Fall 2010

Finding the Right Fit: Unique Challenges Faced by Health NGOs in the Health System of Lamu District

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SIT Study Abroad

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SIT Kenya: Swahili and Islam Identity

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ACKNOWLEDGMENTS

In the process of doing research for this project, I had the help and support of many people who must be properly thanked. First and foremost, I am extremely grateful to the community members of Lamu District. These people were enormously obliging and always willing to point me in the right direction, whether it be where to find certain offices or who to contact within particular organizations. They were also incredibly generous with their time and always found a minute to engage me in conversation. I would like to thank Amos Odacha in particular from AMREF for being both informative and encouraging, as well as my fellow Lamu SIT students for their care and good humor. Secondly, I must thank the SIT staff for providing me with the tools I needed to be successful in my research. Athman and Dr. Jama in particular were very helpful. Finally, I would like to thank my family and friends back home who helped foster my love of learning and supported me through my travels and new experiences abroad.

ABSTRACT

This study examines how nongovernmental organizations and community-based organizations in Lamu District interact with the governmentally structured health care system at the district level. This is done through participatory observation, interviews and removed observation of NGOs, CBOs and government officials. From these observations, this study then identifies major challenges faced by health NGOs that inhibit them from performing to the best of their ability, and at times even compromise the health of the people they are trying to help. The results of this study show that in Lamu District, the most relevant challenges are continuity of care, dissemination of information, working within an existing health care system and community and foreign skepticism. After looking at these challenges, their underlying causes are acknowledged to attempt to discern how exactly certain issues are created or exacerbated. These causes were found to be requirements of simultaneously satisfying both patients and donors, an overarching lack of ownership from both the community and the NGOs, and a lack of clear vision for many organizations. Finally, best practices are recommended to suggest various ways in which health organizations can prevent problems from occurring, minimize them or ameliorate them. These include Project Management Cycles and Concept Notes, as well as

reversing the order in which nongovernmental organizations obtain funding and speak with district level government officials.

BACKGROUND

Health care systems are incredibly complex structures. With a limited amount of resources, they must strive to provide accessible, equitable and affordable health care to a population at large. A health care system as defined by the World Health Organization is a system composed of "all the organizations, institutions and resources that are devoted to producing health actions."[1] A successful health system should work to both minimize risks of catastrophic costs to households and individuals, and maximize the quality of treatment at all levels of health care. Finally, a health system should strive for horizontal equity – treating all patients with the same need in the same manner and with the same quality of care – and vertical equity – treating preferentially those whose needs are most severe.[2] This reduces health inequalities as much as possible and promotes a high quality of care for all.

Throughout the past few decades, international health concerns have swung back and forth between health as a whole and health for the poor. The 1970s saw a large health concern focusing specifically on the health of the poor, pushing for various developing countries to implement government-supported health care. This changed in the 1980s due to the international debt crisis developing countries were facing combined with the drastic shift in economic policies of countries such as China towards a more privatized, capitalistic paradigm. The international community began to question the government-driven health systems it had initially argued for, believing that such a structure would not be as sustainable or cost-effective as one that was privatized. With this new attitude, the concern shifted back to the health distribution and the lack of access the globally impoverished had to health care in the 1990s. Finally in the year 2000 social indicators began to be used instead of merely per capita GDP growth to measure health levels of national populations. These changes in international approach have built the contextual framework that health systems are looked at through today.[3]

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[1] World Health Organization. *World Health Report 2000 Health Systems: Improving Performance.* Geneva: World Health Organization, 2000. pxi
[2] Ibid, p55
[3] Gwatkin, Davidson R. *Reducing Health Inequalities in Developing Countries.* World Bank, 2002.

The health care system of any given nation is typically composed of many actors, including the national government, private organizations such as hospitals and insurance companies, and individuals. Although in some nations health care systems are largely successful and are able to reach their entire population with maximum efficiency and minimal inequalities, as a whole these systems are considered somewhat imperfect and can be fraught with contention. Health care systems in developing countries are particularly troublesome as they often lack the governmental infrastructure considered necessary to implement changes on a national scale. They also tend to be deficient in the natural resources or economic vitality to fund such changes.[4] As a result, the past few decades have witnessed the emergence of external institutions such as the World Health Organization, the World Bank, as well as NGOs.

While in general all NGOs have nothing but good intentions, oftentimes they do not have enough information, funding, flexibility or self-awareness to make the positive impact they intend. NGOs tend to have short-term time tables, and therefore they can sometimes spend as much time becoming introduced to a community and then down-scaling their project before leaving as they spend implementing their work in full force. Additionally, NGOs tend to come from outside the community they interact with. At its most simplistic level, this means that a group of people is working in a nation that they have little to no direct responsibilities to, which can heavily influence the actions an NGO decides to take; a misunderstanding of cultural norms could result in an NGO taking a misdirected approach when trying to help out with a specific problem.

Health NGOs specifically face even more of a challenge, as health systems are so complicated to begin with. In addition to worrying about cultural miscommunications, precarious funding and heavily input-driven programs, health NGOs must also negotiate obstacles such as relationships with governmental health facilities and assurances that patients have access to continuous care. They must simultaneously look at the level of health of each individual that they treat and the overall viability of the health care system. If these factors are not taken into account, instead of strengthening health systems and improving overall vitality, NGOs can leave little to no impact and sometimes even hinder the health process.

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[4] Gros, Jean-Germain. "Towards a Taxonomy of Failed States in the New World Order: Decaying Somalia, Liberia, Rwanda and Haiti." Third World Quarterly, Vol. 17 No. 3, 1996: 455-471.

LOCATION

The country of Kenya is divided into eight provinces, and within each province are many districts. Lamu District is one of the seven districts within the Coast Province, and has a catchment population of around 105,087.[5] Within Lamu District itself there are seven divisions: Amu, Hindi, Mpeketoni, Faza, Kzingitini, Witu and Kiunga. As Lamu is an archipelago, these divisions are spread out among a few islands and small sections of the mainland. Amu, Faza and Kzingitini each have population densities of over 100, but the remaining sections are very sparsely populated, with a density ranging between 2 and 19. This makes travel very difficult, especially to access medical care: the majority of the population lives over 5 kilometers from health care of any kind.[6]

Many unique characteristics about Lamu make health care even harder to reach than other districts with a similar population demographic. One such distinction is the lack of transportation: there are only 2 ambulances and 3 boats for the entire archipelago.[7] This is compounded by the fact that access to certain divisions is completely dependent on the tide, and therefore is very unreliable. In this way, patients must both have access to a boat and be able to utilize that access at the right time of day in order to reach the hospital in a reasonable time. Unfortunately, this is rarely possible. Furthermore, even land transportation is severely restricted. One ambulance is kept in Amu, a district with streets so narrow that it cannot fit anywhere except the seafront. This results in people having to literally carry their sick family and friends or push them in wheelbarrows, often walking for well over an hour before they arrive at a health facility.

Lamu District has 3 hospitals, 5 health centers, 1 nursing home, 20 dispensaries and 16 clinics.[8] For the purpose of this paper however, all private health facilities will be overlooked; although these are important in a health system, the private health sector typically targets the more affluent section of Lamu District and therefore runs relatively independent of the governmental health system and of NGO involvement. This study is focusing on NGO

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[5] *Annual Operational Plan 6*. Lamu, Kenya: Ministry of Public Health and Sanitation, 2010
[6] *Lamu District Strategic Plan 2005-2010*. Lamu, Kenya: Ministry of Planning and National Development, 2005.
[7] *Lamu District Work Plan.* Annual Report, Lamu, Kenya: Ministry of Health, 2004-2005
[8] *Annual Operational Plan 6*. Lamu, Kenya: Ministry of Public Health and Sanitation, 2010

involvement and its relationship with the governmentally structured health system, and in this way private facilities are relatively extraneous. Unlike governmental ones, private facilities may turn patients away who do not have enough money to pay for treatment, thus making themselves as inaccessible to the poorer population of Lamu District as if they did not exist at all. Therefore, the private facilities will be omitted, leaving the following: 3 hospitals, 5 health centers and 20 dispensaries.[9] Almost all of these struggle with a lack of medical staff, illustrated by the fact that Lamu District Hospital has only one doctor, and that just a decade ago the doctor patient ratio was an astounding 1:36,343.[10]

It would be inaccurate to try to portray the health profile of Lamu District without including the many NGOs and CBOs that supplement the work of the government. The difference between a CBO and an NGO is primarily that an NGO must be registered nationally, while a CBO only registers with the Office of Social Services at the district level. NGOs have a larger mandate and are often of an international nature, while CBOs stem directly from the community they work with and typically have a smaller scope.[11] In the case of Lamu, only two health NGOs are physically present: AMREF and Kenya Red Cross (KRC). AMREF is currently in Lamu on a four year project entitled Putting African Mothers and Children First. The program will last until 2014 and focuses on maternal and child care health. Conversely, KRC is permanently stationed in Lamu, and acts primarily as a disaster relief organization. It is peripherally involved in ongoing health programs as well, though, and conducts an HIV/AIDS Peer Educator Program and a Home Management of Malaria program (HMM).

The number of CBOs is much larger, although this number is impossible to get specifically due to their precarious nature: oftentimes they will close down without the government's knowledge or remain "open" for years even if they are truly inactive. Also, it is very common for the specific programs and/or projects that a CBO participates in to vastly change in subject, from health to micro financing to child care. As a result, it is difficult to

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[9] See Table 1 in Appendix for a breakdown of facility by sector, and Table 2 for a list of each facility and its utilization rate.

[10] *Lamu District Strategic Plan 2005-2010*. Lamu, Kenya: Ministry of Planning and National Development, 2005.
Assuming that the other two hospitals each only have one doctor as well as Lamu District Hospital, and that the current population estimate is accurate, the current doctor patient ratio would be roughly 1:35,029.

[11] Interview. Haji Shibu. Lamu District County Councilman. 4 November, 2010.

separate specifically health-related CBOs from others. An example of CBOs that have participated in health care advocacy at least one time within the past year includes Sauti ya Wanawake, Anne Spoerry Sailing Doctors, the Kikozi Programme, Tawasal, Lamu Safi and LAMCOT Sailing Doctors.

APHIA II also has a large presence in the health sector, but is not technically an NGO. Instead, APHIA II is a nation-wide project funded by USAID that links together larger NGOs – termed Strategic Partners – with smaller CBOs – classified as Implementing Partners – to work together on prevalent HIV/AIDS issues. The Kikozi Programme is an example of a CBO that takes part in the APHIA II project. Finally, World Wildlife Fund (WWF) is an NGO that deals almost exclusively with environmental issues, but has involved itself in health care issues as of late through its involvement in the Population, Health and Environment Survey.

It is important to note the aforementioned differences between NGOs, CBOs and multilateral projects. For the ease of referring to all of these organizations as one collective group, however, this paper will use the term "NGO" in its broadest sense of any organization operating independently of the government, unless otherwise mentioned.

STATEMENT OF PROBLEM

Due to the already complex nature of health care in general, health NGOs face many unique obstacles that other types of NGOs do not have to struggle with. These can include economic complications, challenges of providing continuous health care, unpredicted cultural obstacles, and difficulties navigating within the already existing health care system. These problems are exacerbated when NGOs do not have well-oiled monitoring and evaluation procedures to assess their overall impact on the community. If not properly identified and dealt with, these challenges could evolve into unintentional detriments upon the health system of Lamu District. The following questions highlight just a sampling of the type of challenges that may be found with health NGOs. It is not possible to answer all of these within the narrow scope of this paper, but the purpose is to try and give the reader a frame of reference as well as contextual background as to the complexities of existing as a health NGO in a developing country.

Are health NGOs aware of their economic footprint on the local community? Many times, NGOs neglect to consider the business aspects of their operation. They are so passionate about their health mission and goals that they forget to place themselves within the larger framework of the community's economy. Do the NGOs participate in mass-scale mosquito net donations without thinking about how that would impact local mosquito net producers, or do they engage in conversation with various other businesses to ensure they are working harmoniously? Health NGOs in particular must worry about economic competition with governmental facilities such as hospitals and dispensaries. For example, they may provide medical care for free to patients who would otherwise still be able to pay, thus diverting them from going to governmental facilities and therefore economically hindering the government's health care system. It is important to engage these other facilities in conversation so as to minimize possible negative outcomes.

Are health NGOs addressing the health needs of the community in which they work in an appropriate and sustainable way? Due to the sudden spike in the number of international foundations and other grant-giving organizations over the past few decades, certain health problems have become "trendier" than others. An NGO which is tackling malaria, for example, is much more likely to find a funding source than an NGO which is fighting against typhoid, even though each may be equally prevalent in the areas in which the NGOs are working. At times, this can lead organizations to direct their services towards easily fundable health issues instead of those which are most prevalent for the people in their community. Have the health NGOs grown out of truly relevant health care needs, or easily accessible grant money? Additionally, NGOs typically have a short-term time table, and therefore can sometimes "cover bullet holes with band-aids." Providing short-term solutions to long-term problems can ultimately be very detrimental to an individual's health and be even more disastrous if it perpetuates the existence of a communicable disease. How are NGOs addressing this challenge of continuous care?

Do health NGOs actively foster a positive relationship with each other and with the national government? In almost every case, the reason that NGOs become involved with a particular community is because the current structures are not providing a health system that is satisfactory to the people it is supposed to serve. As a result, the relationship that develops

between the NGO and the governmental institutions is somewhat tenuous at best, and can devolve all the way into blatant opposition and even sabotage. Even amongst the NGOs themselves, competition can arise as they fight to gain access to limited funding. Are health NGOs making sure to keep open communication with the government and other NGOs to prevent duplicity of programming and to ensure a cohesive health system for community members? How are NGOs choosing to deal with other actors within the health system that are less than cooperative?

Do health NGOs actively assess their overall impact on the community? One of the most crucial aspects to developing a highly effective organization is being willing to self-reflect with a critical eye. This allows one to see what operations are working well, and what operations need to be improved. Furthermore, it allows an organization to see if it has reached its initial targets and goals. In the case of health NGOs, this is crucial to ensure that the only outcomes the organization is making on the health care system are the intended ones. What assessment strategies for health NGOs exist, if any? On a broader level, how are health NGOs measuring their progress at all?

OBJECTIVES

1. This study will examine the presence and characteristics of the health system at the district level in Lamu, as well as the NGOs and CBOs who work there.
2. It will also observe how these organizations interact both with each other and with the government, and how this affects their struggle to fit in with the already existing health care system.
3. Additionally, it will identify the unique challenges faced by health NGOs and CBOs that, if left unchecked, would unintentionally facilitate the creation of largely detrimental consequences on the Lamu community.
4. From these observations, it will attempt to gauge underlying causes of such challenges as well as what aggravates them.
5. Ultimately, this study will recommend any best practices that help to prevent or navigate these challenges, and therefore minimize any unintentional negative impacts on the community of Lamu.

LITERATURE REVIEW

Nongovernmental organizations have been sprouting up across the globe for centuries to try and counter the increasing failure of governments to appropriately address the needs of their people. Although this movement dates back to colonial times, it was not truly galvanized until the 1970s. This was the period of neoliberal economic theory in which economic growth was measured by GDP per capita, and neoliberals felt that economic growth was essential to the success of a country and would be fostered best by deregulation and economic liberalization.[12] Nations everywhere saw an increased trend in non-state actors taking over where governments were weak or ineffective. NGOs in particular were emphasized due to their perceived abilities to work closely with local communities, write legislation and treaties, fundraise and function outside of control of governments, in addition to their overall income and topic specific focus.[13] Neoliberal economists argued that these NGOs would work to "create pluralism" in nations where there was typically no other form of competition to the government.[14] In fact, many saw NGO involvement as the cure-all solution which would remedy all problems rooted in weak nations. In the past two decades however, these solutions have begun to fall through.

Recently, literature has begun to surface which questions the efficacy and merit of the same NGOs which were once seen as the "policy panacea" for development problems.[15] These scholars question the economic and cultural viability of NGOs, as well as their ability to follow through on their good intentions. While by no means are they claiming that NGOs are a negative development in the geography of developing countries, they are suggesting that a framework needs to be developed to allow NGOs to be assessed and held accountable in the same way that

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[12] Lee, Kelley. *Health Impacts of Globalization: Towards Global Governance.* New York: Palgrave Macmillan, 2003.
[13] Laird, Thomas. "Human Rights." INTS 3952. Denver: University of Denver, 2009. 24.
[14] Lee, Kelley. *Health Impacts of Globalization: Towards Global Governance.* New York: Palgrave Macmillan, 2003.
[15] Flynn, Patrice, and Virginia A Hodgkinson. Measuring the Impact of the Nonprofit Sector. New York, NY: Kluwer Academic/Plenum Publishers, 2001.
Fowler, Alan. "Demonstrating NGO Performance: Problems and Possibilities." Development in Practice, February 1996: 58-65.
Montague, Joel. "The Fuss About NGOs- Are They Worth It?" Nonprofit Management & Leadership, Fall 1998: 95-97.
Spiro, Peter J. "Accounting for NGOs." Chicago Journal of International Law, 2002: 161-170 .

other organizations such as governmental institutions are to try and minimize detrimental unintentional consequences.

Scholars such as Andrew Green and Ann Matthias were some of the first to write these critical studies. In their paper "Where do NGOs fit in?" they suggest that over the past few decades, the role of health NGOs has evolved dramatically, and deserves an examination as to how these actors should fit in with the rest of the health sector. Although many health NGOs are relatively new themselves, Green and Matthias argue that their origins stem from the same history, especially in Africa. During colonization, many colonial governments focused solely on the implementation of laws and other order-maintaining devices. They tended to neglect the provision of health care – especially in rural or otherwise hard-to-access places – and as a result churches and other faith-based organizations came in to fill the gap. This strong external presence remains in most developing countries today. Green and Matthias go on to claim that this strong presence is not properly reflected on in current health policy; there is no evaluation or assessment of the NGOs. While a thorough study that gives an excellent historical context for NGOs, its analysis of current struggles health NGOs is somewhat superficial. My study adds to this by focusing more on these struggles and where challenges in the fit between NGOs and the public health system lie.[16]

Richard G. Wamai conducted a comparative study between Kenya and Finland regarding NGOs and the transforming public health care system. This paper argues that health NGO presence in public health systems is often underestimated by the general population, and is very important when looking at health policy and health service delivery. In particular, it focuses on how health NGOs affect health systems during a time of reform, seeing more and more mechanisms being created to help officially institutionalize the role of the health NGOs within an existing health structure. Although it does not touch on challenges that health NGOs face, it is important to my study because it establishes the notion that NGOs are an important force that both influence and assist health systems specifically in Kenya.[17]

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[16]Green, Andrew, and Anne Matthias. "Where Do NGOs Fit In? Developing a Policy Framework for the Health Sector." *Development In Practice*, November 1995: 313-323.
[17] Wamai, Richard G. *NGO and Public Health Systems: Transformative Trends in Comparing Health Systems in Kenya and Finland*. Toronto, Canada: International Society for Third Sector Research, 2004.

One study that delves further into criticisms of NGOs is "Accountability for Empowerment: Dilemmas Facing Nongovernmental Organizations." As NGOs tend to be from outside the community in which they work, NGOs may not truly understand the values or other cultural markers of that particular community. Patrick Kilby points out that although almost all NGOs have a strong set of core values within the organization, rarely is there a mechanism set in place to ensure that these internal values line up with the external values of the community the NGO is interacting with. This means that although the NGO is holding its members accountable to its internal values, there is nothing to hold the organization accountable to external community values. If an NGO's values do not align with the values of the community it is working with, this could catalyze serious problems down the road. My study takes this theory and studies it further within the specific context of health NGOs.[18]

A study done by Tyler Green, Heidi Green, Jean Scandlyn and Andrew Kestler examines a case of this in Guatemala. A North American short-term NGO sent a group of doctor volunteers to work who did not properly understand the difference in living standards, and inaccurately perceived everyone in Guatemala as "poor." Therefore, they felt they did not feel a need to do a socioeconomic evaluation of the community before they began their work, not choosing a specific location and providing medical care free to anyone who waited in line. The study expertly highlighted the faulty logic in this, explaining that in reality there was a vast difference in financial status among Guatemalan citizens, and such an evaluation would have proved extremely useful in assessing needs of the community and where to target the most assistance. Because the NGO allowed everyone to obtain medical care for free instead of targeting needy groups, they ultimately served a large portion of the population that was already able to access health care before the organization's arrival. Additionally, the time spent serving these people was time not spent on those who needed the care most. This study clearly illustrates the ease with which a well-intentioned health NGO can mitigate its own positive impacts.[19]

My study will focus directly on health NGOs in coastal Kenya and their impacts on the health care system, however minimal scholarly work can be found on this topic in this area.

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[18] Kilby, Patrick. "Accountability for Empowerment: Dilemmas Facing Non-Governmental Organizations." World Development, Vol. 34 No. 6, 2006: 951-963.
[19] Green, Tyler, Heidi Green, Jean Scandlyn, and Andrew Kestler. "Perceptions of short-term medical volunteer work: A qualitative study in Guatemala." Globalization and Health, Feb 26, 2009.

Indeed, minimal scholarly work can be found on the topic of assessing health NGO impacts at all. The absence of literature within coastal Kenya may just be because it is such a specific niche; however the prevailing lack of literature on a much wider geographical scale points to deeper reasons. Although it is impossible to truly know why there is such an absence, one possible reason is the precarious nature of aid: a community may be so grateful to get any kind of help at all from these NGOs that they would be reluctant to evaluate it, thinking that if they are too critical the organizations may become offended and refuse to give further aid. Additionally, the unique characteristics of health NGOs may not yet be fully realized by the academic community and therefore would be lumped together with all other types of NGOs. Finally, so many intergovernmental organizations such as the World Health Organization and the International Monetary Fund are providing their own analyses of national health profiles that at first glance it may seem redundant to provide one on health NGOs alone. For whatever reason, it should be noted that there is a widespread hole in current literature that leaves the issue of health NGO impacts relatively unexplored.

SIGNIFICANCE OF RESEARCH

Research on the impacts of health NGOs on local health systems in general is very significant because health outcomes are critical to the wellbeing of a nation. A robust health system can even be thought of as a nation's backbone as it supports economic growth, state stability and development. It is also a form of enhancing and maintaining human capital in a way similar to furthering professional skill or education level: people who are healthy can work at a higher quality and can work for more hours per week for more years as their quality of life and life expectancies increase. Therefore, as the overall health of a population rises, so does the output level of the national workforce. Outside of the community, foreign direct investment is encouraged as well by the visible signs of a healthy, and therefore economically active, population that is not likely to collapse under the strain of health problems.

The concept of NGO assessment has gained popularity immensely in the past few years, however the unique situation NGO presence specifically within the health sector presents is still extremely under acknowledged, especially within the wider frame of existing health systems. In

all of health funding worldwide, less than 0.02% is spent on health systems research.[20] Few scholars have delved into the problem and no in-depth studies have yet been done on the East African Coast. My study is different from previous academic works in that it addresses the characteristics of health NGOs head-on, and in a new geographical location that presents new learning opportunities. Lamu presents a very unique set of characteristics as it is an archipelago that is heavily dominated by a Muslim community, and also has many hard-to-access towns and villages. Additionally, its geographical proximity to the equator leaves it a breeding ground for mosquitoes, and therefore malaria. My study could therefore reveal best practices that could be applied to many other communities in which NGOs are struggling to adapt to cultural and geographical challenges with endemic health problems. It could also highlight areas in which the Lamu community could further strengthen the efficacy of its health NGOs.

METHODOLOGY

In order to obtain the necessary information to build a complete picture of the health system at the district level in Lamu, I needed to conduct interviews with multiple groups. The first group I chose was the public sector. I interviewed members of various sections of the government such as Lamu District Hospital, the Public Health Office, the County Council, and the District Health Management Team. Input from these actors was essential to gaining an understanding of how the overall health system worked in Lamu District, which is very convoluted. Additionally, I wanted to ascertain how government workers defined the ideal role of NGOs and CBOs, and if they believed the current organizations in Lamu were fulfilling that role. If they were not, I wanted to know if there was any mechanism in place for the government to stop those organizations or hold them accountable in any way.

Secondly, I conducted several semi-structured interviews with members of NGOs and international aid organizations such as AMREF, USAID and the KRC. With USAID I specifically interviewed members working under the project APHIA II Coastal Province, both in Lamu and in Mombasa. With AMREF and KRC, I conducted interviews with multiple organization members including employees and interns, and observed the facilities of each office, studying how each worker interacted with each other and with the community when

[20] *TDR News* Issue No. 85. World Health Organization. Accessed 11 November, 2010.

possible. My purpose in these meetings was to understand the basic functioning of each NGO, how each saw itself portrayed in the community, and how each understood its relationship with other NGOs and CBOs. When needed, I conducted follow-up e-mails and phone calls to further clarify information we had discussed or to elaborate on certain points. I also accompanied AMREF on multiple outings such as a Baseline Survey Indicator Data Collection De-Briefing, and an excursion to the AMREF Clinic stationed in Kibera, Nairobi. This allowed me to develop a frame of reference for how AMREF's involvement in Lamu compared with AMREF's involvement in other districts, as well as the overall health profile in Kibera compared to Lamu.

To put Lamu in context with the larger framework of Kenya health policy and structure in general, I attended a conference in Nairobi hosted by HENNET, the Health-NGO Network of Kenya and directly interviewed HENNET members and employees. This conference allowed me to observe firsthand the dialogue of larger NGOs as they worked with one another and shared challenges they were facing, and opinions they held about the smaller CBOs and larger government. It also helped me to understand how Lamu compared with other districts throughout Kenya both in health issues such as Malaria prevalence and maternal mortality, and in health accessibility and overall level of NGO aid.

Finally, I conducted semi-structured interviews with members of CBOs such as Kikozi Programme, Anne Spoerry Sailing Doctors, Sauti ya Wanawake, Tawasal, and LAMCOT Sailing Doctors. For these locations too I was able to study their offices, dispensaries where some worked and observe personal interaction between members. The purpose of these meetings was to grasp how the more local organizations viewed the health care system, the outside NGOs, and the other CBOs. Furthermore, I wanted to understand how their operations were affected by larger NGO projects and various grants. These observations proved crucial to see how programs that were articulated at the higher governmental level or even the higher level of large projects such as APHIA II were actually implemented on the ground.

Most interviews took place at organizational headquarters, and lasted between 30 minutes and two hours. The majority were completely in English, although some were mixed between Swahili and English, particularly in more rural areas. This was no problem however, as my ability to speak Swahili was by far sufficient enough to understand the Swahili sections without difficulty. As some of the material of the interviews became political or involved other

organizations mentioned in this paper, I have kept some organizational contributions anonymous to protect privacy and the relationships between various organizations by omitting names and changing various identifying characteristics.

STUDY FINDINGS

Existing Health System in Lamu

The health system as it stands in Lamu is a complex overlay of multiple systems working in close proximity to finance and deliver health care. The breakdown of service delivery, organizational management and financing are all separate and relatively independent from one another. In order to effectively strengthen health systems and improve overall communal health, as is the goal of most health NGOs, these NGOs must first have a comprehensive understanding of the existing health system in Lamu. It is only once this is achieved that NGOs will know best where to place themselves or know which segments need strengthening most.

Service Delivery

The breakdown of service delivery as classified by KEPH, Kenya's Essential Package for Health can be thought of as a pyramid, shown in Appendix B. Level 1 consists of the community itself, as well as Community Health Workers who act as an interface for household caregivers, keeping them up-to-date on health care information and making sure they have accurate information on which facilities provide which services, and when it is necessary to seek further medical care. Each CHW supports approximately 20 family households, and is supported in turn by a Community Health Extension Worker. Level 2 is composed of health dispensaries and clinics, where community members can go to get simple services such as birth control and malaria medication. Level 3 is made up of health centers, which are more developed than dispensaries, but not as large as district and sub-district hospitals, which comprise level 4. Secondary and national hospitals make up level 5, and referral hospitals for specialized surgeries and other medical procedures are last at level 6. In Lamu District specifically, service delivery is available at the lowest four levels: there are three hospitals at level 4, five health centers at level 3, eighteen dispensaries at level 2, and ninety CHWs at level 1. One result of this breakdown is that communication between levels is crucial in order to ensure that information regarding

financial or policy changes trickle all the way down to the bottom, where the community members are.[21]

Organizational Management

A second breakdown of the health system is by organizational management, as seen in Appendix C. Although technically there is currently not a Ministry of Health, it is included in the diagram to show how the Ministry of Medical Services and Ministry of Public Health and Sanitation grew out of it and because people often still refer to it. When Raila and Kibaki entered in a power-sharing agreement after the post-election violence in 2007 and 2008, the MOH was split into the MOMS and MOPHS. The new constitution, which was recently voted upon and will be implemented in 2012, will merge these two ministries back into one MOH. Currently, MOMS is in charge of matters dealing with the upper levels of KEPH – 4,5 and 6 – while MOPHS focuses on the lower levels – 1 through 3 – with a special emphasis on community health. In order to facilitate communication between the two ministries, the DMOH acts as the chairman of the DHMT, and then as the secretary of the DHMB representing the interests of the DHMT during DHMB meetings. The DPHO is also a member of the DHMT, and reports back to the divisional PHOs who work in the seven divisions of Lamu. Often, people will still use the term MOH when referring to something which involves both the MOMS and the MOPHS.[22]

In general, the DHMB is comprised of various community members and stakeholders in the district. It meets once a quarter and usually has approximately 9 members. Conversely, the DHMT consists of more technical people such as the District Public Health Nurse, the District Public Health Officer, the District Reproductive Health Coordinator and the Nursing Officer, just to name a few. While the DHMB meets once a quarter, the DHMT is always running and coordinates the daily running of the district facilities at levels 1,2 and 3. Within the district, each hospital has its own HMT and HMB. Lastly, the HMT appoints sub-committees to help reach goals on specific areas, such as Infection Prevention. Appendix C shows only 3 sub-committees for viewing ease, but typically there are approximately nine different groups. Ideally, the

[21] CHW numbers from Interview. Raya Famau, Secretary on Board of Directors, Sauti ya Wanawake. 8 November, 2010.
[22] Interview. Dr. Samuel Ngandu, Lawrence Nyambari and Mashua Galugalu, Health Management Team and District Health Management Team members. 3 November, 2010.

DHMB and the HMB are supposed to be completely separate entities, but often they are one and the same, as is the case in Lamu. The DHMT and HMT are always separate entities, as each hospital has a different head technical person in each department. Although there is large overlap between the MOMS and MOPHS, technically the DHMT is completely under the MOPHS. The MOMS is supposed to have an equivalent and identical organization that would coordinate facility activities at the higher KEPH levels, but due to shortage of staff this has yet to be established.[23]

In theory the DHMT is supposed to oversee the workings of all lower level facilities. On the ground in Lamu however, the health centers, clinics and dispensaries run almost completely separately from the DHMT and often even from Lamu District Hospital as well. Additionally, one divisional public health officer confided in me that although the various divisional PHOs are supposed to meet quarterly with the DPHO, due to difficulties of scheduling and transport – each facility is on a different section of the archipelago and therefore almost all must take boats and jeeps in order to reach the public health office itself in Amu – the meetings occur extremely infrequently.[24] As a result, there is sometimes a knowledge gap between what is happening at the various district locations and what is going on between the DHMT, DPHO and DMOH.

Financial Structure[25]

The third system that must be taken into consideration is the flow of money to and from the health facilities. This was recently changed by the Health Sector Services Fund, HSSF, to be more decentralized. Originally, money would flow to the facilities in two ways: from the government, and from the patients themselves, shown in Appendix D. Quarterly government money would move from the Ministry of Finance to the MOPHS, where it would get divided by province and then again by district until it reached the DMOH, who then would divide it again among the various health hospitals, clinics, dispensaries and centers depending on the their perceived need. The second method in which facilities were funding was through aids and

[23] Ibid.
[24] Interview #9. 2 November, 2010.
[25] The information on financial structure below is a conglomeration of information received from four main interviews: Interview #7, 1 November, 2010; Interview #9, 2 November, 2010; Interview #10, 3 November, 2010; and Interview #22, 12 November, 2010. These interviews included members of the DHMT, the DMOH himself, and divisional PHOs, as well as multiple employees of NGOs.

appropriations, or A&A. A&A is also known as cross-sharing and is essentially a fee-per-service cost that patients must pay when receiving various medical services from the hospital. This money is pooled into a Facility Improvement Fund. From there, a budget is created by the HMT on how to spend the FIF within the facility. The HMB then votes to either approve or veto the budget, or approve it after making minor adjustments.

Although this system worked well in theory, in practice there were many problems accompanying it that hindered both the delivery and the finance of health care. Oftentimes due to the large number of middlemen and competing interests, very little government funding – if any – would make it all of the way down to the smallest dispensaries and clinics. Therefore, many facilities relied on A&A to cover their operating costs. This too became a problem, as many patients in the Lamu District found these cross-sharing fees too high to pay, and therefore would choose not to receive care. Ultimately the A&A that was keeping the facilities operational and allowing them to provide services was simultaneously preventing patients from actually utilizing these same services. To reduce A&A and eliminate it where possible, and also to minimize the bureaucracy that dried up the quarterly governmental funds, the government created the HSSF, shown in Figure 4. This plan was rolled out to 590 health centers with grants totaling 143 million shillings. With the HSSF, money would go directly from the Ministry of Finance to the local facilities themselves in the form of grants instead of being cut up and siphoned off by its previous more indirect route. Then, the money would be directly budgeted and controlled by the local facilities themselves in the form of Health Facility Management Committees, under wider guidelines from the DMOH to prevent misappropriations.

This change is seen as both a positive and a precarious one by members of the Lamu community. Most members of the government, especially local ones, are very happy about the change. Jilo Kitasi, a divisional PHO in Mpekentoi, explained how it is the people at the lowest level that truly know the priorities of their community best, and therefore are best equipped to prioritize how to spend governmental funds. With the new change, no one is able to push ill-fitting priorities upon the lower facilities.[26] Conversely, some NGOs and CBOs worry that the government made this change without looking at the realities at the district level. One NGO worker explained that a crucial government assumption in this change is that the rural health

[26] Interview. Jilo Kitasi, Divisional Public Health Officer, Mpeketoni. 2 November, 2010.

facilities have the management capacity to manage these grants. Many times this is not the case, and rural facilities lack necessary skills and training to properly distribute the funds in a manner that ensures facility management structure and community representation are both present.[27]

There is one way outside of the HSSF that health facilities can receive funding, and that is through the National AIDS Control Council, or NACC. This is a government-funded council that doles out money to those who submit proposals on projects regarding the prevention, treatment, support and/or advocacy of HIV/AIDS. Unlike the HSSF fund, which automatically is sent to divisional level health facilities, the NACC is directed towards NGOs and CBOs working collaboratively with KEPH and must be applied for. In Lamu West there are 22 CBOs presently receiving grants from NACC ranging from 350,000/ksh to 1.75 million ksh.[28]

Characteristics of NGOs and CBOs in Lamu

As previously mentioned, there is a distinct difference between NGOs and CBOs operating in Kenya. NGOs tend to have a larger mandate and scope, while CBOs grow directly out of the community and focus on smaller issues. Because the core of these organizations is so different, their characteristics are inherently different as well. By understanding each organization's individual nature, one will also be able to better comprehend why they interact the way they do and how they fit in with the existing health system in Lamu.

NGOs

There are two main NGOs working in Lamu District: Kenya Red Cross and AMREF. A third entity, APHIA II, is not an NGO but a nation-wide project funded by USAID that works in proximity with the MOH to link CBOs with NGOs to better tackle prevalent issues regarding HIV and AIDS. APHIA II is included in this section because while technically it is not an NGO, it shares many characteristics with the NGOs and is more similar to an NGO than a CBO.

African Medical Research Foundation

Over a century ago, missionaries became involved in providing emergency services in remote areas of Africa. This concept eventually evolved into what is now known as Flying

[27] Interview. Amos Odacha, AMREF Program Manager. 1 November, 2010.
[28] Interview. Haji Shibu, Lamu District County Councilman. 4 November, 2010.

Doctors, an organization in which people travel to places that have little to no access to health care and provide much-needed services. The African Medical Research Foundation, otherwise known as AMREF, developed out of Flying Doctors because they saw a need greater than what Flying Doctors could give: although it was doing a phenomenal job of attending to acute health issues, due to its short time-table there was nothing in place in any of these locations to stem the chronic health system failures that were fostering these health issues to begin with.[29] Currently, AMREF is funded by the European Union and other government institutions, as well as fundraising and donations from high net-worth individuals.

AMREF has the overall vision of "better health for Africa," and believes it can achieve this by focusing on the following goals: strong health systems, community partnering for better health, heath systems and policy research, and capacity building. As a result of this, they have a strong focus on remote, marginalized areas. In these areas, each AMREF office focuses on a single specific project, but also works on these overarching goals. The Lamu Office is developed as part of a four year project on Maternal and Child Health, which means that all of its major initiatives focus on improving health care for children and mothers. At the same time however, it is also working with the secretariat of the district level MOPHS to improve the secretariat's capacity and organizational skills to better run meetings. Although meetings held at the public health office has little to do with MCH, AMREF is assisting because it is part of their larger goal to build capacity and strengthen health systems.[30]

Although it does have country offices as well as international headquarters, AMREF does not believe in placing itself indefinitely into a community. Therefore, all other offices are temporary installments as part of projects with closed timetable. All AMREF projects typically run on a 4-5 year schedule to give them enough time to be introduced to the community, perform a baseline indicator survey, scale up their activities, run at maximum capacity, and then scale down again and prepare the community for their departure. The Lamu Office is scheduled to be in effect from 2010 to 2014. "We come in the house but sit looking at the door," Amos Odacha,

[29] Interview. Amos Odacha, Lamu Office Program Manger, AMREF. 27 October, 2010.
[30] Interview. Amos Odhacha, Lamu Office Project Manager, AMREF. 1 November, 2010.

the Program Manager for the AMREF Lamu Office explains. "We prepare you from day one that we are not here to stay long."[31]

In spite of the clear timeline, however, some community members do get confused about AMREF's presence in Lamu. One local said that he thought AMREF had been in Lamu for the past eight years, while another said they had just arrived a few months ago. Still another thought that AMREF came for days at a time once every few years to provide medical surgeries such as repairing club foots. AMREF's presence in Lamu is this convoluted due to its slow growth out of Flying Doctors, which is still a very prevalent organization in Lamu, and its previous project on Child Health and Sanitation in 2004 – 2006. The Lamu Office is located in Amu and has five permanent staff members: one project manager, two project assistants, one office assistant, and one driver.

AIDS, Population and Health Integrated Assistance Project II

The AIDS, Population and Health Integrated Assistance project (APHIA II) is a five-year program funded by USAID. Started in June of 2006, the program is ending on the 30th of November this year. It is built upon shared goals of the United States Government and the Government of Kenya regarding HIV/AIDS and TB, and more peripherally reproductive health, family planning, malaria and MCH. APHIA II has three target result areas: Result Area 1, improved care and treatment; Result Area 2, improved prevention techniques; and Result Area 3, improved care and support.[32] These can be seen in more detail in the Appendix.

To ensure that it is working with the community, APHIA II has both strategic partners and local implementation partners.[33] Strategic partners are large, typically international NGOs such as Catholic Relief Services. Each partner has one program area to focus on, such as CRS being responsible for care and support to people living with HIV.[34] Local implementing partners then coordinate these programs on the ground. It is impossible to identify exactly how many local implementing partners there are – some estimates say there only 40 in the whole of the

[31] Interview. Amos Odacha, Lamu Office Project Manager, AMREF. 27 October, 2010.
[32] Interview. Mohamed Mbwana, Kikozi Programme Project Coordinator. 5 November, 2010.
[33] Interview. Phyllis Sande and Patience Loro, APHIA II Coast Province, Malindi & Mombasa Office. 3 November, 2010.
[34] United States Agency for International Development. *APHIA II Partners.* http:// .com (accessed 7 November, 2010).

coast province, while others state that there are over 30 CBOs affiliated with APHIA II in the division of Amu alone.[35] This confusion is most likely due to unofficial collaborations that take place on the ground and are not heard of higher up in the project.

Through these partnerships, APHIA II works to join the private and public sectors of the health system to reduce community stigma of people living with HIV/AIDS, reduce gender violence, support OVCs and provide them with education, increased utilization of HIV testing and family planning services, and increase palliative care available for people living with AIDS.[36] APHIA II prides itself on its close relationship with the government, specifically the MOH. This can be seen in the fact that all APHIA II work must be published in the Annual Operational Plan that the MOH publishes each year.[37]

The APHIA II project is coming to an end in December, and all funding to all strategic and local implementing partners will cease on November 30, 2010. Although this will greatly affect almost all of these organizations, APHIA II has tried to be cognoscente about this and performed various trainings such as financial management and internal governance classes to help these organizations sustain themselves after APHIA II has left.[38] Additionally, another USAID program by the name of APHIAplus will soon begin to take over where APHIA II left off. As of right now, very little information about APHIAplus is known. Current partners of APHIA II do not know if they will be invited to become involved in APHIAplus or not. Even the leading partner organization for APHIAplus is unknown, although many Lamu community members believe it will be headed by Pathfinder. Whether or not CBOs in Lamu will be invited to continue in APHIAplus's work will greatly determine their future.

Kenya Red Cross

The Kenya Red Cross is the longest-standing NGO present in Lamu District. The Lamu Office is a branch of the Kenya Red Cross, which then reports to international headquarters of International Red Cross Red Crescent in Geneva, Switzerland. Kenya Red Cross Itself has over

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[35] Interview. Haji Shibu, County Councilman. 4 November, 2010.
[36] United States Agency for International Development. *APHIA II Background.* http://_____.com (accessed 7 November, 2010).
[37] Interview. Phyllis Sande and Patience Loro, APHIA II Coast Province, Malindi & Mombasa Office. 3 November, 2010.
[38] Interview. Mohamed Mbwana, Kikozi Programme Project Coordinator. 5 November, 2010.

63 branchesIt has four full time staff, and over 160 volunteers that are tracked on a data book. KRC is funded by other Red Cross organizations such as the Netherlands Red Cross, Canadian Red Cross and International Federation of the Red Cross, and also by other governmental institutions such as the French Embassy.[39] Kenya Red Cross also funds itself by IGAs such as the Red Cross-owned Red Court Hotel in Nairobi. IGAs for the Lamu Office specifically include renting out tents, a boat and a car to other organizations in the area.[40] It also has a local resource center which provides internet, typing and printing services.[41]

Ultimately, KRC is a disaster-oriented organization. In this way, it operates closely with the MOH to deploy resources as soon as possible and as appropriately as possible to assist the government in ameliorating natural disasters. Under normal circumstances in Lamu, if such a natural disaster were to occur, the DMOH would be responsible for declaring emergency status and then requesting the help of KRC. However, Abdul Basheikh, the branch coordinator of the Lamu Office of KRC, explained in an interview that sometimes the KRC can act as a voice of the locals, communicating with the DMOH and alerting him of a problem he may not be aware of. This lack of awareness can happen easily in Lamu District due to the difficulty of transportation from one division to another. The locals will often know about something far before the DMOH, and will call KRC to alert them. KRC will then call the DMOH, who will investigate and from there determine whether or not it is worthy of a declaration of emergency status.[42]

In addition to its focus on disaster relief, KRC also has multiple programs depending on the needs of the community. In Lamu, KRC has two presently ongoing programs: Home Management of Malaria program (HMM) and its HIV/AIDS Peer Educator Program. HMM was started in October of 2008, and targets children younger than five years old, as these are at particularly high risk for dying from malaria.[43] It also focuses on hard to reach areas within Lamu District such as Manda Maweni, Manda Yawi, Basuba, Mararani, Kiunga, Ntangawanda

[39] Interview. Zahra Aboud, Administrative Assistant & Project Officer of AIDS and HMM Programs. 18 November, 2010.
[40] Interview. Fatma, Kenya Red Cross Accountant. 9 November, 2010.
[41] Interview. Zahra Aboud, Administrative Assistant and Program Officer of HIV and HMM Program. 18 November, 2010.
[42] Interview. Abdulswamad Basheikh, KRC Branch Coordinator. 17 November, 2010.
[43] Interview. Zahra Aboud, Administrative Assistant and Program Officer of HIV and HMM Program. 18 November, 2010.

and Milimani. In these areas, KRC trains CHWs on how to treat children under five who are exhibiting symptoms of malaria – these CHWs then report back to KRC branch office in Amu on a weekly basis.[44]

KRC's second program, HIV/AIDS Peer Educator Program, started in 2004 and is set to end in December of 2010, although its Program Officer, Zahra Aboud, is currently looking for funding to extend it.[45] The program targets youth up to the age of 28 years old, who are then educated in means of HIV prevention and advocacy. KRC also goes to schools and local events and attempts to incorporate health education into community activities. Because of strict gender roles throughout Lamu District combined with a largely Islamic community, KRC creates different programs for men and women: to reach men, KRC will set up activities at sports centers, while to reach women, KRC peer educators will attend events such as art galas.[46] Both of these programs run completely independently of APHIA II, but to avoid duplicity KRC and APHIA II often invite each other to their outreaches, or do joint planning such as was the case for World AIDS Day.[47]

CBOs

It would be impossible to give an accurate portrayal of health advocacy work in Lamu without including the many CBOs that work there. The CBOs are crucial because although they are much smaller than NGOs and are often popping up and dying out without notice, they are almost always comprised of local community members themselves, and grow out of a legitimate community need. There are far too many CBOs in Lamu District to describe them all, so three are listed below used to represent the various types of CBOs that exist.

Kikozi Programme

The Kikozi Programme is a locally-grown CBO established in 1998. Over the years, Kikozi has moved around from project to project depending on the community's needs and available funding. Previously, it worked on an Early Childhood Development and Nutrition

[44] Interview. Zahra Aboud, Administrative Assistant and Program Officer of HIV and HMM Program. 25 October, 2010.
[45] Interview. Zahra Aboud, Administrative Assistant and Program Officer of HIV and HMM Program. 18 November, 2010.
[46] Ibid.
[47] Ibid.

project with CRS, and also as a microfinancing institution giving out small loans to businesswomen. Kikozi also functions as a financial intermediary for the district level government. It began working with APHIA II as an implementing partner in August of 2008, in Result Area 2: improvement of prevention of HIV/AIDS.[48]

Within Result Area 2 APHIA II uses the cluster model, in which organizations with similar characteristics are grouped together to unite and prevent through one project. In Lamu there are three main cluster groups: one for women's organizations, men's organizations, and youth organizations. Kikozi acts as the head of the women's cluster, which has 13 CBOs in Amu alone. This cluster works on an intervention program that provides linkages and referrals in the community and facilities for a variety of needs including HIV/AIDS treatment, family planning, prevention of MTCT, and home based care for people living with HIV/AIDS. Kikozi emphasizes advocacy and linkages, and the Project Coordinator Mohamed Mbwana hopes Kikozi's work will end in encouraging people to uptake health services and facilities in the community.[49]

When APHIA II leaves in December, Kikozi's operations will undergo a large change and there will definitely be a gap: currently, Kikozi Programme is funded by USAID through APHIA II, and one IGA of a printing and photocopying center. When USAID funding stops on the 30th of November, it will subsist merely on its one IGA and submit proposals to other funding sources, such as NACC, to do other projects in the community.[50] While working under APHIA II, USAID funded training programs on both financial management and internal governance, and helped Kikozi develop an extensive strategic plan. Kikozi is hoping to work with APHIAplus when it arrives, but Mbwana asserts that even if they are not invited to work with APHIAplus, "the impact is already there" within Kikozi's operating abilities from its involvement with APHIA II.[51]

Anne Spoerry Sailing Doctors

[48] Interview. Mohamed Mbwana, Kikozi Programme Project Coordinator. 5 November, 2010.
[49] Ibid.
[50] Interview. Umulker Ahmed, Kikozi Programme Volunteer. 10 November, 2010.
[51] Interview. Mohamed Mbwana, Kikozi Programme Project Coordinator. 5 November, 2010.

ASSD was founded by Chloe Spoerry at the beginning of 2010 in memory of her aunt, Anne Spoerry. Anne Spoerry worked with Flying Doctors and did work in Pate Island and Boni areas on the mainland of Lamu District. When she died in February of 1999, Chloe wanted to be able to continue her work. Currently, ASSD has an office in Shella and has five permanent staff members: clinical officer who works at Shella Dispensary, a nurse who works at Mangoi on a two year joint contract with MOH until 2012, two health personnel and a project coordinator. Spoerry herself is French, but the rest of the staff is comprised of Kenyans.[52] Its funding comes primarily from the Spoerry family and the French Embassy due to the Anne Spoerry's prominent identity in Lamu, but the Embassy money will run out at the end of this year. ASSD is hoping to compensate for this through fundraising methods which will start in January.

ASSD does monthly mobile clinics in Mkokoni, Mararani, Mangai, Basuba and Milimani. The group includes a clinician, a manager, a project coordinator and three crewmen to navigate the boat. The duration of the trip is around three days by boat and two by jeep. Since its inception, ASSD has seen between 6,500 and 7,900 patients and has performed over 700 immunizations. The immunizations are provided free from Lamu District Hospital, and the rest of the medical equipment is valued at approximately 100,000/ksh per month. On all outings, ASSD brings a GOK representative along, usually an LDH nurse. LDH will allocate a nurse to ASSD, and then ASSD will provide that nurse a salary for the five day trip.[53]

Sauti ya Wanawake

Sauti ya Wanawake was established in 2006, and collaborated with the MOH until August 2009, when it was invited to participate in APHIA II. It is the only CBO currently in Lamu that participates in Result Area 3, care and support. Within this result area, Sauti ya Wanawake participates in two programs: Home Based Care and caring for Orphans and Vulnerable Children. In the Home Based Care program, Sauti ya Wanawake trains CHWs who will then go out into the community, assess families and bring reports back. Then, if deemed necessary by CHWs, they will provide food supplements to the families from Sauti ya

[52] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 30 October, 2010.
[53] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 30 October, 2010.

Wanawake. CHWs also are trained to give psycho-social support to people living with HIV/AIDS. At times, they even remind patients of proper dates and times to take their ARVs.[54]

Sauti ya Wanawake's second program is for OVCs. Orphans of parents who died from HIV/AIDS or children whose parents cannot care for them properly because of HIV/AIDS related illnesses can enroll in Sauti ya Wanawake and receive free school uniforms, and often Sauti ya Wanawake can process birth certificates for them as well. Additionally, if an OVC falls ill, Sawuti ya Wanawake will cover the costs if they go to a government hospital. Outside of these two programs, Sauti ya Wanawake partakes in counseling and testing outreaches such as Family Fun Day, where food is cooked and programs are put on so children will want to come. Then, elements of health education are added, and with parental consent Sauti ya Wanawake will test the children for HIV/AIDS.[55]

Outside of APHIA II, Sauti ya Wanawake implements a Behavioral Change Communication program funded by NACC. This program went from April 2010 until September 2010, and raised awareness that people in a relationship are actually at a higher risk than single people due to lack of control over birth control. When APHIA II funding ends the 30th of November, Sauti ya Wanawake will attempt to continue collaborating with one of the strategic partners it met during its work under APHIA II. On the whole, Sauti ya Wanawake sees itself as being dependent on a larger organization – ideally a strategic partner – to continue with its projects.[56]

Relationships between NGOs, CBOs and Government

During her lecture at the HENNET Quarterly Meeting in November of 2010, Dr. Migio detailed the ideal relationship between the government of Kenya, NGOs, CBOs and large international organizations when implementing new health policy and building up the Kenyan health system. The government of Kenya would be responsible for the development of the policies and strategies themselves, and also for "engaging and coordinating" CBOs and NGOs operating at various levels throughout the nation. The CBOs and NGOs in turn would then

[54] Interview. Raya Famau, Secretary of Board of Directors for Sauti ya Wanawake. 8 November, 2010.
[55] Ibid.
[56] Ibid.

ensure the dissemination of accurate information, and "provide community based support through existing support groups and institutions." Finally, international organizations and larger NGOs would publicize such policies to ensure their placement on the "global public health agenda" and promote necessary policy changes.[57]

In Lamu District, while the relationship does not reach the idyllic balance described above, the overriding atmosphere between CBOs, NGOs and the government is that of collaboration. While each group prefers its own method of providing health, they all see each other as essential parts working together in a larger health system. DPHO Dumila Muhamed explained that NGOs "are our sisters," and that there is a lot of assistance from them.[58] ASSD clinician Nizar Ali termed Lamu District Hospital as "the mother of all projects."[59] When describing relations between NGOs and the district level government, HMT member Mashua Galugalu stated that "down here we work as closely as possible," later reiterating "we work hand in glove."[60] Kikozi Programme assured that it is "very comfortable working with [the government]" and in fact labeled their relationship as a "big achievement."[61] These groups often exchange ideas with each other, work together on big projects, and share resources when necessary.

That being said, there are certainly some issues that are more contentious than others. Money is often a catalyst for conflict, particularly when dealing with organizations that have a large annual budget. One government official asserted that conflicts come when NGOs refuse to fully divulge how much money they are working with: "they will not say how much they have gotten for what."[62] To the official, this is equivalent to not cooperating fully with the government. Between NGOs and CBOs themselves, the struggle to receive money in the form of funding facilitates competition and rivalry. One organization ardently insisted that other CBOs were constantly asking them where they got their money, or saying bad things about the

[57] Migiro, Dr. P. Santau. *Child Survival and Development Strategy 2008-2015*. HENNET Quarterly Meeting. Nairobi, Kenya. 11 November, 2010.
[58] Interview. Dumila Muhamed, Lamu District Public Health Officer. 25 October, 2010.
[59] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 30 October, 2010.
[60] Interview. Mashua Galugalu, Hospital Management Team Member. 3 November, 2010.
[61] Interview. Mohamed Mbwana, Kikozi Programme Project Coordinator. 5 November, 2010.
[62] Interview #2.

organization to make their CBO look better.[63] It is particularly exacerbated now, as everyone is vying to become a participant in APHIAplus.

Communication is also a key factor. When first establishing itself in Lamu, an NGO must announce its presence to the Lamu County Council as well as the DHMT. When this information is not there, conflicts can occur. At times NGOs do not explain everything "on the table" or go on the ground without informing the DHMT, and this causes tension in the relationship with the government.[64] Even NGOs and CBOs themselves will refuse partnerships with other organizations if they do not share goal details on their mission or timetable.

In spite of these challenges, each group understands that they have different types of resources, and will frequently pool these together to try to be as effective as possible. Often groups will trade expertise with funding to make the most of their programs, or work together on one project to avoid duplicity and to expand the scale of the project. Overall, groups that are more willing to share and collaborate with other organizations – particularly the government – are much more successful than those who have given up on partnership and are now trying to work on their own.

Unique Challenges faced by Health NGOs

Continuity of Care

If a disease is only treated at a preliminary level and then left uncared for, it will almost certainly regress back to the level it was at before it was treated, and oftentimes can become even worse. Even the administering of antibiotics without care to ensure the drugs are completed can have very negative consequences on a patient and a community. One only has to look at the development of extremely-drug-resistant tuberculosis in Haiti due to incomplete rounds of antibiotics to understand how catastrophic results like this can be.[65] In this way, NGOs that choose to become involved in communities to try and increase the level of health within a community – be it by deploying emergency relief, designing monthly outreaches, or focusing

[63] Interview # 19.
[64] Interview. Dumila Muhamed, Lamu District Public Health Officer. 25 October, 2010.
[65] Farmer, Paul. *Infections and Inequalities: The Modern Plagues.* University of California Press, 2001.

directly on building capacity within the already existing health care system – have the added challenge of ensuring that the health services they dole out to patients facilitate continuous care.

In Lamu, this task can be difficult for a number of reasons – the most basic of which is due to difficulty of physical access to certain communities. ASSD attests to this in its description of its monthly mobile clinics: reaching every community in a timely manner during its monthly five day trip is nearly impossible due to the trouble of transportation. Frequently it is a matter of timing: the access to many communities is completely dependent on the tides, so at times ASSD may have to wait for hours. Also, some villages that are further back in the mainland cannot be reached during the rainy season due to the poor condition of the roads. Even with an all-terrain jeep, access is completely shut off at certain times of the year. This is compounded by the fact that ASSD does not actually have a jeep of its own, and instead borrows one from WWF, a fellow NGO. Therefore, if WWF has something important come up at the last minute, ASSD can lose access to the jeep with extremely little prior notice. The difficulties of transportation make timing of the essence, and therefore can result in patient care being rushed: because ASSD has to see so many patients in such a small time and has to make the next tide to ensure it will be able to reach the next village, it is sometimes not able to take a long medical history, or deeply investigate to verify diagnoses given to it by the patients. These issues make it extremely tough for ASSD to provide care at a reliable time to each community each month.[66]

Funding is possibly the second most prevalent impediment to continuous care in Lamu, and possibly the most important, as it ultimately denotes whether or not a health NGO can execute their planned programs. Sauti ya Wanawake serves a crucial position in the Lamu District health system as an on-the-ground member of the community that is able to form relationships with household caregivers and truly ensure that people living with HIV/AIDS are taking their ARVs and other medications at the right time – an essential aspect of continuous care. However, it admitted in an interview that it ultimately sees itself as dependent on a larger organization to fund it.[67] This sentiment is shared by many CBOs throughout Lamu and has serious impacts on continuity of care: when APHIA II truncates all funding on the 30th of November, smaller CBOs that are working with it are having to reduce their programs by over

[66] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 4 November, 2010.
[67] Interview. Raya Famau, Sauti ya Wanawake Secretary of Board of Directors. 8 November, 2010.

half, or cancel them all completely. Sauti ya Wanawake is hoping to continue its work by partnering directly with one of the strategic partners it is currently working with under APHIA II, however this will not be possible for all CBOs in Lamu. While many of these programs are designed to end in December and not truncated prematurely, many CBO members have assured that there is a demonstrated need for their programs to continue. "There will definitely be a gap," said one CBO worker.[68] Many of these programs include activities where continuous care is crucial, such as counseling and care for OVCs. Having outreaches be intermittently brought in and out of existence due to fluctuations in funding sends a strong message of inconsistency and lack of commitment that erodes not only patient care but patient confidence as well.

A third hindering factor is a lack of proper information. Keeping records is very difficult in Lamu District, particularly in the rural areas where virtually no one has a Kenyan ID card. Children often lack birth certificates completely. People also change their name frequently either in pronunciation or spelling, and therefore become exceedingly difficult to identify. Photographing patients to keep track of them is not an option either, as ASSD has found, because many people became quite offended.[69] Even relying on governmental health facility records is close to impossible, as the majority of locations targeted by health NGOs for clinic outreaches have no existing health facilities nearby, and those that do use merely paper notebooks that the patients are in charge of remembering to bring to and from the facility each time they visit. This precarious paper trail results in health NGOs having to rely almost solely on self-kept records and the memories of the patients themselves. In this type of environment, routine checkups can easily be missed out on and medication can easily be given without any mechanism to ensure it is taken completely by the patient. This can happen even in spite of the best intentions by a health NGO and all of their hardest efforts.

Community and Foreign Skepticism

In addition to the challenge of continuity of care, health NGOs in Lamu must work against prevailing stigmas on all sides of the spectrum. Community members are cautious of working with outside entities, NGO workers themselves are cynical of working with the Kenyan government, and patients are wary of programs oriented towards "shameful" diseases such as

[68] Interview # 17.
[69] Phone Interview. Chloe Spoerry, Anne Spoerry Sailing Doctors Founder. 5 November, 2010.

HIV/AIDS. Each of these guards acts as an obstacle that health NGOs must overcome in order to provide meaningful health care to the citizens living in Lamu District.

Just ten years ago, health NGO presence in Lamu was of an extremely different breed than it is today. Termed a "fiasco" by one local, NGOs were coming into the district without any idea what they were doing, and "ripping off millions of shillings."[70] Although this is unconfirmed by any NGOs themselves, community members saw many organizations coming into Lamu District and applying for funding for various health programs not at all tailored to the local community members themselves. Then, once they had acquired funding, they executed dwarfed versions of their proposed programs, or did not execute them at all. This built up much resentment within the Lamu, and when newer, better-informed and better-intentioned NGOs began to arrive the people as a whole were very skeptical.[71] They were particularly afraid of getting money from American organizations and governmental institutions such as USAID, believing that they would later begin a military attack or try and gain control over the land. They also worried that religious organizations such as CRS would try to convert the local Muslims to Christianity or restrict their services to Christians only.[72] Over the years these foreign NGOs have slowly built up a good relationship and these fears are being assuaged; however it is still a challenge that each new NGO must overcome upon its arrival.

Of course, prejudice is a two way street, and the Lamu community must also face the jaded attitude that many NGOs bring with them when they come to work. One organization expressed great frustration with the government for criticizing its methods and preferring locals over foreigners: it lamented that Kenyan authorities would not like to see foreigners become permanent volunteers because "it would be foreigners filling a job that could go to a Kenyan, even… working absolutely free in a place where there is a huge shortage of doctors and the [volunteers] would be much more qualified than [their Kenyan counterparts]."[73] In order for NGOs to be able to work effectively, they must also be willing to critically examine their own beliefs and set aside preconceived notions that their ways and goals are always the most accurate or most important. One example of an NGO that realized this is the World Wildlife Fund.

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[70] Interview #23.
[71] Ibid.
[72] Interview. Raya Famau, Sauti ya Wanawake Secretary of Board of Directors. 8 November, 2010.
[73] Interview #18.

Initially just an environmental NGO, WWF recognized after a time that to the majority of people living in Lamu District, health services took a much higher priority than the environment. WWF therefore changed their methods, realizing that the goals of WWF and Lamu locals could be jointly reached by focusing on reproductive health services with AMREF.[74] In this way, people would be gaining more control over their health, and the overall district population, therefore decreasing the population pressure on the environment. This also served as a way for WWF to gain community acceptance.[75]

The third way in which skepticism manifests itself within the realm of health systems is regarding the diseases themselves. Often, it is exceptionally challenging for health NGOs to provide outreaches to community members who are suffering from certain diseases such as STIs and HIV/AIDS. These people are often heavily criticized, and therefore want as few people to know about their status as possible. APHIA II has greatly helped with reducing this stigma by integrating health education programs into myriad community events, and by training madrasa teachers on HIV/AIDS. Madrasa teachers are a cornerstone of moral society in Lamu due to the large Muslim population, and therefore by reducing stigma from them it is also reduced in the classrooms where they teach, and then the families the students return to.[76] However, it is still a powerful force to contend with that prevents patients from receiving the care that they need. When APHIA II first came to Lamu District and conducted a baseline survey, it assigned goals for Sauti ya Wanawake to have 1,000 children enrolled in its OVC program and 2,500 people enrolled in its Home Based Care program. Currently, Sauti ya Wanawake has 850 OVCs enrolled, which is very close to its goal for 1,000. However, there are only 150-180 people in the Home Based Care program. The reason for this large discrepancy is that by enrolling in the Home Based Care program, individuals must assert that they are HIV positive, and therefore be vulnerable to criticism from their community. Sauti ya Wanawake explained that although less than 200 people are enrolled in their program, 700 people are directly seeking HIV/AIDS care at

[74] Interview. Amos Odacha, AMREF Project Manager. 1 November, 2010.
[75] Interview. Haji Shibu, Lamu District County Councilman. 4 November, 2010.
[76] Interview. Haji Shibu, Lamu District County Councilman. 4 November, 2010.

LDH. These are people that could be benefitting from the Home Based Care program, but are too afraid due to the heavy stigma which still pervades Lamu District.[77]

Working Within an Existing System

An architect will often tell you that it is easier to build a new house than to repair a broken one. Unfortunately, the ability to build a completely new health system is not an option for health NGOs. They must navigate through the already existing health system created by the government, and learn what they can change versus what is ultimately out of their control. In Lamu District, the existing health system has a solid theoretical base fractured by high turn-over rates and distinct physical barriers that prevent access to health facilities and hinder overall communication. The NGOs and CBOs that have chosen to work within this structure must also work with these unique characteristics of the Lamu District health system.

One way that this can be a challenge to NGOs is when the attitude of the public health workers is not as ebullient as that of the NGO workers themselves. Lamu District in particular suffers from having "low knowledge among health workers of current reproductive health issues… lack of commitment by community leaders for anti HIV/AIDS programme… [and] inadequate knowledge on management of childhood illness among health workers."[78] In part of their goals to encourage health seeking behavior within the community, NGOs rely heavily on health workers to do their job in a sort of public-private partnership. When this falls through, there is really nothing the NGOs can do except report it to authorities higher up in the system.[79] Often however there is a large gap between higher up officials and those implementing policy on the ground. Even when policy changes to reduce or eliminate patient fees are well established, for example, local health workers may still attempt to charge patients or keep them against their will until they pay a fee.[80] This erodes trust in the health system that NGOs are trying to build and makes it very difficult for NGOs to continue their work.

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[77] Interview. Raya Famau, Sauti ya Wanawake Secretary of Board of Directors. 8 November, 2010.
[78] *Lamu District Development Plan 2002-2008*, p56. Lamu, Kenya: Ministry of Finance and Planning, 2002.
[79] Interview. Allan Oginga, HENNET Programme Officer. 12 November, 2010.
[80] Ibid.

Working within an existing system also proves challenging when the system changes without notice, or does not change when it is supposed to. A National Health Insurance Fund was gazette in July, for example, which proclaimed that starting shortly all Kenyan citizens would pay a small contribution in return for coverage of health care if they fell sick. The contribution amounts were a graduated schedule based on income, so that the higher a person's salary, the higher their payment. It was supposed to start in September, but a group of people in the higher income bracket and therefore higher contributions was very unhappy, and took it to court. It will probably start in January instead, if it is not pushed back even further.[81] This fluctuation of programming makes it nearly impossible for NGOs to plan ahead and proactively cater to the changing needs of the community. Instead, they are put in a position where they are constantly waiting to see if changes actually go through, and then must program reactively.

Although working in an existing health system is painstaking work, it is a necessity in order to build a strong and sustainable healthy population with access to health care that is affordable and continuous. When NGOs try to work around the existing system, they end up creating alternative structures that cannot be maintained without the presence of those same NGOs, therefore fostering unhealthy dependencies. An example of this can be seen in the work of APHIA II: although they pride themselves on their close relationship with the MOH, in actuality they are building a parallel system that cannot persist without USAID's continued supervision and funding. In theory, APHIA II is supposed to "support country ownership and promote long-term country capacity to plan, manage and evaluate high-quality health services for all Kenyans."[82] In actuality however, APHIA II has left most CBOs very dependent on the presence of APHIAplus to carry them along. APHIA II incentivizes CHWs to work with it by providing them with a stipend. This stipend allows the CHWs to commit more of their time to their work and worry less about having to balance health work with a job to put food on the table. However, during APHIA II's existence this creates an uneven pull for CHWs to want to work for APHIA II over other programs, and when APHIA II leaves in December, these same CHWs will have to cut back on their work to find a form of income replacement. APHIA II's work has also reinforced the community to use NGOs and CBOs as a gateway into governmental

[81] Interview. Dr. Samuel Ngandu, District Medical Officer of Health, Superintendent of Lamu District Hospital. 3 November, 2010.
[82] *USAID/Kenya Annual Report 2009*. pp45-46. Accessed 11 November, 2010.

services instead of going straight to the government services themselves. As a result, when many of these CBOs terminate their programs in December, members of the community will simply stop the health-seeking behavior they have slowly gained through the APHIA II project. There is no substitute for working directly within the already existing health system to strengthen it, instead of trying to find ways around it or building a new one next to it.

Dissemination of Information

Due to the many overlays of the current health system – from finance to politics to geography to the interaction between government and non-government actors – a proper flow of information to ensure that all sectors are well informed and thus performing their jobs accurately is extremely challenging. In theory, Lamu District has many inadvertent worker overlaps to keep this information flow alive: the DMOH is also the Medical Superintendent of LDH, the only doctor in the hospital, and the chairman of the DHMT; many who volunteer for KRC are also APHIA II project coordinators. Put well by Zahra Aboud, the Administrative Assistant for the Lamu Branch of KRC, it is "the same faces wearing a hundred caps."[83] However, in spite of these overlaps – and sometimes because of them – large gaps remain in the dissemination of information along the various sections of the health care system in Lamu District.

The previously mentioned DMOH has been replaced three times in the past month, severely disrupting all of the other positions he simultaneously works for. When I asked one HIV/AIDS related CBO for some hard numbers regarding its work, the worker was at a loss. Even when I asked for basic questions regarding HIV prevalence in general in Lamu or even Kenya, the response was "statistics I don't know."[84] Another CBO detailed plans of beginning to work with APHIA II, but had no idea that APHIA II was leaving in December, and had not heard of APHIAplus in any context.[85] Out of the two employees working at a small dispensary, completely different answers were given regarding whether or not AMREF was helping to fund their outreach program, and the one in charge of running the finances of the dispensary had

[83] Interview. Zahra Aboud, Administrative Assistant and HMM and HIV Peer Educator Program Officer. 18 November, 2010.
[84] Interview # 19.
[85] Interview # 18.

almost no understanding of HSSF – only that it was "some government thing" designed to replace their previous funding from Danida.[86]

One way in which information is lost along the way is by meetings that simply do not take place the way they should. One such meeting is that of the HMB. This is as a crucial organization because it is made up of members of the community, and approves or disapproves of the budget for district level facilities. In spite of this importance, it has not yet been able to meet because it must first be mandated through gazettement by the Kenyan government, and this has not happened. Additionally, divisional PHOs are supposed to meet with DPHO quarterly in Amu to get updated on government policy and exchange current happenings within their respective divisions. Because of scheduling and transport difficulties though, these theoretical meetings rarely occur and important information does not get shared.[87]

Many times, there is not even the option of attending a meeting to gain relevant knowledge, or even consult a book. If one wanted to find out a current list of all the NGOs and CBOs in Lamu District for example, he or she would soon find that although All NGOs and CBOs should have Memorandum of Understanding between the District Hospital and the organization itself, and should also have registered with Social Services District Office, there is no actual record of these agreements in one location.[88] Even at the County Council, the only place where one can find documentation of meetings between the county council and the NGOs is by coming through the meeting minutes.[89] While there is no requirement for any government department to have such records, and the county council itself is so small that one could certainly gain almost all the desired information directly by asking a council member, it is an example of how the dissemination of information is not a clearly delineated or well-oiled process.

Underlying Causes

Knowing that the biggest obstacles facing health NGOs in Lamu are continuity of care, community and foreign skepticism, working within an existing system and dissemination of information is certainly important. But what is it that is creating these challenges in the first

[86] Interviews # 14 & # 15.
[87] Interview. Jilo Kitasi, Mpeketoni Divisional Public Health Officer. 2 November, 2010.
[88] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 30 October, 2010.
[89] Interview. Haji Shibu, County Councilman. 4 November, 2010.

place? This study argues that the underlying causes for such challenges are an overriding lack of personal investment by both the community and the NGOs, a misguided sense of accountability, overarching funding restrictions, and the impossibility of having to satisfy both donors and community members simultaneously.

Lack of Personal Investment

Often, many of the challenges listed above could be minimized if initiative was taken by every party involved to work together and pool personal resources. Instead, a pervading lack of ownership throughout Lamu District deeply exacerbates community skepticism, erodes commitment to provide continuous care, facilitates the missing of meetings in which important information could otherwise be exchanged and stresses relationships that are required when fitting NGOs into an existing health system. This is present on both on the side of community members and even the health NGOs themselves.

In the Lamu District Development Plan, a main challenge listed in the overall development process was low community involvement: "…participation by [citizens] in project development is minimal. This is created by general apathy and the beneficiaries' belief that projects are to be done by 'government,' 'donors' and/or outsiders."[90] This statement was reiterated greatly by an NGO worker who wished to remain unnamed. Having lived in Lamu her whole life, she has seen the huge change in behavior that citizens undergo when they see a "wazungu NGO" – an NGO run by Europeans that is coming into Lamu from outside of Africa. She commented that when Lamu locals see white skin, they immediately think of money instead of their own initiative; "they don't trap the community's capacity."[91] She exemplified this by recounting the presence of an international NGO who came to Lamu a few years ago and started drilling wells to enhance access to fresh water sources. A short time after the wells were built, a cat fell into one of the wells and drowned. Once the community realized what had happened they went over to the NGO office and complained, repeating the phrase "you have a dead cat inside your well" to various officials.[92] Because it was built by outsiders, the locals refused to see the

[90] *Lamu District Development Plan 1994-1996,* p105. Lamu, Kenya: Ministry of Finance and Planning, 1994.
[91] Interview #23.
[92] Ibid.

well as their own and therefore refused to invest time and work to maintain it. One can easily see how this could evolve into a lack of continuous care, as water sanitation health issues would immediately return to the locals using the well in spite of the work of the NGO.

Low participation also occurs with health NGO workers. HENNET, the Health NGO Network of Kenya, holds quarterly meetings in which members attend and learn about relevant policy changes coming from the ministry as well as ongoing projects that their fellow members are holding. This is to increase information networks, build partnerships and avoid duplicity in programming. In theory this is an extremely useful organization, and its conferences are organized very well, containing relevant and accurate information, and creating a positive space for meaningful networking to occur between its members. However, it is currently struggling with unsatisfactory member participation. Although it has over 80 registered member organizations, typically only 20 to 30 attend conferences, and at HENNET's most recent conference in mid-November under 10 of these were actually present.[93] Additionally, only 35% of HENNET members currently participate in the district government level process of creating the Annual Operational Plan – in order to accurately support district needs, this percentage must be much higher.[94] Being fully present and involved at these meetings and processes could greatly work to increase proper dissemination of information regarding government policy and other NGO activities, but instead routine organizational absences prohibit and erode this.

The same lack of ownership explains NGO tunnel vision as well. Often, a health NGO will be doing a specifically oriented program in a particular geographical section, such as one focusing on HIV/AIDS prevention in the Witu division of Lamu District. While this NGO is working valiantly in its one sector, it neglects to acknowledge other health issues that are in the same district. Dr. Vincent Orinda criticized health NGOs for doing this exact thing during the HENNET Quarterly Meeting, saying that often an organization will go to a household and see a child with diarrhea, but do not address it because in its proposal that it received funding for it

[93] HENNET Members Quarterly Meeting. Nairobi, Kenya. 11 November, 2010.
[94] HENNET Secretariat. HENNET Quarterly Meeting. Nairobi, Kenya. 11 November, 2010.

said it would increase HIV/AIDS awareness, not treat diarrhea. The organization therefore does not see it as its responsibility.[95]

One possible explanation for this absence of personal investment is an inaccurate understanding of what commitment working in a health NGO in Lamu District truly entails. One worker admitted that his fellow volunteers "just loved the idea of going to a remote and beautiful place in Africa and working for free for a few days," showing that he saw it almost as a short-term vacation in which he doled out gifts instead of a long-term project working to strengthen the district's health care system.[96] This mentality rejects the notion of ownership in favor of a charity-type process that emphasizes one-time action and therefore precludes chronic personal responsibility.

Simultaneous Satisfaction Requirements

During the HENNET Quarterly Meeting in November of 2010, Dr. Oringa confronted the host organization: "HENNET, you must challenge your members: Where is the accountability... Who are you working for?"[97] Accountability is commonly thought of as being in a state of responsibility and being answerable to another party. Because health NGOs and CBOs in Lamu District all have visions based on relatively similar messages of increasing the health care of the Lamu people, one would think that they would see their first responsibility to those same people, their "patients." When CBOs and NGOs in Lamu District were asked who they ultimately felt their organizations were accountable to though, the answer was never that simple. In fact, the majority of the time organizations replied that they were accountable to their donors. This highlights one of the biggest underlying causes for the aforementioned challenges: the unique aspect of simultaneous satisfaction health NGOs and CBOs must supply to both the patients that they treat through their programs and the donors which make their programs possible to begin with.

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[95] Orinda, Dr. Vincent. *High Impact Health Interventions in MNCH- An Introduction*. HENNET Quarterly Meeting. 11 November, 2010.
[96] Interview # 18.
[97] Orinda, Dr. Vincent. *High Impact Health Interventions in MNCH- An Introduction*. HENNET Quarterly Meeting. 11 November, 2010.

On one hand, these organizations must work towards satisfying the people they serve. Their existence would be a moot point if they were not striving to ameliorate the very problems which antagonized them into existence. However, without also satisfying their financial donors they cannot exist in the first place. To exacerbate the issue, donors and patients have very different priorities. Donors equate best practices with cost effectiveness, tangible results and expansion capabilities. Statistics are very important to them, yet very hard to actually receive; NGOs must worry about perception of being "costly" and evaluating their cost-effectiveness, which is outside their expertise. This is illustrated by the Canadian High Commissioner's comments during a visit to the AMREF Kenya Country Office, where he framed the idea of continued funding with the phrase "I'm all in favor of backing success."[98]

This is manifested in Lamu District in a dilemma which ASSD faces during every monthly mobile clinic: each time they venture out to the various rural locations in which they do their work, ASSD members must fight between seeing as many people as they can and delivering meaningful health service. Currently, it sees so many in such a small time that some patients don't feel satisfied with the level of care they receive.[99] At the same time, seeing an increased number of patients will make it easier for ASSD to receive more funding and therefore offer a higher level of service later on and reach an even higher number of people.

ASSD also must balance needs of people and donors for future planning. For now, it has a much stronger emphasis on curative rather than preventative measures when treating patients – it is "relieving their immediate pain or situation," according to founder Chloe Spoerry, "but we're not actually investing in them not getting more sick next time."[100] ASSD hopes to be more involved in preventative actions in the future, but this poses challenges as well: when going into village that has almost no means of health care, should it focus on HIV/AIDS awareness or hygiene education? How does it know which one will be more effective? Having a limited budget means limited ability to assess and carry out programs, and ASSD does not want to move blindly into a complex sector such as HIV/AIDS without having the proper assessment in place.[101] Furthermore, depending on the size of an organization and level of funding, it can be

[98] Public Statement. Canadian High Commissioner. 12 November, 2010.
[99] Interview. Nizar Ali, Anne Spoerry Sailing Doctors Clinician. 4 November, 2010.
[100] Phone Interview. Chloe Spoerry, Anne Spoerry Sailing Doctors Founder. 5 November, 2010.
[101] Phone Interview. Chloe Spoerry, Anne Spoerry Sailing Doctors Founder. 5 November, 2010.

ignored even if its issues are very relevant.[102] Therefore, in order to sustain itself and open up possibility for expansion, it must put the needs of its donors temporarily above the needs of its patients, and cater more towards what institutions and individuals are willing to fund.

Lack of Clear Vision

Upon entering the office of the Kikozi Programme in Lamu District, one can see tacked up on the wall its founding vision "…to be the leading organization in empowering the community by improving the quality of life."[103] The Kikozi Programme used to do microfinancing, giving out loans from around ten thousand to thirty thousand Kenyan shillings in Mkowe, Witu, Faza, Kzingitini, and Mapenya to help women in small business. After people chronically failed to repay the loans however, they had to close down these locations. Presently, they have shifted focus and are working with APHIA II to direct the women's cluster in Result Area 2, inadvertently redefining themselves to the community as a health NGO. When AHPIA II funding ends on the 30th of November however, the Kikozi Programme will scale operations back to just its IGA of printing and typing until it receives funding for some other program that may or may not target the same individuals that were targeted by APHIA II's women's cluster.[104]

While this certainly illustrates a versatile CBO that is determined to help its community however it can, it also exemplifies a large underlying problem that faces many NGOs and CBOs today: that of a lack of direction and vision. The vision statement, though uplifting, is impossible to quantify meaningfully. It does not mention through what means it wishes to empower the community, who exactly the community is, or what part of life specifically needs improvement. Similarly, its mission statement "to improve the life standards of the women of Lamu through socio economic empowerment and capacity building" is no longer relevant to its work in any way.[105] This must have acted as a guiding compass when Kikozi was geared towards microfinance, but now as a health NGO it seems to have no structured direction outside of the instructions from APHIA II.

[102] Interview. Allan Oginga, HENNET Programme Officer. 12 November, 2010.
[103] Posted Bulletin at Kikozi Programme Office. Accessed 5 November, 2010.
[104] Interview. Umulker Ahmed, Kikozi Programme Volunteer. 9 November, 2010.
[105] Posted Bulletin. Kikozi Programme Office, Lamu. Accessed 5 November, 2010.

This absence of any clear purpose is dangerous to any organization because it can lead to many challenges down the road: for one, dissemination of information is extremely hindered: a CBO or NGO cannot get word out to the community about what type of organization it is if the organization itself is unsure what its own goals are. Having a confused idea about organizational purpose will also erode faith in the organization and contribute to community skepticism. It is also impossible to work within the existing health care system if one's goals are constantly being changed from one topic to another. Finally, a lack of clear objectives can also be difficult because it prohibits the organization from being able to perform any meaningful evaluation of what its impacts truly are.

Best Practices

The aforementioned challenges that health NGOs and CBOs face when trying to work in Lamu District to increase the overall quality of the health system residing there are nothing to underestimate. Indeed, when looking at how deeply the underlying causes are entrenched in both the current health system and the structure of nongovernmental organizations in general, it is impressive that they have been remained as controlled as they have. Many organizations have developed coping strategies and best practices to try and minimize the possible negative outcomes of these challenges. For some, these strategies remain ideal goals instead of concrete practices, but should be highlighted nevertheless to encourage growth in these areas and to emphasize where there has been progress.

When looking at the challenge of simultaneous satisfaction requirements between patients and donors, HENNET offers a valuable practice to keep health NGOs and CBOs in check. In order to be a member of HENNET, organizations must be registered with the government for at least three years, and also must sign a Code of Conduct, called a CoC. By signing the CoC, NGOs promise that they are acting in the community's best interest instead of only the donor's best interest.[106] While there are no repercussions for neglecting to follow it, the CoC acts as a reminder that NGOs have multiple parties they need to satisfy instead of just those who are funding them. It reinforces a proper feeling of accountability, and at times can also help to clarify an organization's overall vision.

[106] Interview. Allan Oginga, HENNET Programme Coordinator. 12 November, 2010.

A second best practice is one that greatly helps to ensure continuity of care, and is currently carried out in various versions by both AMREF and KRC. In AMREF, this practice is called a Project Management Cycle. It is a system put in place to deal with evolvements that come into a project midway to make sure that changing needs to not either alter the program's objective too greatly or get forgotten completely. The ideas that cannot be implemented on the ground are put into the Program Management Cycle, where other AMREF employees at other AMREF offices may read and access them. This ensures that when other resources are freed up, these ideas may be turned into projects. This has already proven useful in Lamu - AMREF came to Lamu for MCH work, but once there it realized that lack of education was actually a large problem that stagnated child health: women typically go back to their mother's house when pregnant, whereupon the uneducated mothers persuade their daughters to have home births instead of going to a hospital. However, adding a women's education component was too far out of the scope of AMREF's current MCH program to be immediately incorporated. Normally the idea would be abandoned completely, but instead AMREF was able to put it into the Project Management Cycle so it could be picked up again at a later point.[107]

At KRC, this same practice is present in the form of a Concept Note. If a branch office of KRC notices a particular need in its community that is not being properly addressed, it can create a Concept Note that goes to the regional officer and then to KRC headquarters. The officer can then choose to use certain funds to implement programs to address those needs. This program is very well used – in fact, both the Home Management Malaria program and the HIV Peer Educator Program in Lamu District were created from Concept Notes.[108] This practice of proactively creating a mechanism for handling unexpected changes greatly increases continuity of care by providing a long-term way in which needs will be documented and later acted upon. Additionally, it facilitates dissemination of information by having a known database that NGO workers can access at any time. This simultaneously prevents both duplicity and neglect on behalf of the NGO as long as the mechanisms are properly followed up with.

The final practice that would deeply help to minimize the unique challenges that health NGOs face is something which has not yet been done in Lamu District. County Councilman

[107] Interview. Amos Odacha, AMREF Project Manager. 27 October, 2010.
[108] Interview. Zahra Aboud, Administrative Assistant & Project Officer of AIDS and HMM Programs. 18 November, 2010

Haji Shibu commented in an interview that in Lamu, NGOs come and present to the council only after they have been funded and after they have already drafted a plan. This leads to NGOs being reluctant to listen to any advice the council would give because they are already so far along in the process. Also, they often fear that if they change their projects too much they will have to relinquish funding, especially in cases where there is overriding duplicity. Shibu suggested that it would be better for health NGOs and CBOs to come to the council before getting funding. That way, the government would be able to have a meaningful conversation with the organization about what Lamu District actually needs, and whether or not there is an organization already doing a particular activity.[109] In many respects government is like a living, breathing literature review for Lamu District, knowing exactly what has been tried in the past, what has worked well and what has failed. This would greatly help the problem of simultaneous satisfaction as well as dissemination of information, as facilitating the flow of health organizations to the district level government before having written a detailed plan would allow them to fully access this information with as few preconceived notions regarding what they need to do as possible. Then once the organizations have worked with the government to help create a program specifically tailored to Lamu, they can focus on making minor adjustments to appease their donors.

CONCLUSION

"If there are no differences arising, you do not have two people thinking."

– Amos Odacha[110]

The health system in Lamu District is a complex structure involving many actors with many different agendas. The government of Kenya, health NGOs, health CBOS, health care providers and the Lamu community itself are just a few of these groups. With so many differing priorities and background opinions, it is no wonder that the interactions between them are sometimes so fraught with contention. Each member is trying to balance its own interests with others within the group and come to a productive outcome at the same time. Unless every agent is working in a perfectly synchronized fashion, conflict is bound to happen and challenges will inevitably arise. Health NGOs and CBOs are particularly vulnerable to falling victim to various

[109] Interview. Haji Shibu, Lamu District County Councilman. 4 November, 2010.
[110] AMREF Baseline Indicator Survey Data Collection Debriefing. 2 November, 2010.

obstacles specific to the health care sector due to their relatively new presence and lack of experience to give them best practices.

The challenges mentioned in this study – continuity of care, working within an existing system, dissemination of information, and community and foreign skepticism – are merely some which are most salient at this point in time. Likewise, their underlying causes of unclear visions, simultaneous satisfaction requirements, and lack of ownership will evolve and change over months and years. What will not change with time is the constant need for these health NGOs and CBOs to be willing to engage in a critical self reflection that identifies these challenges, and ideally causes as well. It is only with a higher level of self-awareness that these organizations will be able to recognize challenges on their own and therefore deal with them institutionally in an appropriate manner. The Concept Note, Project Management Cycle and Code of Conduct all stemmed from organizations that were willing to critique themselves and then develop coping mechanisms. Practices such as these should be deepened and expanded so that identifying challenges and causes comes not from an outsider or an academic researcher but from within the heart of the organization itself.

It should be noted that by no means are the organizations mentioned in this study failing to operate as valuable members in the Lamu District health care system. Providing health services in any kind of environment is an extremely challenging task, and is made all the more difficult in an isolated location within a developing country that is neglecting to meet the needs of its people in a myriad of ways. Instead of being disparaged or tossed aside, the Lamu NGOs and CBOs should be commended for having the compassion and wherewithal to operate in such a complex environment and with so few resources. This study brings up challenges and causes only as a way to strengthen these organizations further and help them on the path to increasing capacity of the Lamu District health system, so that people may have better access to better health care, and be able to participate in a higher quality of life.

LIMITATIONS

Probably the most limiting factor of conducting research for this study was the short amount of four weeks that was allotted. This resulted me having to pass up opportunities for further research and primary observation such as attending mobile clinics, and also prevented in-

depth relationship from being formed which would have fostered more honest and forthcoming conversations regarding true challenges that health organizations faced. Moreover, because I was American, it is very possible that many smaller CBOs believed I was there as a member of USAID, coming to scout out possible organizations for APHIAplus to work with in the future. This would have greatly influenced the information they were willing to give me and also prohibited them from saying anything negative about APHIA II or USAID. An additional roadblock was. Finally, although I was able to conduct interviews partially in Swahili, my lack of fluency precluded me from being able to have in-depth discussions with more rural members of Lamu District who did not know English.

FUTURE RECOMMENDATIONS

Although Lamu is a small place compared to other areas such as Mombasa or Nairobi, the topic of its health care system is an expansive one that could easily be delved into in a number of areas. Recently in Kenya a new constitution came to pass that will begin to be implemented over the next few years. Already, this is catalyzing big changes within the health system and would be a great subject for a research paper. The Ministry of Public Health and Sanitation and the Ministry of Medical Services will be merged again into one Ministry of Health; power will continue to be decentralized, giving lower level facilities more autonomy; funding methods will change and department heads will be rehired. It would be fascinating to see how these changes are implemented at the district level, and Lamu would be an excellent place because it is small enough that one can have in-depth interactions with higher up officials that would be too busy in other locations. The National Health Insurance Fund is also supposed to be in full swing by next year. It would be a very interesting and new topic to see how efficiently Kenya is able to implement such an ambitious program with such fractured infrastructure.

Another research option that would supplement this study well would be to look at how private institutions influence the overall dynamic of the health system. Some citizens of Lamu have to walk almost an hour to reach the nearest government facility, passing many private clinics on the way. It would be very interesting to see where the cutoff line is between people that are able to afford private services and those that are not. It could also be taken from the

angle of seeing what the relationship is like between health NGOs and private clinics, or how the level of care is different between private and governmental facilities.

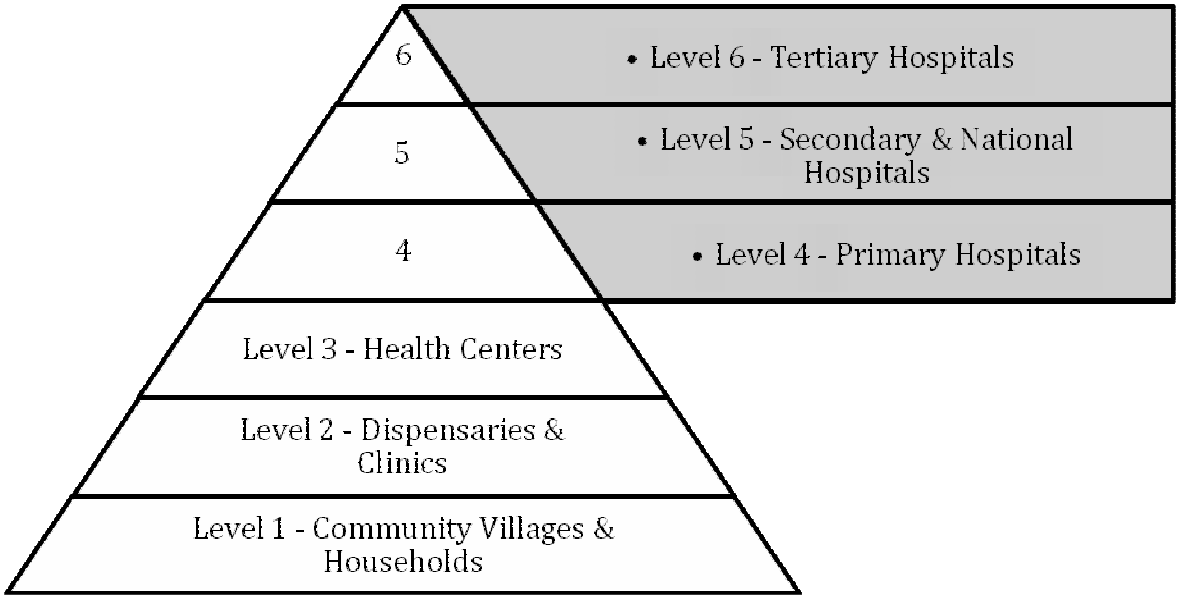
A final angle that could be taken is getting the perspective from the Lamu community itself. One could do an intriguing comparative analysis looking at how health NGOs perceive themselves versus how the people receiving their care perceive them. Examining how observation of health NGO work varies between divisions could also be a very telling illustration of the challenge of dissemination of information, as well as community skepticism. Additionally, one could also choose to look at the general community's perception on health NGO presence in Lamu.

Lamu District is an extremely pleasant working environment for doing an ISP. People in Lamu are very willing to share their stories and talk with you, especially if you are cognoscente of their time. A comprehensive knowledge of Swahili will be a crucial tool if one wants to have meaningful conversations with those who live in more rural areas, however. Also, transportation between different divisions within Lamu takes time and money as you must be boated during certain phases of the tide.

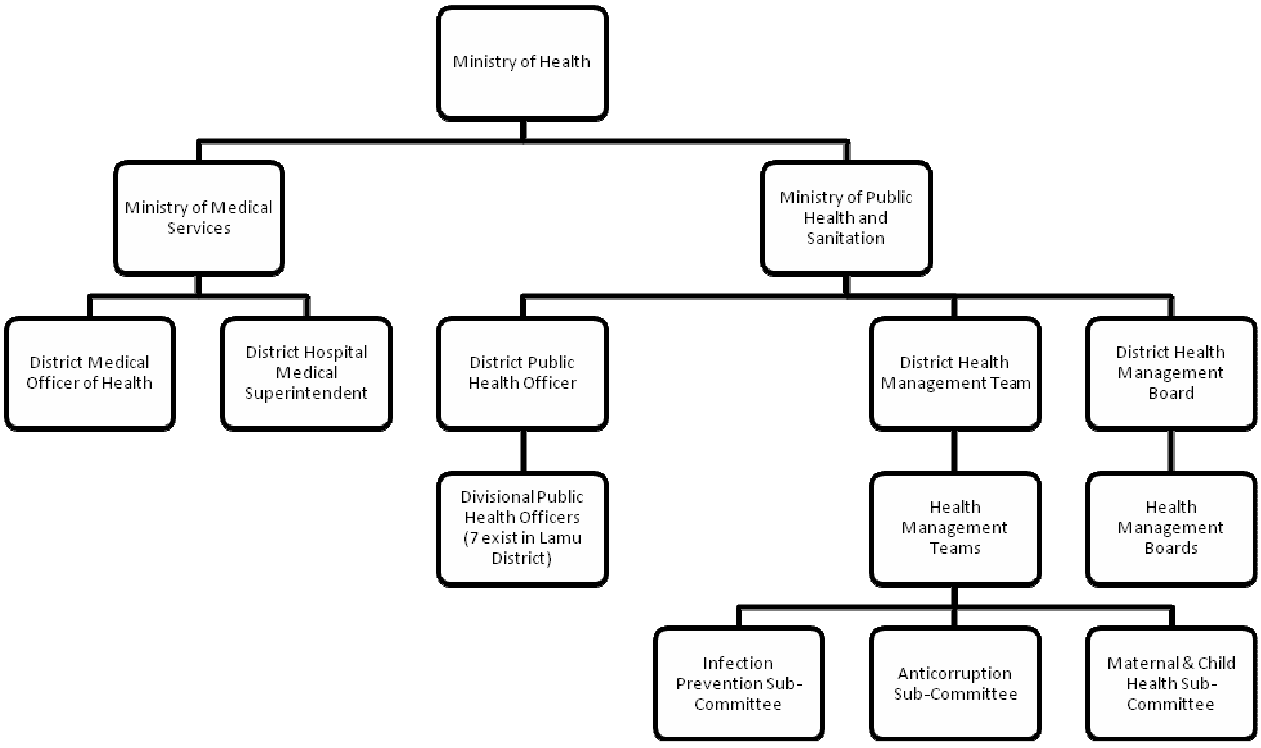
APPENDIX A: Acronyms Used

A&A	Authority and Appropriations
AIE	Authority to Incur Expenditure
AMREF	African Medical Research Foundation
AOP	Annual Operational Plan
ARV	Antiretroviral Medication
ASSD	Anne Spoerry Sailing Doctors
CBO	Community Based Organization
CHW	Community Health Worker
CHEW	Community Health Extension Worker
CIDA	Canadian International Development Agency
CoC	Code of Conduct
DANIDA	Danish Development Agency
DASCO	District AIDS/STI Coordinator
DDP	District Development Plan
DHMB	District Health Management Board
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
DPHO	District Public Health Officer
FBO	Faith Based Organization
FIF	Facility Improvement Fund
GOK	Government of Kenya
HENNET	Health NGO Network of Kenya
HMB	Health Management Board
HMM	Home Management of Malaria
HMT	Health Management Team
HSSF	Health Services Sector Fund
IGA	Income Generating Activity
KEPH	Kenya Essential Package for Health
KRC	Kenya Red Cross
KSH	Kenyan Shillings
LDH	Lamu District Hospital
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
NACC	National Aids Control Committee
NHIF	National Health Insurance Fund
NHSSP II	National Health Sector Strategic Plan, 2005-2010
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PHO	Public Health Officer
USAID	United States Agency for International Development
WWF	World Wildlife Fund

APPENDIX B: Levels of Service Delivery Under KEPH[111]



APPENDIX C: Organizational Management of Ministry of Health



[111] Government of Kenya Ministry of Health. *Key Health Messages for Level 1 of Kenya's Essential Package for Health*. Nairobi: Sector Planning and Monitoring Department, 2007.

APPENDIX D: Funding Methods for Ministry of Health

Figure 1: Old MOH Funding Method

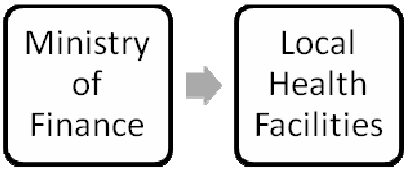
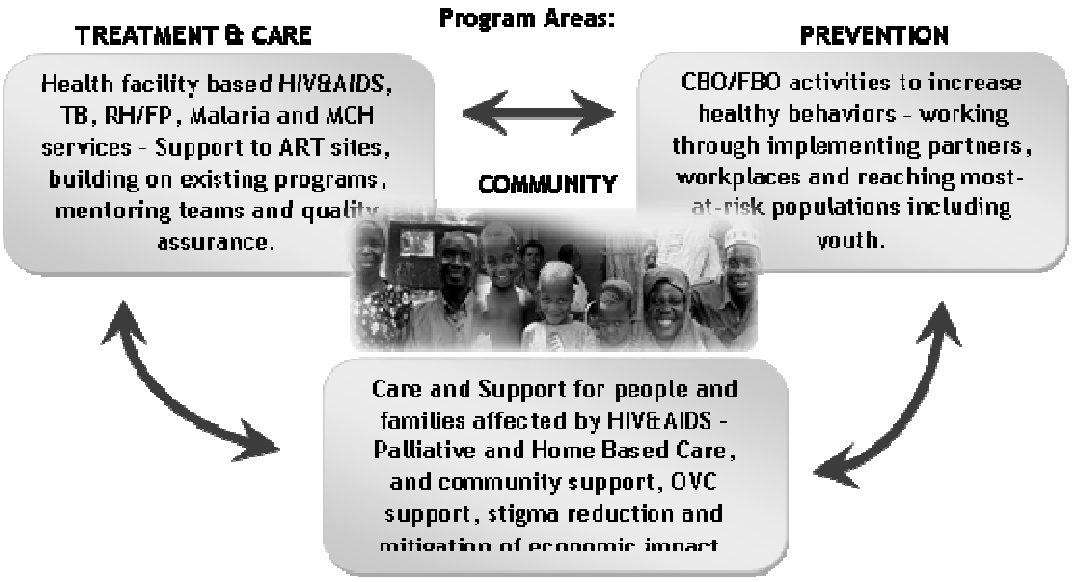


Figure 2: HSSF Change in MOH Funding Method

APPENDIX E: Program Areas of APHIA II, Coast Province[112]



[112] United States Agency for International Development. *APHIA II Background.* http:// .com (accessed 7 November, 2010).

APPENDIX F: Health Facilities in Lamu District[113]

Table 1: Types of Health facilities in Lamu District, Kenya					
	GOK	FBO	NGO	Private	Total
Hospitals	3	-	-	-	3
Health Centers	2	1	1	-	5
Nursing Homes	-	-	-	1	1
Dispensaries	18	1	1	-	20
Clinics	-	-	-	16	16

Table 2: Facility Names & Utilization Rates			
Name & Type of Facility	Catchment Population	Outpatient Attendance	Utilization Rate
Lamu District Hospital	18187	22600	124%
Faza District Hospital	2691	14270	530.3%
Mpeketoni Sub-District Hospital	14205	24314	171.2%
Witu Health Center	2367	23948	1011.7%
Mokowe Health Center	3605	12198	338.4%
Kiunga Health Center	2583	5308	205.5%
Maria Teresa Health Center	6780	1516	22.4%
Didewaride Health Center	2152	2540	118%
Pandanguo Dispensary	5165	4320	83.6%
Hongwe Dispensary	8932	2983	33.4%
Mkunumbi Dispensary	7318	7255	99.1%
Hindi Magogoni Dispensary	4950	8211	165.9%
Moa Dispensary	3121	3012	96.5%
Hindi Prison Dispensary	400	3294	823%
Bargoni Dispensary	915	2904	317.4%
Kipungani Dispensary	646	2160	334%
Matondoni Dispensary	2260	2040	90.3%
Shella Dispensary	3282	1011	30.8%
Patte Dispensary	2368	4956	209%
Siu Dispensary	2260	2944	130.3%
Tchundwa Dispensary	2044	2392	117%
Mbwajumwali Dispensary	2990	2604	87%
Kzingitini Dispensary	4758	5472	115%
Ndau Dispensary	969	723	74.6%
Kiwayu Dispensary	647	1284	198.5%
Mkokoni Dispensary	538	1422	264.3%
Mangai Dispensary	972	2880	296%

[113] *Annual Operational Plan 6.* Ministry of Public Health and Sanitation. 2010.

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