USAID's five regional service delivery projects scaled up maternal, newborn, and child health services at the facility and the community level. USAID also trained 6,395 community health workers in maternal and/or newborn health. Because more than 50 percent of the women in Kenya still deliver at home without skilled care, community health workers play a critical role in decreasing maternal and infant mortality.
In addition to encouraging women to use skilled care at birth, community health workers encourage women to use early antenatal services, which include testing for HIV, a critical first step in the prevention of mother-to-child transmission of HIV and preventative treatment against malaria in pregnancy. Community health workers also promote immunization, hand washing with soap, and use of latrines (USAID/Kenya, 2013).

The USA based organization has supported activities in the population, health, and nutrition sectors since the early 1970's. USAID funded the roll-out of Kenya's family planning program in the 1970s by supporting the creation of 590 service delivery points, 400 full-time and 190 part-time, served by 17 mobile units and the training of personnel at the district and provincial levels to staff them (USAID, 2000).In the late 1970s and early 1980s, USAID funded several pilot projects in rural areas. USAID intended for these projects to demonstrate the efficacy of providing family planning services at the rural level and in combination with maternal/child health services. The projects also provided an opportunity for officials in the Ministry of Health to gain hands-on experiences with project design and management, with the goal that the Ministry could eventually assume full responsibility for the management of the projects. USAID, through a contracting agency, provided consulting services to Ministries of Health and Planning so that a Division of Planning and Implementation would be created to oversee rural health programs and services over the long term (Mehlika, Martin, Flaherty, & Higgins, 2004).

However, these early projects were only partially successful. It quickly became apparent to USAID and other donors that the Government of Kenya lacked the technical expertise and experience to staff and manage new projects. Thus, in the early to mid- 1980s, USAID, the World Bank, and other donors adopted a strategy of creating new government entities, supported by a hand-picked advisory staff, to implement family planning projects. This strategy resulted in the creation of the National Council on Population and Development under the Ministry of Home Affairs and the National Family Welfare Center ("NFWC") in the Ministry of Health. The former coordinated activities among public and private agencies working on family planning, and the latter provided training to community nurses and clinical officers to work in dispensaries, health centers and sub-centers across Kenya, as part of a strategy to decentralize the health system (Mehlika*et al.*, 2004). This is clear indication that public health diplomacy can fail to achieve its objectives without a sound public health policy.

To promote increased public health diplomacy, donors began to collaborate more extensively with the private sector to create and administer programs. For example, in 1983, USAID started the Family Planning Private

Sector Project which created smaller scale projects to do the same work of project design and community health worker training. In contrast with government efforts, this project exceeded program targets and implementation time frames, and became a successful model for implementing family planning projects in Kenya. By the mid-1980s, under the Family Planning Services and Support project, USAID began giving direct support to NGOs, including the Family Planning Association of Kenya (FPAK), the Christian Health Association of Kenya (CHAK) and the Christian Organizations Research Advocacy Trust.

In 1995, USAID launched the AIDS Population and Health Integrated Assistance (APHIA) project to "consolidate all USAID support to public healthcare" to "reduce fertility and the risk of HIV/AIDS transmission in Kenya through integrated health and family planning service delivery." This effort, implemented by Kenyan NGOs and the Ministry of Health, in collaboration with the Japan International Cooperation Agency and several USAID Washington- based projects, combined past efforts in public and private service delivery and sustainable financing (aimed at reducing dependency on outside support) with district-level activities. On the government side, new elements of USAID efforts included strengthening the Ministry of Health Reproductive Health Logistics Unit and upgrading the Ministry of Health Rural Health Training Centers. On the NGO side, USAID earmarked funds to help FPAK, CHAK, and Chogoria Hospital become financially stable. The focus on HIV/AIDS resulted in funds being directed to Nyanza, Western and Coast Provinces "where the need is the greatest."

USAID Kenya (2015) report indicates that focus to strengthen local mechanisms and skills for gender-based violence prevention, reporting, management, and pathways for response are critical. Youth-focused theater programs such as the in communities, members were educated on gender-based violence through showings of the *SitaKimya film***,** with discussion sessions afterward to encourage communities to take action on gender-based violence by speaking out**.** *SitaKimya* (Kiswahili for "Speak Out") and G-Pange campaigns encourage dialogue on gender-based violence. "Queen and King of Change" mentorship sessions teach children about their rights. USAID also supports the *Suluhishoni Mimi* Centre, managed by the Centre for Rights Education and Awareness in Kibera, to increase the community's capacity to better prevent and respond to gender-based violence through referral mechanisms. Out of the 185 new cases handled, 101 were referred from gender-based violence service providers and other stakeholders in Kibera. The level of awareness and action among community members has also improved, with the number of cases reported increasing from 140 to 185. This shows efforts by international organizations to change cultural perspectives of locals about their programs.

In Kibra, Lea Toto Kibera which partners with USAID to care of children orphaned and infected with HIV/AIDS. *Lea Toto* program in partnership with USAID has been successful in providing quality comprehensive care and support to HIV positive children and their families over ten years, and the area is now registering lower mortality rates. Through continuous training of their behavior change agents they have been able to negotiate, support and maintain safe behavior through community mobilization. As of March 2011, Lea Toto program has reached: 7698 HIV positive children with comprehensive medical care, psychosocial support, educational support; 36,000 family members with education and skills to support and care for people living with AIDS and capacity building for self-sustenance; 2680 children with Antiretroviral Therapy services. All school-age children in the program are enrolled in school, from pre-school to University.

These activities contributed to the expansion of palliative care services for people with HIV, strengthened human resource capacity to deliver palliative care services for HIV, and an improved referral network for HIV care. AMREF's palliative care activities link closely to community services supported by CBOs, such as Kibera Community Self Help Program (KICOSHEP), AMREF-supported PMTCT services, adult treatment services, pediatric treatment services , pediatrics care and support and the established network referral center at Kenyatta Hospital through the referral of complicated cases. The population targeted through this activity include: 1) HIV-infected adults residing in Kibera that will be served by these programs and 2) have a significant need for HIV treatment that relates not only to high HIV prevalence, but also very severe poverty and lack of basic services (e.g., clean water, food, and education). The associated community sensitization activities raise awareness among men and women living in the slums. Other target groups include public health workers and NGOs/private voluntary organizations.

PMTCT activities in Kibera slum contributed to approximately 2.9% of 09 COP. The increase in number of sites contributes to the program's efforts to achieve district-wide coverage for improving equity and access particularly in these underserved areas. The provision of PMTCT+ services to the women, infants and other members of the family provide an entry point for HIV positive individuals to access comprehensive HIV care

and other HIV care and support services including safe infant feeding practices. From this review, it is clear that USA international organizations towards capacity building are hampered by inadequate diplomacy among key partners. The organizations efforts are curtailed by poor health systems and policies in Kenya. This means that to bridge the gap, diplomacy by concerned partners is welcome.

Statement of the Problem

Kenya is one of the beneficiaries of USA international organizations' programs in public healthcare services delivery. These organizations such as USAID, Center for Disease Control and Prevention (CDC), the President's Emergency Plan for Aids Relief (PEPFAR), the President's Malaria Initiative (PMI) programme advance USA public health diplomacy in Kenya. Many health NGOs in Kenya, for example, Family Planning Association of Kenya (FPAK) partner with these organizations in a well-developed system for the community-based health system with the financial and technical support of USAID after the two signed a cooperative agreement. This initiative collaborate with Nye (2004) argument that private organizations are among the actors involved in public diplomacy (Nye, 2004).

Public health, including family planning and HIV/AIDS, depends entirely upon the support of donors such as USAID among other USA international health organizations. Although this strategy of reliance on NGO's may have resulted in more efficient use of donor funds, whether it has resulted in a more efficient use of public health service delivery dollars overall is less clear due to poor health system in Kenya (CDC, 2018).Also, donors shift in terms of public health policy which leads to unintended consequences of undermining the coherence of health policy at the national level and creating transition costs in a highly under-resourced system (Mehlika *et al*., 2004). This means that disharmony between international organizations health activities and national health policy in host countries severely affects public healthcare service delivery. Thus, employing of public health policy without some form of formality may not achieve enough in context of public health diplomacy. It is clear that donors and Kenyan government pull in different directions which affect delivery on public healthcare negatively.

This study was conducted in Kibra where most community based health institutions are funded by USA yet the delivery of health services are still dismal. In Kibra, AMREF-supported PMTCT services, adult treatment services, pediatric treatment services, pediatrics care and support and the established network referral center at Kenyatta Hospital through the referral of complicated cases. The population targeted through this activity include: 1) HIV-infected adults residing in Kibera that will be served by these programs and 2) have a significant need for HIV treatment that relates not only to high HIV prevalence, but also very severe poverty and lack of basic services (e.g., clean water, food, and education). This means that any USA restriction on public health programs negatively affects those dependent on them.

II. Materials and Methods

Study Design: qualitative research design.
Study Location: Kibra sub-county located in Nairobi City County, which is divided into 14 villages which contain varying human populations. The villages include; Kianda, Olympic, Soweto West, Gatuekera, Raila, Karanja, Kisumu Ndogo, Makina, Kambimuru, Mashimoni, Lindi, Lainisaba, Silanga and Soweto East (Mutisya and Yarime, 2011). Kibera was selected because it is one of the largest slums in Africa and in the world, and USA international organization in partnership with health NGOs have tried to address the health concerns in these region.
Study Population: This study targeted regional managers of USA international health organizations such as CDC, USAID, PERFAR and Bill Gates Foundations-4; Managers of Shining Hope for Communities (Shofco) and Lea Toto; administrators of Shofco, managers and employees of the 14 clinics located in Kibera; and managers of the 8 centres of Nyumbani Lea Toto HIV/AIDS community outreach program; as well as the 200 employees of Lea Toto program. This gave a total target population of 632.
Sample Size: 100
Sample Size Calculation: (Kerliger, 1983), a sample size of 10% to 30% is representative of the population. The sample size for the study was calculated using 10%.
Procedure Methodology: The research data was collected using questionnaires and interview guides. The collected data was edited and coded to ensure completeness, after which it was summarized and tabulated before analysis is done.
Data Analysis: Data analysis was done using the SPSS system version 27. Data was basically analyzed descriptively and presented using Tables and Figures. The qualitative data was analyzed by consolidating

emerging themes from the key informant interviews, topic analysis, and cut and paste methods on the focus group discussion transcripts. Quantitative data was analyzed using descriptive statistics such as frequencies and percentages. The researcher presented data findings in form of frequency tables, pie charts, bar graphs and narratives

III. Results and Discussions

Descriptive Statistics

To study sought to assess the effect of capacity building programs funded by USA state agencies on public healthcare services delivery

Table 1: Capacity Building of Health Programs

	Poor		Fairly Good		Good		Very Good	
	F	%	F	%	F	%	F	%
Timely Delivery of Services	4	4.3%	57	62.0%	12	13%	19	20.7%
Care of Patients by Staff	0	0.0%	31	33.7%	48	52.2%	13	14.1%
Availability of Drugs	6	6.5%	11	12.0%	35	38.0%	40	43.5%
Staff Motivation	1	1.1%	29	31.5%	59	64.1%	3	3.3%

From Table 1, it was observed that a majority 62.0% of the respondents rated good and 20.7% of the respondents rated very good. This clearly indicates that there was timely delivery of services due to capacity building programs offered by the USA state agencies. Another 52.2% of the respondents rated good while 14.1% of the respondents rated very good indicating that there was better care of the patients by staff due to the capacity building programs. 38.0% rated good and another 43.5% of the respondents rated very good that the capacity building programs ensured availability of funds while 31.5% of the respondents rated fairly good and another 64.1% rated good that the capacity building programs ensured staff motivation.

Findings indicate that capacity building has increased health service delivery in general, however, availability of drugs remains a challenge. Also, access to health is not really positive as a result of other factors as indicated in an interview where a program health officer lamented of little awareness and receptiveness by Kibra local to issues of health. The need for more sensitization of health programs thus should extend to the Kibra public itself which bring in focus the role of central government in public diplomacy. Public diplomacy has gaps when left to sending state and where the role of host state is not clearly defined.

Cross-tabulation Analysis

A cross-tabulation analysis was also performed to determine the variation of the benefits of capacity building programmes in the USA international organization; this is presented in Table 2.

Table 2: Benefits of Capacity Building

	USA Organizations Partners									
	USAID		PERFAR		CDC		Bill Gates Foundation			
	Yes	No	Yes	No	Yes	No	Yes	No	X^2	p-value
Reduced Cases of	80.4%	19.6%	0.0%	100.0%	0.0%	100.0%	37.5%	62.5%	**49.062(3)**	**0.000**

malnutrition										
Decreased Infections	100.0%	0.0%	64.3%	35.7%	0.0%	100.0%	100.0%	0.0%	**72.385(3)**	**0.000**
Decreased Child Mortality	41.1%	58.9%	100.0%	0.0%	100.0%	0.0%	25.0%	75.0%	**30.358(3)**	**0.000**
Promotion of Family Planning	96.4%	3.6%	0.0%	100.0%	64.3%	35.7%	75.0%	25.0%	**56.571(3)**	**0.000**

From Table 2, all the Chi-square values are statistically significant values indicating that there was a statistically significant variation between the benefits of the capacity building programmes in the USA international organizations. **(Triangulate).**

IV. Conclusion and Recommendations

The study findings indicated that capacity building is limited to NGOs and this leaves out sensitization of health programs to residents of Kibra. It further indicated that public diplomacy has gaps when left to sending state and where the role of local community is not clearly defined. From the study recommends sensitization of the local communities of the existence of the health programs in their locale and encouragement of community participation and involvement in order to reap the benefits of capacity building in healthcare service delivery by the USA international organizations.

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