# CONTRIBUTION OF USA INTERNATIONAL ORGANIZATIONS TO PUBLIC HEALTH DIPLOMACY IN KIBRA, KENYA

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**A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES IN PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN INTERNATIONAL RELATIONS OF THE SCHOOL OF ARTS AND SOCIAL SCIENCES, DEPARTMENT OF POLITICAL SCIENCE, HISTORY AND PEACE STUDIES, KISII UNIVERSITY**

**OCTOBER, 2022**

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This thesis is dedicated to my wife Doricas and my children for their moral support during my thesis writing. Be blessed.

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## ABSTRACT

In order to supply public healthcare services in various areas of Kenya, particularly the informal settlements, international organizations of the US government have long developed an interstate collaboration with Kenya's state and non-state entities. However, due to shortcomings in key elements of public health diplomacy between the two nations, public health delivery systems that depend on foreign funding have not had the expected impact.This study encquired into the contribution of USA international organization in the delivery of public health services in Kenya with a focus on Kibra informal settlement. This study wasguided by three objectives: to examine the nature and extent of USA international organizations partnership in public healthcare servicesdelivery in Kenya; to assess the contribution of USA international organizations on capacity building in public healthcare servicesdelivery in Kenya; and to evaluate how the USA international organizationsfunding and budgeting affect public healthcareservices delivery in Kenya. The study is significant to the academia by highlighting specific elements of public health diplomacy as an emerging international relationssub-field. It is also significant for policy implementation especially the enagement of state, non-state and international actors in public health diplomacy for the benefit of marginalized populations. The study utilized the neo-liberal theory to explain interaction between variables. Data were gathered and analyzed using a qualitative study design and descriptive survey research techniques. Both interviews and questionnaires were employed. Stratified random sampling, census sampling, and purposive sampling techniques were used to establish the sample size of 100 respondents. Descriptive statistics were used to evaluate quantitative data, while thematic analysis was used to assess qualitative data answers. It was discovered that well-known international organizations such as the Bill Gates Foundation, PMI (President's Malaria Initiative), CDC (Center for Disease Control), PEPFAR (The President's Emergency Plan for Aids Relief), and USAID (United States Agency for International Development) are primarily responsible for advancing US public diplomacy. The findings indicated that the nature of partnership includes reproductive healthcare (100%), diet and nutrition (92.4%), sanitation improvement (47.8%) and non-communicable diseases (16.3%) according to the respondents. For the second objective, 72.8% of the respondents indicated increased access to healthcare services, 772% stated reduced costs of healthcare services, 78.3% indicated increased hygiene and 14.1% indicated proper care of patients. However, 81.5% of the respondents stated that they preferred donors to fund malaria projects, 84.8% preferred funding of HIV/AIDS health programmes while 80.4% preffered the funding of sexually transmitted diseases. The aspect of preference indicated that malaria, HIV/AIDS and STDs are still health issues in Kibera. The findings also indicated that 90.2% of the respondents stated that there was need for awareness campaigns about the health projects with the locals, 94.6% preffered involvement in proposal development while the 77.2% of the respondents stated that community participoation was imperative. For the third objective the findings indicate that 68.5% of the respondents stated challenges of trestricted funding, 55.4% indicated challenges of dionor supervision, 35.9% indicated diplomatic interests while 81.5% stated stringent requirements for funding. In conclusion, adequate public health diplomacy is necessary to achieve partneship and capacity building to ensure that donor funding is put into proper use.

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## LIST OF ABBREVIATIONS AND ACRONYMS

AIDS-Acquired Immunodeficiency Syndrome

AMREF-The African Medical and Research Foundation

CDC- Center for Disease Control

CSIS- center for strategic and international studies

EPCMD- end preventable child and maternal deaths

GHD – Global Health Diplomacy
GHSA- Global Health Security Agenda

HIV -human immunodeficiency virus

LMICs- Low and Middle- Income Countries

NGOs- non-governmental organizations

PCID- protecting communities from infectious diseases

PEER- Partnerships for Enhanced Engagement in Research

PEPAR- president emergency plan for Aid Relief

PEPFAR- president's emergency plan for Aids Relief

PERPFAR- president's Emergency Program for AIDS Relief

UHC- universal health coverage

UNICEF- United Nations Children Education fund

USA- United States of America

USAID- United States agency for International Development

WHO- World Health Organization

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background to the Study

International relations and diplomacy are increasingly focusing on public health. The attention on the HIV and Ebola epidemics has led to an upsurge in global health initiatives and international health support (Leslie et al., 2017). They contend that the provision of primary healthcare services is hampered internationally by a lack of suitable infrastructure and a paucity of healthcare workers. For instance, just 3% of the world's workforce resides in Sub-Saharan Africa, despite the fact that basic healthcare services require an additional 1.5 million health professionals. This shows that developing countries lack the necessary workforce to address the needs of their people' health.

So many agreements between national governments and international health NGOs have been negotiated through public health diplomacy rather than through conventional diplomatic routes. Public health diplomacy has mostly focused on relationships among international organizations, regional NGOs, and state parastatals (Abbott, 2005). For instance, divisions of the United States Agency for International Development (USAID) and the United States Centers for Disease Control and Prevention (CDC) may engage into separate cooperative agreements with the health ministry and health NGOs of a certain nation. Depending on the institutional culture and program objectives, these agreements may take many forms, such as a memorandum of understanding (MOU) or a cooperation agreement.

The Global Health (2035) study by the Lancet Commission suggests that the return on investments in global health is higher than previously thought: By 2035, it is anticipated that every dollar invested in health will increase GDP by $9 to $20. The President's Emergency

Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria were two examples of US public health diplomacy that turned the tide on the HIV/AIDS pandemic by focusing on outcomes. Additionally, they said that American diplomats work on cross-border health security concerns to identify, stop, and address pandemic threats like Ebola. The United States of America (USA) promotes public health goals through its numerous international organizations, including the Centers for Disease Control and Prevention (CDC), the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative (PMI) program, among others. These organizations are involved in the development and improvement of public healthcare services delivery globally and in particular developing countries. The Global Health Policy of (2019) report indicates that for more than a centuryUSAIDefforts in the health sector are noticeable and in collaboration with other international development agencies. According to the study, the United States is the top donor to international health initiatives in a number of nations. Through bilateral and regional programs, the USA has funded health initiatives in more than 70 nations, mostly in Africa, South and Central Asia, the Near East, East Asia, Europe, and Eurasia.

In order to address the serious concerns about HIV/AIDS, maternal health, and infant mortality in 15 countries, mostly in Sub-Saharan Africa, the Bush administration started PEPFAR in 2003. According on data on GDP and the prevalence of HIV/AIDS in each of the countries, initially, Botswana, Cote d'lvoire, Ethiopia, Guyana, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia were chosen. Despite having a high prevalence of HIV/AIDS, Zimbabwe was not initially included in the priority countries; it was added in 2006. The number of target nations has increased, and as of FY2014, PEPFAR has provided assistance to 41 nations (Kaiser, 2015).

Public-private partnerships on hospital construction and improvement, HIV/AIDS prevention and treatment, access to drinking water, prenatal care, fighting hunger, preventing and treating infectious diseases, and increasing child immunization have made it possible for public health services to be delivered in these nations (Pew Research Center). Preventing and treating HIV/AIDS is one of the top seven priorities, and nations like Ghana have prioritized HIV/AIDS prevention above all other government agenda items (Pew Research Center).

Kenya has benefited from US health efforts in which USAID, the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and the Centers for Disease Control and Prevention (CDC) collaborate with Kenyan health parastatals and NGOs on health-related issues. For instance, according to USAID (2015) publications, Kenya is a focal nation for the National Malaria Control Programme and the US President's Malaria Initiative, both of which aim to reduce and ultimately eradicate malaria. However, according to the same research, Kenya's human health continues to be harmed by malaria infections and other illnesses. Instead, donor funding is essential for reproductive health, including family planning and HIV/AIDS, particularly USAID and other US foreign development organizations.

This an indication that the kind of public health diplomacy USA advances by way of her international health organizations may not completely meet primary objectives. For instance, the USA stand on what came to be known as the effect of Mexico policy affected public healthcare services delivery in Kenya negatively. When President Bush revived the Mexico City Policy in 2001, two NGOs—Marie Stopes International (MSI) and the Family Planning Association of Kenya (FPAK), who were once significant USAID partners in Kenya—refused to sign the corresponding commitment. Due to the funding loss, both NGOs were compelled to scale back their outreach and education programs, close clinics, restrict service offerings,

impose or raise fees, and more. Due to this significant loss of funding, FPAK was forced to decide whether to cut employees or services.

From this review, it is clear that public health diplomacy through USA international organizations can negatively affect delivery of public healthcare services. The Mexico policy shifted USA stand on issues such as abortion which were in conflict with Kenya's private operators position and Kenya health policy caused funding to be reduced significantly.

### 1.2 Statement of the Problem

Kenya is a recipient of US international organizations' initiatives for the provision of public healthcare services. The USA's public health diplomacy in Kenya is advanced through institutions like USAID, the Centers for Disease Control and Prevention (CDC), PEPFAR, and the President's Malaria Initiative (PMI) program. Family Planning Association of Kenya (FPAK), for instance, and USAID-Kenya have a cooperative agreement for the provision of family planning healthcare services to underprivileged people in Kenya. The FPAK as a result receives financial and technical support from USAID. Family planning, HIV/AIDS treatment, and other aspects of public health are heavily reliant on donations from organizations like USAID and other US foreign health agencies. Due to inadequate health systems, the impact of this donor-dependent strategy on the provision of public health services is less obvious, even if it may have led to a more effective use of donor funding (CDC, 2018). International groups, financial institutions, and even the government continue to intervene to help the situation in this slum. These groups built schools, water kiosks, health clinics, and restrooms in several Kibra slum communities, but the quantity of people living there makes these amenities woefully insufficient (Mutisyaa and Masarua, 2011). With a poor health infrastructure, USA health public health diplomacy becomes ineffective. This explains why

the status of public health remains wanting despite the increase in donor activity with regard to capacity building and budgeting.Kibra, for instance, suffers from much health related problems. HIV/AIDS prevalence in Nairobi's Kibra informal settlement is 14%, double the national prevalence (Umande Trust, 2007).Poverty, lack of improved sanitation combined with poor nutrition among residents' accounts for many illnesses and diseases in Kibra slums. It is estimated that 20% of the 2.2 million Kenyans living with HIV live in Kibra (Mutisyaa and Masarua, 2011). These manifestations are indicators that public health diplomacy is ineffective towards health related issues in Kibra and thus there is need for adequate diplomatic engagement between state and non-state actors. This study was conducted in Nairobi with a focus on Kibra where most community based health institutions are funded by USA yet the delivery of health services are still dismal and health issues continue to be reported from the area.

### 1.3 Objectives of the Study

The overall objective of this study was to investigate USA international organizations contributiontion to public health diplomacy in Kibra informal settlements.

### 1.4 Objectives of the Study

This study was anchored on the following specific objectives.

i. To examine the nature and extent of USA internationalorganizationspartnership in public healthcare servicedeliveryinKenya
ii. To assess the contribution of USA international organizations in capacity building to public healthcare servicedeliveryinKenya
iii. To evaluate how the USA international organizationsfunding and budgeting affect tpublichealthservicedeliveryin Kenya

## 1.5 Research Questions

The following were the research questions to guide the study: -

i. What is the nature and extent of USA international organizationspartner with other actors to deliver public healthcare services in Kenya?
ii. How do the USA international organizations on capacity building contribute topublichealthcareservicesdelivery in Kenya?
iii. How does the USA international organizations funding and budgetingcontributetopublichealthcareservicesdeliveryin Kenya?

## 1.6 Significance of the Study

The study is significant to the academia by highlighting specific elements of public health diplomacy as an emerging international relations subfield. This is because traditionally, the state was the major actor in the field of diplomacy, but in the modern world non actors have emerged to be major actors apart from the state.It is also significant for policy makers,state health agencies, non-state and international actors in public health diplomacy for the benefit of human populations in the planet. The study is also significant to health based non-governmental organizations (NGOs) and government agencies on how to engage in effective public health diplomacy and yield findings to bridge the gap of inadequate public health diplomacy in order to improve the health situation of the poor and marginalized urban populations.

## 1.7 Scope

The scope of the study will be limited to USA international organizations diplomacy towards public health service delivery. The study will focus on USA international organization

partnership with non-state actors in health sector, donor assistance health programs supported by USA state-agencies such as USAID among others. The area of study will limited to kibra sub-county where USA state-agencies such as USAID and other non-state actors affiliated to their programsoperate.The study will also focus on capacity building, donor funding and budgeting towards health programs. The researcher will take three months (November-January, 2021) in the field collecting data.

### 1.8 Limitation and Delimitation of the study

The sample size was a limitation because the sample was drawn from the managers and program administrators excluding recipents of public health care services hence reducing the generalization of results to the beneficiaries. Secondly, there was lack of resources and time contraints which is a major requirement for an effective research undertaking. Thirdly, to ensure accurate collection of data and proper use of the research instruments, the researcher used trained research assistants and ensured content and construct validity in the construction of the questionnaire.

### 1.9 Assumptions of the study

The researcher assumed that the sample of the accessible population and the target population were similar in regard to key characteristics to generalize the research findings with confidence to the target population. Secondly, the researcher assumed that the respondents will provide credible and reliable information.

### 1.11 Operation and definition of terms

**Donor assistance –**assistance from USA to Kenya through her international state agencies in terms of health finance, equipment, and training in Kenya, Kibra sub-county

**Sovereignty –**means that states are supposed to be free and independent to make economic and administrative decisions with absolute independence and without influence from other actors even on health matters

**Public health diplomacy a core diplomatic mission** by building networks that share America's interests; and expanding people-to-people relationships in Kenya

**Health Programmes –** efforts and campaigns intended to reduce the spread of disease such as drugs and substance abuse, screening programmes in Kenya

**Capacity Building** – increasing the level of awareness, knowledge and skills of the people about the various health programmes being funded by American international institutions in Kenya

**Public Health Service Delivery**- management of diseases, related issues such as clean water in Kenya by USA international health organizations in partnership with NGOs

# CHAPTER TWO

# LITERATURE REVIEW

## 2.0 Introduction

This chapter discusses the literature on international health diplomacy, the characteristics of US health diplomacy, and the implications for the provision of public healthcare services. The study's theoretical foundation is also examined.

## 2.1 Global Health Diplomacy

According to Koplanet al. (2009), the terms "global health diplomacy" (GHD) and "diplomacy" have been combined. Global health diplomacy, according to Drager et al., is a more modern term that refers to the multilevel and multi-actor negotiations that form the world's health policy environment (Drageret al., 2007). This encompasses the numerous channels by which States, non-State entities, and international organizations negotiate solutions to health issues (Smith et al., 2016).These studies advocate that diplomacy is important given the nature of interdependence in the contemporary world. However, the studies have not indicated how dependency of developing countries like Kenya on donor funded health programs can adversely affect their health care systems.

A significant number of agreements between national governments have been made in response to the global health emergency through agreements between organizations in each nation rather than through state to state diplomacy (Abbott, 2005). For instance, separate agreements with the health ministry of a certain nation may be reached by departments of the U.S. Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC). Depending on the institutional culture and program objectives,

these agreements may take many forms, such as a memorandum of understanding (MOU) or a cooperation agreement. Although legally contracts, these agreements are typically carried out through the U.S. diplomatic mission, but the negotiations may be primarily between technical experts in the relevant country agencies. Unlike formal treaties, these agreements specify duties but are not always enforceable under international law when dealing with sovereign states._MOUs and other informal agreements have certain benefits over formal treaties in terms of confidentiality and modification, and they are becoming more and more common in the context of health diplomacy involvement. Public health diplomacy can therefore be employed for selfish state interests since agreements reached are not legally binding.

Ross (2010) agrees that the requirement for diplomatic representation for organized non-state entities has been referred to in a variety of ways. Multi-stakeholder diplomacy includes a broader range of interactions between state and non-state entities who don't often engage in international relations. The number of long-term alliances between government and nongovernmental organizations (NGOs) to execute healthcare services, capacity-building initiatives, and research has increased along with the growth of global health assistance during the past two decades.

Numerous global health partnerships, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization (GAVI Alliance), Stop TB, Roll Back Malaria, and the Global Polio Eradication Initiative are supported by both public and private sector organizations (Nishtar, 2004).

Overall, there is agreement that among the actors engaged in public diplomacy are private groups (Nye, 2004). According to Parmar (2012), the US government implemented its foreign

policy to contain communism during the Cold War, which led to the formation of networks between the Ford, Carnegie, and Rockefeller foundations and other newly established foundations like the Bill & Melinda Gates Foundation that carried out similar duties to those of the US government. Public health diplomacy was used in this instance to advance US interests in the Middle East.

The aforementioned instances unmistakably show that public health development assistance forms the cornerstone of health diplomacy, in which a donor nation works with the private sector to provide primary healthcare and other health-related services in an effort to eradicate HIV/AIDS and malaria among people living in developing countries. The World Health Organization's (WHO) intergovernmental procedure and international health diplomacy are both significant, according to Kickbusch (2009).

There is also general agreement that private organizations play significant roles in global health diplomacy that go beyond their financial support. For instance, the Rockefeller Foundation worked with the Japanese government and Occupation forces to advance public health development after the Second World War (Noguchi,2014). Most poor nations benefited from recent donor collaboration with large private foundations in the battle against malaria and HIV/AIDS (Moran, 2014). The WHO (2015) research demonstrates that incorporating non-state actors in public health diplomacy can be successful if a framework and parameters for doing so are explicitly stated.

It is evident from this assessment that public health diplomacy has been used to promote health as well as a soft power tactic to enhance relations between states (McNinneset al.,2012). State and non-state entities, such as private philanthropic organizations, civic society, and NGOs, are participants in this public health diplomacy (Cull 2009). (Bonventure et al., 2009) note that the US Government, through a number of organizations including USAID and state departments, supports healthcare, particularly in developing nations, and as a result, shapes the views and attitudes of those nations' citizens who are from other countries. Notes that a

number of private foundations, like the Bill and Melinda Gates Foundation, have been providing significant financing for the global fight against malaria and other infectious diseases.

## 2.2 The Nature and Extent of USAInternationalorganizationsPartnership to Public Healthcare Service DeliveryinDeveloping Countries

Kate et al (2010), observes that US public health diplomacy encompasses interactions between state actors, representatives of multi lateral and non governmental organizations working together around the world in the field of health sector. They contend that the 2003 unveiling of PEPFAR—the US president's emergency plan for HIV/AIDS relief—was a significant turning point that increased American awareness of and engagement with international health issues. According to Kates et al. (2010), the George W. Bush Institute-founded pink and red ribbon health campaigns, among others, are used as part of the US president's emergency plan for AIDS assistance, which is active in many nations across the world.

Since the Dreams project's launch on World AIDS Day in 2014, which aims to reduce the number of HIV infections among adolescent girls and young women in ten countries with high HIV prevalence in Sub-Saharan Africa, the Pink Ribbon Red Ribbon has been put into practice in Botswana, Ethiopia, Namibia, Tanzania, and Zambia. To keep girls AIDS-free, PEPFAR, the Bill & Melinda Gates Foundation, and the Nike Foundation have been working together through public-private partnerships.

These respective organizations work together to reduce HIV/AIDS infections by supporting prevention from mother to child (PMTCT) health projects in their respective areas of operations in collaboration with host countries. Through this involvement, it demonstrates the US government commitment to advance development assistance to the poor nations internationally.

### 2.2.1 The Nature and Extent of USA International Organizations' Partnership for Public Healthcare Services Delivery in Kenya

According to CDC (2014), for the past 40 years, US government foreign organizations have supported the provision of public healthcare services to the people of Kenya in collaboration with the private sector and health NGOs. Through the establishment of an integrated research and program center in western Kenya, our relationship is renowned for boosting the laboratory systems and the health infrastructure. The author also adds that their programs prevented disease and disability among Kenyans by doing research on the efficacy of novel interventions.

The emergency plan for Aids assistance from the US president, in conjunction with regional groups such faith-based organizations (FBOs), strengthening their organizational framework to ease delivery (PEPFAR, 2015).

The CDC and malaria projects in western Kenya, which has the highest illness burden in the nation, have been working together since 1979. In terms of prevention and treatment, the malaria research program at the CDC Kenya in 2018 significantly aided the fight against Malaria. It showed that more than 7.7 million Kenyans were aware of their HIV status, that 92% of HIV patients were treated, and that pregnant women had access to (PMTCT) programs, which decreased child mortality in Kenya. Additionally, the CDC undertook a survey of fishing communities in 8 islands and beaches of Lake Victoria in partnership with the national aids and sexually transmitted illnesses programs (NASCOP), the Kenya Medical Research Institute (KEMRI), and the University of California (CDC, 2018). Such kind of

programs provided information and improved public awareness about the prevarences of diseases in local communities.

USAID Kenya (2013) reports that their WASH program commonly known as water, sanitation and hygiene program that works in conjuction with government agencies and local communites increase access to fresh water, sanitation facilities and improved hygiene. The WASH program reduces the burden of disease through the provision of fresh water and improving environmental living conditions. This action creates more time for studies and contributes to general community development (USAID Kenya, 2013).

In Kibra, USA based international organizations have partnered with African regional agencies like African Medical Research Foundation (AMREF) to deliver public healthcare services in this informal settlement area. In order to develop community-based HIV/AIDS prevention and care initiatives across Africa, AMREF and CDC have an agreement. Successful HIV treatment facilities run by AMREF are located in Nairobi County's Kibra in official settlements. For people with disabilities, the HIV treatment program in Kibra has been hailed as a leading example of community-based care.

According to a contract between the Kenya AIDS NGOs Consortium (KANCO) and USAID, 56,840 youth and young adults would receive support for abstinence, faithfulness, sex education, and life skills, and 197 persons will receive training to implement AIDS interventions in Kibra. Working with a network model of six partners—the Kenya Medical Association, the National Organization of Peer Educators, the Maendeleo ya Wanawake Association, and the Community Capacity Building Initiative—who cooperate to implement the RAY (Responding to AIDS among Youth) project—enables this to be accomplished.

USAID Kenya (2014) notes that*Lea Toto, a local NGO* has a cooperative agreement with USAID on community-based outreach program.

Six of Nairobi's most impoverished informal settlements are home to HIV-positive children, and the Lea Toto program seeks to enhance their quality of life. Today, it ranks among Kenya's biggest non-governmental providers of pediatric HIV/AIDS care. To do this, the program facilitates an all-encompassing process that includes assistance and access to Comprehensive medical care, Antiretroviral drug provision, Nutrition and food security, Psycho-social support for the children and their families, Education and vocational training, capacity building, and economic empowerment of the children and their families.

From this review, USA international organizations partner with both Kenyan state agencies, regional and local health organizations. USA organizations focus on HIV/AIDS, Malaria and issues of pre-natal healthcare in Kenya. However, the focus of USA international organizations partnership poses a challenge. Although, the American people initiative is to reach Kenyan publics through health programs. There is need to harmonize health polices of the recipient and host states toachieve healthcare services.

## 2.3USA International Organizations Contribution to Capacity Building on Public Health Services Delivery in Developing Countries

The healthcare projects are meant to assist in various activities among them capacity building. Springs (2002) argues that capacity building is a widely used term which is applied interchangeably in reference to different individuals and organizations. Further observes that, capacity building involves various stakeholders which include individuals, organizations and communities working towards the achievement of specified goals.

On the other hand, Baillese*t al* (2008), views capacity building as the capacity to carryout stated objectives. Further observes that, the increased capacity of the communities to solve problems, Leadership and collaboration involve capacity building, which is the method through which people acquire the knowledge and self-assurance to improve their own lives and a shared vision by many stakeholders to achieve shared goals. Additionally, says that partnerships that help increase capacity consist of a variety of members that have a same vision and are willing to combine their resources. Analyzing health nutrition, Barlile (2008), says that leadership is an important component to influence the people to accept health nutritional programmes. This is true but it's not the case for donor supported programmes. This is because the foreign donors implement the projects without the input of the locals, assuming that they are not knowledgeable. This means that USA public health diplomacy many not achieve much unless there is shared vision with locals in implementation of these programs which is a concern of the current study.

This arguement is supported by Crip Swerissen and Duckett (2001) who argues that capacity building involves a bottom up organizational approach which is concerned with adoption of new ways of doing things, development of skill, improved partnership among various stakeholders and increased involvement of community members in various programmes. Capacity building according to Crip Swerissen and Duckett (2001) also refers to increasing the ability of the community to address health issues through new healthcare interventions. For Kibra to increase such kind of capacity building requires involvement of community leaders, programmes intended to reduce poverty, lack of housing and sanitation among others to reduce the burden of diseases.

On the other hand, Langsang and Dennis (2004) note that for developing nations, the process of integrating research into theory-based health systems calls for qualified local scientists and

an environment that will for research to be conducted to provide new approaches to old problems..However they note that this is a major challenge for most countries in sub Saharan Africa where health budgets are not sufficient and most importantly where there is allocation of 0.5% of the national budget towards health care services and where 1% of Gross domestic product is used to fund health projects.This means that it is difficult to achieve capacity building in developing world where health programs are not funded fully by the state due to lack of adequate funding from development partners.

In these countries, public healthcare priorities for USA international organizations are to prevent and treat HIV/AIDS. According to officials in Nigeria and South Africa, two of the original 15 PEPFAR target nations, HIV/AIDS is their top public health concern. Through PEPFAR, the U.S. government and private organizations have been putting numerous HIV/AIDS prevention and treatment initiatives into place in response to these requirements.

The president's emergency plan for AIDS relief (PEPFAR), for example, receives US global development assistance, according to the US department of state (2015). PEPFAR funds health programs that aim to prevent the spread of HIV/AIDS and guarantee that those who are infected with the virus have access to treatment. The report says that this improves strained relations between the US government and other states worldwide. Thus health diplomacy is a softpower instrument which is used by the US administration to influence international affairs and to further the US interests in various corners of the world.

However, lack of indigenous research scientists in most African countries is a major obstacle towards achieving affordable health care for poor populations. This is because health care services depends on the availability of medical technology and research centers which are

important for health care services. This can be attributed to high poverty indexes and over dependence on the developed countries in the health sector.

Cross-border infections, however, are where public health diplomatic initiatives are more apparent. For instance, the Ebola outbreak in West Africa demonstrates how crucial it is for us to increase our ability to quickly identify and respond to risks from infectious diseases. Ebola is preying on a poor public health system after years of conflict and turmoil in Liberia, Guinea, and Sierra Leone, much like cholera preys on weak water systems after a tragedy. USAID is collaborating with the White House Office of Science and Technology, the Department of Defense, and the U.S. Centers for Disease Control and Prevention to establish Fighting Ebola: A Global Response in response to the Ebola outbreak: Healthcare professionals in Ebola-affected countries were given the personal protective position by A Grand Challenge for Development (USAID, 2014).

Unfortunately, even the participating international organizations occasionally lack the abilities necessary to operationally combine the fields of diplomacy and health. The methods for systematically integrating scientific, technology, and health information into the field of foreign policy have evolved over time, and the political and financial environments influence interest in developing such knowledge. This may cause a gap for the United States between its interests in global health as a component of diplomatic interest and its capacity to assess and react to developing developments. The situation is then made worse by the increasing participation of stakeholders from other branches of government or organizations in conversations that may have previously only included the state or simply not existed. International organizations clearly lack that touch, making them a poor choice for advancing public diplomacy.

According to the Global Journal of Advanced Research (2015),community participation and involvement is an important factor for project sustainability and this requires communities' members who are the beneficiaries to be included at all stages of project implimentation. This is important because it will promote community support because beneficiaries are able to understand how the programmes will benefit the community. But this is not the case because, the donors assume that the local community is not knowledgeable and their involvement therefore lacks impact. But, when the local people are involved in the identification of programmes, the project will be more successful. Thus, public health diplomacy is a new phenomenon that needs to be studied since assumptions by donor's countries such as USA isolate locals from health programs.

Further, the journal argues that recruiting staff from the community to manage project provides ideas, funds and materials encourages community participation which is an important aspect for project development. But this is not the case for most foreign funded development projects. This is because; most of the managers and senior staff are obtained from their home countries, while junior positions are given to the local community. The goals of the projects may not be addressing the local needs as perceived by international funding agencies. The authors of this journal continue to argue that, because of this, the projects fail to be responsive to the needs of the people. This is because the projects are supposed to have cultural support by not conflicting the beliefs, norms and religion of the people. The authors argue that, programmes which undermine a community's socio-cultural orientation will experience resistance. This is happening because, international aid organization are in most cases not interested to learn the cultural values of the community before initiating new programmes. Therefore, a gap exists on how to promote community involvement and participation.

However, the fundamental foundation of international organizations is undermined by the subpar health systems in poorer nations. For instance, the U.S. Agency for International Development (USAID) has spent the last 20 years focusing on maintaining and strengthening health systems (HSS). USAID is seen as a valuable partner in HSS by governments and donors due to its contributions of vital resources, technical know-how, leadership, and country presence (USAID, 2015).

The ability of individuals and people living with HIV and AIDS to access treatment through a variety of health providers is a requirement for progress toward an AIDS-free generation, according to a report by USAID (2019). This is one of the activities carried out through collaboration between the agency and recipient countries. This necessitates a strong healthcare system that promotes HIV/AIDS prevention and care. For instance, around 15,000 community health workers have been trained to better connect communities to the healthcare system in order to have sustainable investments in HIV-focused community-based facilities. For the benefit of the American people, the U.S. Government is committed and determined to save lives, stop suffering, and advance human rights via the work of USAID and other USA-based organizations in public health diplomacy. Pandemic dangers are addressed by sound health systems. Stable populations ease domestic and international economic strains, which is essential for lowering humanitarian threats.

From this review, it is clear that engagement of public health diplomacy can be a failure in situations of poor health systems. Finding new ways of collaboration between states and non state actors will improve development assistance in the health sector consideration that non state actors have become major actors in international relationships.

## 2.4 USA international organizations' Contribution to capacity building on healthcare service delivery in Kenya

Most American international health organizations collaborate with Kenyan private sector entities to create capacity for providing public health services. For instance, the Centers for Disease Control and Prevention (CDC)-Kenya has supported the development of an integrated research and program center while also strengthening Kenya's public health and laboratory systems for the past 40 years. This model integrates many program areas while utilizing technical expertise and a solid cooperation with the Kenyan government to create long-lasting public health capability. By implementing evidence-based public health initiatives, preventing disease, lowering death and disability rates, and researching the effectiveness of new interventions, CDC Kenya saves lives. Kenyan CDC, 2004. They mention how USAID collaborated with other partners, including the Ministry of Health Services, to develop a competency-based emergency obstetric and newborn care training curriculum. Consequently, maternity, neonatal, and child health services were expanded at the facility and community levels through USAID's five regional service delivery initiatives. Additionally, 6,395 community health workers were educated by USAID in maternal and/or neonatal health. Community health workers are crucial to reducing maternal and infant mortality because more than 50% of Kenyan women still give birth at home without access to trained care.

Community health professionals also urge women to use early antenatal services like HIV and malaria testing, which are essential measures in the prevention of HIV/AIDS and the reduction of malaria throughout pregnancy, in addition to urging women to seek expert care during birth. Additionally, community health professionals encourage the use of latrines, hand washing with soap, and immunizations (USAID/Kenya, 2013).

Since the early 1970s, the organization, which is based in the USA, has helped the health and nutrition sectors. In the 1970s, USAID supported the establishment of 590 service delivery points in Kenya, 400 of which were full-time and 190 of which were part-time, served by 17 mobile units, as well as the training of staff at the district and provincial levels (USAID, 2000). In the late 1970s and early 1980s, USAID funded a number of pilot projects in rural areas to support family planning and maternal health care in Kenya. The initiatives also gave Ministry of Health officials the chance to receive project design and management experience, which was crucial in preparing ministries to take full responsibility for the management of the projects. Through a contracting organization, USAID offered consultancy services to the Ministries of Health and Planning in order to establish a Division of Planning and Implementation to manage rural health services and initiatives for the long term (Mehlikaet al., 2004).

These early initiatives, however, were only partially effective. USAID and other funders soon realized that the Kenyan government lacked the technical know-how and experience necessary to staff and manage new projects. Thus, to implement family planning projects, USAID, the World Bank, and other donors devised a strategy in the early to mid-1980s that involved the establishment of new governmental bodies supported by a specially chosen advisory team. The National Council on Population and Development, under the Ministry of Home Affairs, and the National Family Welfare Center ("NFWC"), under the Ministry of Health, were both founded as a result of this approach. At an effort to decentralize the health system, the former coordinated efforts between public and private organizations working on family planning, and the latter trained community nurses and clinical officers to work in dispensaries, health centers, and sub-centers across Kenya (Mehlikaet al., 2004). This is a blatant example of how public health diplomacy can fall short of its goals in the absence of solid public health policy.

Donors started working more closely with the private sector to develop and manage programs in order to encourage improved public health diplomacy. For instance, USAID launched the Family Planning Private Sector Project in 1983, which led to the creation of smaller-scale programs to carry out the same project design and community health worker training tasks. In contrast to government initiatives, this project exceeded program goals and deadlines and turned into a successful model for carrying out family planning initiatives in Kenya. By the middle of the 1980s, USAID had started directly assisting NGOs like the Christian Health Association of Kenya (CHAK), the Family Planning Association of Kenya (FPAK), and the Christian Organizations Research Advocacy Trust through the Family Planning Services and Support initiative.

In order to "consolidate all USAID support to public healthcare" and "decrease fertility and the risk of HIV/AIDS transmission in Kenya through integrated health and family planning service delivery," USAID developed the AIDS Population and Health Integrated Assistance (APHIA) initiative in 1995. This initiative merged prior work in public and private service delivery, sustainable finance (aimed at reducing dependent on outside help), and district-level operations. It was carried out by Kenyan NGOs, the Ministry of Health, and various USAID Washington-based projects. The Ministry of Health's Reproductive Health Logistics Unit was strengthened, and the Ministry of Health's Rural Health Training Centers were upgraded, as part of new USAID initiatives on the government side. On the NGO front, USAID set aside money to support FPAK, CHAK, and Chogoria Hospital's monetary stability. Funds were allocated to Nyanza, Western, and Coast Provinces "where the need is greatest" as a result of the emphasis on HIV/AIDS.

According to a report by USAID Kenya (2015), it is crucial to develop local structures and expertise for gender-based violence prevention, reporting, management, and response pathways. In order to encourage communities to speak out freely against gender-based violence, youth-focused theater programs have been developed where members of the community were educated about this issue through screenings of films like Sita Kimya and discussion sessions that followed. *SitaKimya and gender-based initiatives promote conversation on gender-based violence. SitaKimya is Kiswahili for "Speak Out." Mentorship sessions with "Queen and King of Change" teach kids about their rights. Through referral mechanisms, the Suluhishoni Mimi Centre, run by the Kibera-based Centre for Rights Education and Awareness, aims to improve community capacity to prevent and address gender-based violence. For instance, of the 185 new cases addressed, 101 were referred by service providers for gender-based violence and other interested parties in Kibera.* With the reported cases rising from 140 to 185, community members' awareness and responsiveness have also improved. This demonstrates efforts by international organizations to alter locals' cultural perceptions of their activities.

Over the past ten years, Lea TotoKibera, which collaborates with USAID to care for orphaned and HIV-positive children and their families, has been successful in providing high-quality, all-encompassing care and support to these children and their families. As a result, the mortality rate in the region has decreased. Through community mobilization and ongoing training of their behavior change agents, they have been able to negotiate, support, and maintain safe behavior. The report says that,the Lea Toto programmes were made available to 7698 children who were Hiv positive and they were also able to be provided with psychosocial support and responsiveness to their educational needs.

These initiatives strengthened the human resource capacity to provide palliative care services for HIV, increased the referral network for HIV care, and increased the availability of palliative care services for people with HIV. Through the referral of complex cases, AMREF's palliative care activities are closely linked to community services funded by CBOs, including the Kibera Community Self Help Program (KICOSHEP), PMTCT services supported by AMREF, adult treatment services, pediatric treatment services, pediatrics care and support, and the established network referral center at Kenyatta Hospital. Adults with HIV infection are included in the demographic targeted by this program, which also addresses the high prevalence of HIV infections in the research area.

The program's attempts to establish district-wide coverage for enhancing equity and access, particularly in these underserved areas, are aided by the rise in the number of locations. A gateway to comprehensive HIV care and additional HIV care and support services, such as safe newborn feeding techniques, is provided by the provision of PMTCT services to women, infants, and other family members.

This analysis shows that insufficient diplomacy among important partners hinders the ability of US international organizations to create capacity. The ineffective healthcare systems and policies in Kenya limit the organization's work. It follows that any diplomatic efforts by interested parties are welcome to close the gap.

## 2.5 USA International Organizations Contribution to Funding and Budgeting on Healthcare Service Delivery in Developing Countries

Pratt Gaido, Shadwick and Hayman (2012) observed that United States international health organizations dominate public health financing in the global scene with foundations such as the Gates, Ford and Rockefeller dominating health financing globally. They noted that among the top ten foundations in the USA which are giving towards healthcare financing include the

Bill and Melinda Gates Foundation, the Susan Thompson Buffett Foundation, and Betty More Foundation among others.

On the other hand, Mccoy*et al*., (2009) observed that due to the emergency of various diseases which are threatening humanity globally, international partnership to address them has become necessary. The report further indicates that, there is an increase of global health funding through various health actors internationally. For instance, in 2006 the total amount of official development assistance in the health sector was 104.4 Billion US dollars which was supporting reproductive healthcare, family planning, control of sexually transmitted infections and HIV AIDS among other health programmes. Thus, public health diplomacy by way of donor funding and budgetary allocations is at the cornerstone of USA health donor aid.

The report also revealed that private foundations, the general public and business and the corporate sector were the largest contributors in terms of funding for the development of public healthcare globally. For instance, the gates foundation awarded 195 global health grants in 2006, which amounted to US Dollars 2.25 billion (Mccoy, Chand and Sridhay (2009). In this report, they further noted that, non-governmental organizations spend a lot of money to support healthcare delivery and their funds are received from various sources. The majority of recipients of development assistance from bilateral and multilateral officials, according to these authors, are developing countries. The role that international organizations functioning in the health sector play in bilateral and multilateral relations must be noted.

The International Bank for Reconstruction and Development, the World Bank, and the United States Agency for International Development (USAID) are all sources of funding for the health budgets of six nations in Africa, according to Barstan (2019).These countries include Burundi, Malawi, Tanzania, Rwanda, Gambia and Liberia. However, he argues that bilateral

aid is given by donors with intentions of achieving self-state interests, which can be economic and strategic in nature.Selfish state intrests can therefore affect and influence public health diplomacy, international relationships, negotiations and agreements between states.

Tarp (2002), on the other hand, argues that foreign aid and developmenttraditionally was based on humanitarian concerns, political ideology, commercial and economic development. The report for instance cites hard economic times and the rising health costs to be major challenges even among the richest countries on health funding. Further, WHO (2013) observes that, health financing in Africa is obtained from various sources, which include donors, governments, households, employees and non-governmental organizations.

In Africa, PEPFAR contributes $180 million, the Gates Foundation $25 million, and the Nike Foundation $5 million for development assistance in the health sector. 24 U.S. philanthropic groups gave more than US$300,000 apiece to HIV/AIDS projects abroad in 2008, according to statistics gathered by Funders Concerned about AIDS on global philanthropy funding to address HIV/AIDS. According to the 2012 data, a handful of new private organizations gave international HIV/AIDS programs 100% of their overall HIV/AIDS disbursements. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), which made the 17th highest U.S. donation to international HIV/AIDS programs in 2010, is one such organization. that year's philanthropic funder in the area. Since 2001, EGPAF has been working with PEPFAR to build a PMTCT program in Zimbabwe, and from 2007 to 2012, USAID partnered with EGPAF as part of the PEPFAR Zimbabwe Family AIDS Initiative (Elizabeth Glaser Pediatric AIDS Foundation).

It should be emphasized that PEPFAR has developed reliable relationships with FBOs all around the world since its founding in 2003. More than $945,000,000 has been given by

PEPFAR's implementing agencies to FBOs as primary partners to deliver efficient services for underserved or difficult-to-reach populations in many of the countries where PEPFAR works.

The poor's underutilization of basic services can, however, create a vicious cycle of poverty because those who are ill or vulnerable cannot participate in the labor force. USAID advocates for HSS investments that drive each nation toward UHC in order to break this cycle of poverty. For instance, the ground-breaking UHC program from USAID/Rwanda offers as an example of how coverage for all can be expanded, especially to the very poor. Rwanda started offering community-based health insurance, and 94% of the population is now covered. In order to improve access equality in Rwanda, USAID collaborated closely with the Ministry of Health to develop an insurance program. About 25% of Rwandans live in poverty, and they were not charged for health treatments at public institutions or for insurance. Other income categories, however, paid an annual membership fee based on household financial situation and 10% of healthcare expenses. 90% of Rwandans who qualified for insurance were covered. As a result, household membership fees and service payments produced 65% of the system's income. The Rwandan government and commercial insurance firms financed the remaining expenses in addition to the household membership fees (USAID 2015).

The interaction of global health, diplomacy, and foreign policy is receiving more attention as a result of a variety of issues. Senior policy makers were forced to reconsider health issues in a new way because of a number of high-profile global health challenges, such as HIV/AIDS and emerging infectious diseases like SARS (severe acute respiratory syndrome) and pandemic influenza, which are now seen as direct threats to fundamental national security and foreign policy interests. Prior to this, senior policy makers had previously regarded health issues as a lower priority. Donors have increased funding for international health programs

and established new channels of assistance partly in response to this, but also in recognition of the need to address persistent global health disparities and achieve the Millennium Development Goals, which has increased public policy attention and scrutiny (Michaud &Kates, 2012). Donor governments concentrate on improving the policy environment since bad health policy is a problem in developing nations. This is because efforts by international organizations to provide top-notch public health services have been impeded by bad policies.

The aspect of funding goes beyond money but includes other components such a vaccination programmes. For instance, when the Indonesian government declined to submit H5N1 (avian influenza) virus samples with the Global Influenza Surveillance Network starting in 2006, a wide range of diplomatic actors engaged in a series of formal and informal conversations with Indonesian government representatives. The Indonesian government was worried that its actions threatened attempts to monitor the possible spread of an H5N1 pandemic and that the nation did not gain anything from releasing these samples. The parties eventually came to an agreement on the immediate problem, but debates on benefit-sharing and pandemic influenza surveillance and prevention are still ongoing today (Kaufmann & Feldbaum, 2009). Thus, health diplomacy is surroundedwith mistrust when recipient countries perceive it as asecurity threat to their people and causing losses of intellectual property rights.

Donor support for health has, however, declined and, in some cases, reduced (Kates et al., 2009). Following the global economic crisis, which forced nations to reevaluate their international development aid (ODA) programs, find methods to cooperate and leverage other donors, while also requesting stronger domestic commitments to health programs from low- and middle-income countries themselves (Luet al., 2010). In order to promote fair relationships and address country ownership, public health diplomacy must pay close attention to these challenges (Kateset al., 2009). However,this is not the case because recipients are not

involed in the initial development of projects which is important to ensure ownership and continuity. Points noted that aid from the United States and other Western nations "reflected anti-communist Cold War tensions" and centered on limiting Soviet influence in Latin America, Southeast Asia, and Africa between the 1960s and the 1980s. The signing of the Camp David peace accord in 1978 was made possible by US aid promises to Egypt and Israel, and ever since then, these two nations have topped the list of nations that receive US help. Israel, Afghanistan, Egypt, Jordan, Pakistan, and Iraq were the top 6 recipients of US aid in 2008 (in descending order), demonstrating a clear preference for assisting strategically essential countries rather than the poorest states (Congressional Research Service, 2009).

Public health diplomacy sometimes erodes public trust while multi-stakeholder diplomacy is considered to be more involving and time-consuming. This is so that some national security and public health diplomatic objectives might be more subtly tied to development aid for health initiatives. For example, Iraq received more health-related development aid than any other nation in the North Africa and Middle East region between 2002 and 2004. This is a reflection of US and European objectives in utilizing health as a tool to support stable, pro-Western regimes in the region. Other health development programs have been justified on the basis of their comparatively intangible advantages, such as increasing efforts to forge diplomatic relations between nations through public health channels.It is clear that USA health diplomacy in Middle East was geared towards politics of stable war torn countries. For instance, it has been claimed that the US President's Emergency Plan for AIDS Relief will help Americans' perceptions of Africa (OECD, 2007).

Despite this, it is obvious that decision-makers have great hopes for the results of global health diplomacy at all levels. For instance, the Oslo Ministerial Declaration of 2007 (adopted by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand)

explicitly outlined a plan for giving global health challenges a higher priority in international relations (Amorimet al. 2007). As part of its broader foreign policy efforts, the United States openly supports global health projects as a projection of "smart power," which depends on public health practitioners and researchers to fulfill their technical goals. To date, American organizations have not consistently provided such experts with a framework for comprehending the political context in which they operate.

The funding for public healthcare services is focused on health programs and research, according to this evaluation. It was noted that while the majority of financing goes through NGOs, the delivery of health care in underdeveloped nations is hampered by weak health systems and legislation. Since public health diplomacy is generally informal, formality must be added in order to handle some issues.

### 2.6. United States of America International Organizations Funding and Budgeting on Healthcare Service Delivery in Kenya

The goals of donor nations and organizations, including the International Monetary Fund (IMF) and the World Bank, have always had an impact on Kenya's development of contemporary health policy. According to USAID, multilateral donors finance 16% of Kenya's total health spending and over 28.4% of the Ministry of Health's development budget (USAID, 2000).

USAID has been the sole major donor throughout the creation of Kenya's reproductive health program (Mehlikaet al., 2004).The USA diplomatic interests on other areas depicts on Kenya’s control over the provisionof healthcare which undermines funding even when Kenya is accountable under international law to ensure that her citizens access healthcare services

for all the citizens.According to USAID Kenya (2015) report on health, population and nutrition the efforts of USAID to promote family planning increased the percentage of women who started to use family planning methods by 12%. This report further says that, this was achieved through the use and access to contraceptives. Freeman and Boynton (2011), note that, foreign assistance concerning health issues increased from $ 5.6 billion in 1990 to $21.8 billion in 2007, in which HIV and AIDS took $4.9 billion. These authors reports that bilateral health assistance in Sub-Saharan Africa increased in which Kenya received $545 million, South Africa $510million, Tanzania $ 323 Million among others. Freeman and Boynton (2011) argue that the United States of America provides bilateral health assistance to various countries through different agencies such as the US president's Emergency Program for AIDS Relief (PERPFAR), department of defense, commerce, health and human services, international non-governmental organizations (NGOs), faith based organizations and through other health programs which are funded by the US government

Although this reliance on NGO's may have led to a more effective use of donor money, it is less certain whether it has led to a more effective use of health care funds overall. More crucially, the tactic contributed to the development of a system that is especially susceptible to constraints imposed by the US. With regard to the regulation of family planning, USAID's reproductive health policy-making was distinguished by a position of political neutrality.For example, a 1967 Guideline for Assistanceto Population Programs stated that USAID did not advocate any specific population policy and lacked specific methods of family planning among the populations. Its goal is to provide necessary aid when requested so that everyone can enjoy the fundamental right to manage their own reproductive, health, and welfare (WHO,

2000). This means that when the state is not involved in cooperative agreements between USA-based groups and local NGOs, questions of monitoring and accountability arise.

For illustration's sake, let's look at the difficulties encountered when a faith-based organization collaborated with USAID/Kenya on HIV prevention; the lessons learned regarding efficient finance models; and the organization's emphasis on shared accountability for national HIV/AIDS leadership. In addition to national governments, local civil society also plays a leadership role in this shared responsibility (USAID/Kenya, 2000).

This shows that the quality and accessibility of health care in Kenya, as well as the organization of the health care delivery system, depend on donors more than other factors. For instance, money from external donors like USAID have switched in recent years from family planning to HIV/AIDS. Sometimes, the shifting interests of the donors do not align with those of the Kenyan government's policy. In any case, they invariably trigger a change in stakeholders' priorities. Whatever the benefits of such a change in public health policy, it has unintended consequences that undermine national coherence in health policy and add transition costs to an already severely underfunded system (Mehlikaet al., 2004). In this study, it is evident that the Kenyan government and donors are pulling in opposite directions, which has a negative impact on the provision of public healthcare.

For illustrative purpose, the USA stand on what came to be known as the effect of Mexico policy affected healthcare services in Kenya negatively. When President Bush revived the Mexico City Policy in 2001, two NGOs—Marie Stopes International (MSI) and the Family Planning Association of Kenya (FPAK), which were once significant USAID partners in Kenya—refused to sign the corresponding commitment. Due to the funding loss, both NGOs

were compelled to scale back their outreach and education programs, close clinics, restrict service offerings, impose or raise fees, and more. Due to this significant loss of funds, FPAK was forced to decide whether to cut staff or services. The Association had to strike a balance between its competing responsibilities as an employer, a service provider for underprivileged Kenyans, and a group with a well-established reputation abroad. While economically sound, this confluence of forces resulted in the closure of clinics in some of the poorest neighborhoods, including Eastleigh, Embu, and Kisii (Mehlikaet al., 2004).

The FPAK Eastleigh clinic had been in operation since 1984 in a heavily populated slum where many refugees from the Democratic Republic of the Congo, Ethiopia, and Somalia resided. The facility closed in 2002. There were no public health facilities to serve the residents of this area. For STD testing and treatment, family planning, pre- and post-natal obstetric care, and newborn checkups, patients went to the Eastleigh clinic. Women who resided in Mathare Valley, one of Nairobi's most impoverished neighborhoods, were also served by the clinic. Due to its close proximity to the Eastleigh Youth Counseling Center (YCC), which was also supported by FPAK, the Eastleigh clinic offered significant services geared at adolescents.

Forty employees in all, including those directly involved in service delivery, were let go by FPAK. FPAK has had to review its price structure in order to retain services at the remaining clinics. Although FPAK initially offered free family planning services, it ultimately started charging for some of them. FPAK was establishing a charge structure when it lost USAID financing; clients from disadvantaged areas would pay market prices for services, and the money raised would be used to subsidize services for the underprivileged. Following the cuts, FPAK discovered that the cross-subsidization model does not produce enough revenue to

support clinics in underserved rural and urban areas. As indicated in this study, donor states force their health policy down even to NGOs which may not be coherent with national health policy of host Country. Thus, such a scenario does not effectively serve the purposes of public health diplomacy.

The well-established mechanism for the community-based distribution of contraceptives used by FPAK has been undermined, which is one of the less evident but potentially more damaging repercussions of the loss of USAID financing. In order to provide information on reproductive health, contraceptive supplies, and referrals for medical care, FPAK established and trained a sizable network of community health workers with the financial and technical assistance of USAID. In 2001, FPAK's community health workers distributed 89,600 condoms, made 30,000 referrals, and offered 56,000 people with reproductive health information, education, and counseling. Through this network, FPAK was able to assist women who found it challenging to access healthcare due to their location or other factors. An international coalition of NGOs keeping track of the consequences of the Mexico City Policy reported that FPAK cut the number of community-based distribution agents by 50%. The loss of financing has undermined not only the community-based distribution of contraceptives, but also the community health professionals' instructional role.

In addition, educational initiatives, notably those aimed at young people, have been reduced as a result of the funding loss. For instance, the Eastleigh-based FPAK Youth Counseling Center (YCC), which is close to the previous location of the FPAK clinic, played a significant role at this time. A group of fifteen volunteer "Peer Educators" answered questions from the

Crowley delegation during their tour to the center. A total of 48 Peer Educators who are associated with the YCC offer training at the YCC as well as in schools all throughout Nairobi. International family planning policy in Kenya was significantly impacted by domestic abortion politics in the United States. For instance, they had a significant impact on the Helms Amendment, which was passed in response to the Supreme Court's historic Roe v. Wade ruling and limited the scope of abortion regulation in the United States by striking down a criminal abortion statute. The Helms Amendment forbids using population assistance to perform abortions, pay for them, or to force any woman to get an abortion (Peter, 1997).

In response to the U.S. policy announcement in Mexico City, USAID released agency regulations to implement the new financial limitations. Essentially, USAID adds a "standard clause," or boilerplate contractual language, outlining the pertinent limits, into each new grant and each renewal grant for population support. The ratification of the clause by a recipient is a requirement for funding. Grants from USAID for population assistance can be distributed in one of three ways: directly to foreign governments, directly to non-governmental organizations, or indirectly to non-governmental organizations (NGO) through U.S.-based family planning intermediaries called Office of Population Cooperating Agencies (Cooperating Agencies). Cooperating Agencies sign cooperative contracts to provide subgrants to FNGOs on USAID's behalf. Foreign NGOs that receive funding from USAID, either directly or via a cooperating agency, may also distribute additional sums to "sub recipients" and "sub-sub recipients."

In Kibra, most community based health institutions are funded from America despite that they are operating in Kenya. Such include health programmes which are being funded by the Centre for Disease Control, the Bill Gates Foundation among others. The PMTCT operations in the

Kibra Slum involve CDC/KEMRI ARV Services, AMREF ARV Services, VCT, and TB/HIV services. In order to strengthen the connections between the PMTCT program and the ART program in order to provide PMTCT+ services to the women, the infants, and members of the woman's family, AMREF has been supporting a successful ART site in Kibra. This site will be used to test the appropriate model for this site.

This analysis shows how deeply rooted American state organizations that conduct business abroad have diplomatic interests. When US interests are threatened, funding to these organizations is cut or some projects are discontinued, which immediately has an impact on healthcare delivery, even in Kibra area. It has been demonstrated that there is a need for coordination between national health policies in the host nations and the health operations of international organizations. Therefore, implementing public health policy without some sort of state to state cooperation may not result in adequate public health diplomacy being delivered.

### 2.7 Theoretical Framework

The neo-liberal institutionalism theory put out by Keohane and Nye supports this study (1977). The theory's primary justifications center on the significance of international organizations in fostering cooperation on problems like global health. This indicates that the theory is concentrated on the function of international organizations, such as multinational corporations, international governmental organizations, and international non-governmental organizations, in problem areas like health, and in particular cross-border diseases that threaten overall global security. In order to collaborate or partner with both state and non-state actors, these institutions build norms and networks.

According to Nye (1977), neo-liberal institutionalism is concerned with both so-called "high politics" and "low politics" (economic and social issues) (security issues). As a result, this explanation is compatible with the study because security threats related to health are widespread. This eliminates the element of global interconnectedness that drives the demand for international institutions and significantly reduces opportunities for collaboration in world affairs. However, the degree of cooperation byinternational institutions can vary and affect outcomes or even promote conflict.For instance, a state through international organizations can pursueabsolute gains by cooperating with others actors.Therefore, the focus on common problems or interests is lost in pursuit of selfish interest of the state. In the context of health issues, a states use of public health diplomacy can be marred by state interests such that delivery of public healthcare is affected.

This theory explains that health is a low politics issue in international relations. It fits this study since it explains the need for diplomatic cooperation between state and non-state actors in alleviating health issues in Kibra sub-county. The cooperative agreement between USAID, PERFAR, CDC and Kenyan Health based NGOs, government agencies defines the diplomatic processes that occur. Since health issues pose international security threats, donor countries see the need to cooperate to eliminate diseases among the poor. Thus, the interdependence aspect works towards diplomatic collaboration in health diplomacy. However, the reality is that there is a thin line between health diplomacy and interest of USA and international development agencies such as USAID through which the US government provide public health diplomacy to other states in the world.

This study is also grounded on the arguments of Hans J. Morgenthau (1984). Political realism theory in interntional relations which observes that states are the most important actors in international relations and their actions are intednded to achieve power and self interests.

However, there are multiple actors today in international relations which include non-state actors working in collaboration with states in various fields. For instance, in the field of health diplomacy, international development agencies work together with states to achieve universal healthcare which inturn improves relations between donor and recipient states. The main assumptions of political realism theory is that states are the most important actors but other actors are equally important which influence outcomes of interactions between states. Thus the theory recognizes the importance of international organizations and various kinds of partnerships in the health sector which in turn improves relations between states.

The proponent of the political realism theory further argues that the behaviour of states is determined by their rational pursuit of self interests and power. For this study, political power can be achieved when there is interdepenance and collaboration in various fields such as health which indirectly improves state relationships in the global scale. Political realism theory further acknowledges that, for states to achieve their interests, cooperation and interdependence is a fundamental factor. Both theories are in agreement that collaborations and partnerships are inevitable in the world today for states to achieve self interest and both economic and political power.

## 2.8Conceptual Framework

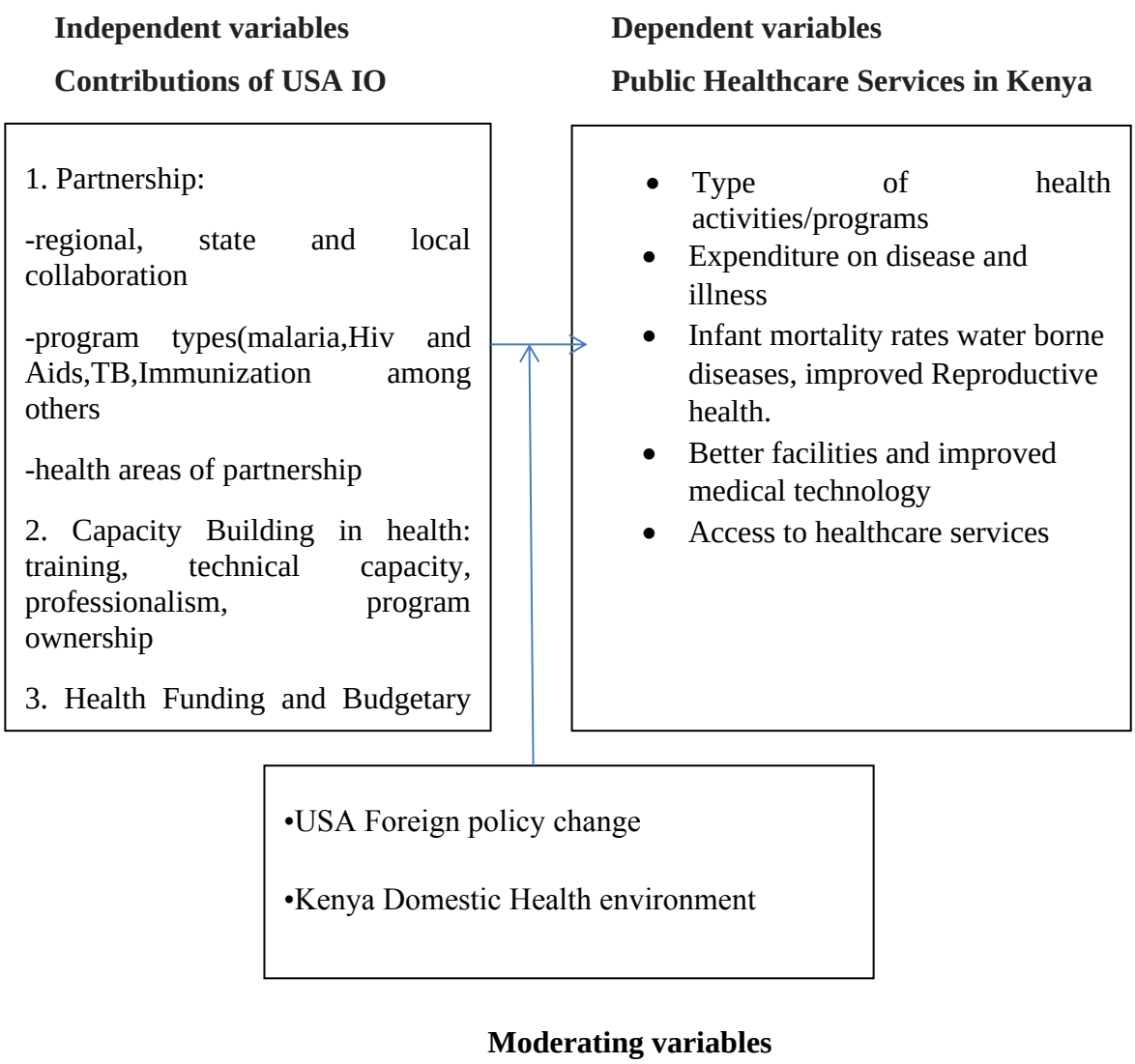



**Figure 2.1: ConceptualFramework**

**Source: Researcher, 2020**

The above conceptual framework indicates the interaction of the independent and dependent variables. Collaboration between the US international development agencies and stakeholders in the health sector stranghtens the provisions of the healthcare services through the availability of medical equipment, training of health workers, creation of research centers and funding of healthcare activities. Capacity building promotes research of new interventions to fight diseases, improvement of awareness, community participation and ownership of health projects by the local communities. Funding of health projects by the US international development agencies improves medical technology, availability of drugs and the total

number of people receiving healthcare services. However, intervening variables such as conflicting cultural values, beneficiary attitudes, donor funding requirements and lack of harmonization of donor health policies are a major hinderance which affect the independent variables not to have a direct impact on the dependent variables.

# CHAPTER THREE

# RESEARCH METHODOLOGY

The methods to be applied in conducting the study is presented in this chapter. It covers the research plan, target audience, sample size, research tools, instrument piloting, data collection process, data analysis, and ethical issues.

## 3.1 Research Design

To examine the impact of US international health organizations on the provision of public health services in Kibra, Kenya, the researcher employed a descriptive and qualitative research design based on a descriptive survey research approach. According to Mugenda & Mugenda (2003), questionnaires and an interview schedule are used to gather descriptive survey data. The goal of a descriptive study was to provide an accurate account of how the variables interacted in a particular field of study, such as the impact of international organizations on the development of capacity and funding for various health programs.This prompted the researcher to prefer descriptive research design for this particular studybecause it was appropriate in consideration of the instruments used to collect the data.

## 3.2 Study Area

This study was carried out in Kibra sub-county, which is divided into 14 settlements with various human populations and is part of Nairobi City County. In addition to Kianda, Olympic, Soweto West, Gatuekera, Raila, Karanja, Kisumu Ndogo, Makina, Kambimuru, Mashimoni, Lindi, Lainisaba, Silanga, and Soweto East, there are also a number of other villages (Mutisya and Yarime, 2011). As one of the biggest slums in both Africa and the globe, Kibera was chosen because health NGOs and an international organization from the United States have worked together to try to solve the health problems there. Second, Kibra is the best location

for the study because it is where the majority of American international organizations that provide healthcare services are based. Therefore, the goal of the study was to evaluate the success of the health care programs that were funded by donors in each of their geographic regions.

### 3.3 Target Population

A population is a group of individuals, things, or events that share at least some common characteristics and to which the researcher hopes to extrapolate the results from the sample. It alludes to the population for which the researcher hopes to generalize the findings of the investigation (Fisher,1958). This study focused on regional managers of US international health organizations like the CDC, USAID, PERFAR, and Bill Gates Foundations(4), as well as managers of Shining Hope for Communities (Shofco) and Lea Toto, two donor-funded organizations operating in the Kibera slums, and 22 clinic administrators. Therefore, the target population consisted of four regional USA international organizations, the director of KEMRI, the director of the ministry of health, the director of the ministry of foreign affairs, the director of NASCOP, the manager of two Kibra-based organizations, the administrator of 22 clinics, and more than 600 healthcare professionals. This resulted in a target population of 632 in total. The target audience is shown in table 3.2 below:

**Table 3.1: Target Population**

| Respondents | Population |
|---|---|
| **Directors, USA Regional international organizations** | 4 |
| **Director, KEMRI** | 1 |
| **Director  Ministry of Foreign Affairs** | 1 |
| **Director, Ministry of Health** | 1 |
| **Director, NASCOP** | 1 |
| **Managers, of two NGOs** | 2 |
| **Administrators of -clinics (Shofco)** | 14 |
| **Administrators in centers (Lea Toto)** | 8 |
| **Health workers** | 600 |
| **Total** | 632 |

Source: Researcher Constructed, 2020

### 3.4 Sample Size andSampling Technique

According to Mugenda and Mugenda (2013) a sample size is a small population selected to represent the relevant characteriscs of the target population of the research area. The study used census, purposive sand simple stratified random sampling to select respondents for the study. According to (Kerliger, 1983) a sample size of 10% to 30% is representative of the population. For the purpose of this study, 12% was used to sample health workers who operate in various health clinics. The respondents contained representative sampling in terms of characteristics to enable the generalization of the research findings. Purposive and census sampling methodologies were used to sample directors, administrators and program managers. The sample size was 100 for this study. The following table 3.2 is a summary on sample size.

**Table 3.2: Sample Size**

| Category | Population | No in Sample | Sampling technique |
|---|---|---|---|
| **Regional Directors (CDC, USAID, PERFAR, Bill Gates)** | 4 | 4 | Purposive and census |
| **Directors (KEMRI, NASCOP Foreign Affairs and Health Ministry)** | 4 | 4 | Purposive and census |
| **Managers (Shofco and Lea Toto)** | **2** | **2** | **Purposive and census** |
| **Administrators (Shofco and Lea Toto)** | **22** | **22** | **Purposiveand census** |
| **Health workers** | **600** | **68** | **Purposive, stratified simple random (12% applied)** |
| **Total** | **632** | **100** | |

**Source: Researcher Constructed, 2020**

### 3.5 Instruments of Data Collection

The study used a questionnaire and interview guide to collect information from the respondents.

#### 3.5.1 Questionnaire

There were100 questionnaires to be administered todirectors of KEMRI-1, Health Ministry-1, Foreign ministry-1, NASCOP-1, Managers of 2 NGOs, administartors of clinics -22 and health workers-72. The researcher distributed structured questionnaires to administrators and healthcare professionals with the assistance of two study assistants. In each study location, the questionnaires were given to the participants and collected after they completed them over the course of five days. To facilitate the gathering of both quantitative and qualitative data, the questionnaires included both closed-ended and open-ended questions.

### 3.5.2 Interview Schedule

The researcher also conducted key informant interviews. To obtain comprehensive information, it was used. The interview was selected because of its versatility and flexibility. It gave the researcher some degree of control over the research environment, allowing the researcher to change the questions and elicit more information (Prewitt, 1975). Open-ended questions on the calendar allowed for the collection of additional data that was not possible with surveys. The data gathering approach of interviews was utilized to verify the responses provided by survey respondents.The respondentswereregional directors of USA based health internationalorganizations(4) and directors of Kemri, Ministry of Foregnaffairs,Nascop and Ministry of Health(M.O.H) respectively.The interviews were both structured and unstructured. Interviews provided opportunities for interviewers to ask probing questions about the topic and objectives of study in order to answer the research objectives.

### 3.5.3 Focus Group Discussion

For the research, health professionals employed concentrated group talks. A focus group discussion (FGD) is a useful method for getting information from important responders, such healthcare professionals. It was employed in this study to examine the interpretations of survey results that could not be explained statistically as well as the diversity of viewpoints on the subject. It was helpful in revealing the various viewpoints held by the respondents. There were a total of five focused group discussion groups, each with eight participants, for a total of forty (40) respondents. The members were gathered for a facilitated discussion of the predetermined subjects. Each group discussion lasted two hours, according to the researcher. The discussions were moderated by the researcher and tape recorded with the participants' consent before being transcription. With the respondents' consent, the focus group discussion was also taped for the purpose of transcribing. Using Zoom meetings, the focused group

discussion was conducted online. In the final formulation of the proposal, the F.G.D. results were triangulated.

### 3.5.4 Secondary Data

Last but not least, the researcher collected secondary data through analysis of publications like public health diplomacy, international health legislation, and government documents. The researcher specifically aimed to ascertain whether the nature and intent of the aforementioned documents would shed more light on the contribution of USA international health organizations on the provision of public health services in Kibra, Kenya.

## 3.6 Piloting of Research Instruments

The researcher piloted the research instruments by choosing 1% of the target population and incorporated the suggestions in the construction of the questionnaire. The researcher involved experts in the initial development of the questionnaire and their concerns were considered in the construction of the final questionnaire. However, because the pilot sample was small, the pilot results are not reported in the final findings. This is because results were so insignificant in the final report.

### 3.6.1 Validity of Research Instruments

Validity refers to the ability of a test or tool to measure what it intends to measure (Kothari, 2004) . The researcher adopted the application of content and construct validity which according to Mugenda and Mugenda (2013), the research instruments provides adequate indicators of the topic under study. This makes it possible for the generalization of research findings to the target population. To achieve content validity, the tools of the study covered as many aspects and indicators on USA international organizations in relation to pub;lic health diplomacy. The indicators of the content validity were selected and analysed by experts in the

field of internalional relations. The researcher used trained research assitants for accuracy and consistency of the data collecting procedures. Mugenda and Mugenda (2019), observes that validity is axchieved when an instrument measures what it purpots to measure.

Therefore, the research instruments ensured quality data which s an important condition to ensure reliability and generalizations of the research findings.

### 3.6.3 Reliability

Mugenda and Mugenda (2013), notes that reliability is the consistency of the instruments to obtain similar data by the use of the same research methodology. Further observes that reliability of a questionnaire is established through pre testing the questionnaire on chosen subjects who will not be part of the final study. The pre test sample used was 1% and because the sample size was very small, the results were not analysed because they were so insignificant. The researcher also pre tested the questionnaire with the supervisors who are experts in international relations at intial stages of development of the research instrument. This ensured that the questionnaire achieved consistency, accuracy and consistently indicated the characteristics and the variable of the study. Piloting and pre testing of the questionnaire enhanced the reliability of the instruments as a consistent measure of the concepts which were being studied.

## 3.7 Data Analysis and Presentation

Descriptive statistics were used to analyze the quantitative data, while emerging themes were used to arrange the qualitative data. Using the SPSS system Version 27 for data analysis. Tables, pie charts, bar graphs, and frequency tables were used to illustrate the data after it had been primarily descriptively evaluated. By combining emergent themes from the key informant interviews, topic analysis, and cut and paste techniques on the focus group conversation, the qualitative data was analyzed.

### 3.8 Ethical Issues in the Research Process

The Kenyan government will be contacted to request approval for the study. We will get a letter of introduction from Kisii University's Directorate of Postgraduate Studies. The researcher pre-prepared the research instruments and administered them to the respondents they chose as a sample for the study. Interview schedules were followed, and questionnaires were distributed. Mistreatment of human research participants constitutes an unethical activity, according to Okoth (2012). In research, the protection of informants' rights and their consent are of utmost importance. Therefore, it is crucial to protect research assistants and informants.

# CHAPTER FOUR

# DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS

## 4.1 Overview

The methods used for analysis and the results of the data gathering are presented in this chapter. To determine whether the data were sufficient for data analysis, the response rate was initially given. Following the presentation of the findings, the demographic data of the respondents was displayed. Tables and figures were used to present the findings, and when necessary, pertinent explanations were provided beneath each table.

## 4.2 Questionnaire Response Rate

100 questionnaires were distributed as part of this study to administrators and employees of the foreign organizations providing healthcare services in Kibra. The healthcare professionals and administrators returned 92 of these questionnaires, representing a 92% response rate. This response rate was sufficient and complies with Mugenda and Mugenda's (2003) definition of an adequate response rate for data analysis and reporting as 50%, a good response rate as 60%, and an exceptional response rate as 70% or higher. Return rates of more than 60% are deemed to be excellent by Best and Khan (2006).

## 4.3 Social Demographic Characteristics of Respondents

This information comprised of gender, age distribution, level of education and work experience of the healthcare workers and administrators as shown in Table 4.1 below.

**Table 4.1: Demographic Characteristics**

| | | Frequency | Percentage | $X^2$ | p-value |
|---|---|---|---|---|---|
| Gender | Male | 57 | 62.0% | **5.261(1)** | **0.220** |
| | Female | 35 | 38.0% | | |
| | **Total** | **92** | **100.0%** | | |
| Age | 18-30 Years | 15 | 16.3% | | |
| | 31-43 Years | 30 | 32.6% | **20.783(3)** | **0.000** |
| | 44-56 Years | 37 | 40.2% | | |
| | 57-60 Years | 10 | 10.9% | | |
| | **Total** | **92** | **100.0%** | | |
| Level of Education | Certificate | 5 | 5.4% | **51.217(4)** | **0.000** |
| | Diploma | 50 | 54.3% | | |
| | Undergraduate | 25 | 27.2% | | |
| | Post graduate | 12 | 13.0% | | |
| | Others | 0 | 0.0% | | |
| | **Total** | **92** | **100.0%** | | |
| Work Experience | Less than 1 year | 8 | 8.7% | | |
| | 1-3 Years | 15 | 16.3% | | |
| | 4-6 Years | 18 | 19.6% | **15.283(4)** | **0.004** |
| | 7-10 Years | 31 | 33.7% | | |
| | More than 10 Years | 20 | 21.7% | | |
| | **Total** | **92** | **100.0%** | | |

From Table 4.1, the results show that majority of the respondents were male. In the study, the male participants were 62.0% and female were 38.0%. Chi-square test ($X^2(1) = 5.26, p = 0.220$)revealed that there was no statistically significant difference between males and females Majority of the respondents were between 44-56 years (40.2%) and 31-43 years (32.6%). It was also observed that there was a statistically significance difference between the age brackets ($X^2(3) = 20.783, p = 0.000$). It was also observed that majority of the respondents were 54.3% were diploma holders while 0nly 5.4% of the respondents had certificate as their highest qualification. A Chi-square test ($X^2(4) = 51.217, p = 0.000$)of variation revealed that was a statistically significant variation between the levels of education. Additionally, majority of the respondents 33.7% had worked between 7-10 years and another 19.6% had a work experience of between 4-6 years. However, only 8.7% of the respondents had work experience of less than year. A chi-square test($X^2(4) = 15.283, p = 0.004$) of variation revealed that there was a statistically significant difference in work experience.

Level of education was important to guage the ability of respondents to respond competently to question item in the questionnaire. From the findings, majority of the repondents were of right age and knowlegeble on USA public health diplomacy and thus correct responses to question items. Also, the gender distribution was balanced to get correct responses on issues of gender in context of health public diplomacy. The level of work experience was critical with regard to accuracy in answering questions since public diplomacy in health is anchored on time aspects. This meant that work experience was important to get responses that cut across a number of years with regard to effects of USA public health diplomacy to the targeted population in Kenya whether positively or negatively. In conclusion, the demographic elements analysed reflected the nature of results that are discussed in this chapter.

### 4.4 Nature and extent of USA international health organizations partnership towards Public Health service delivery in Kibra Sub County

The first objective of this study was to examine the nature and extent of USA international organizations partnership in public healthcare services delivery in Kenya. To establish the nature and extent of USA international health organizations partnership towards public health service delivery in Kibra subcounty, healthcare workers were asked to tick appropriately on which USA organizations partnered with their organization in delivery of health care services in Kenya, their responses are as shown in Table 4.2.

**Table 4.2: USA Organizations**

| Organization | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| USAID | 56 | 60.9 | 60.9 |
| PERFAR | 14 | 15.2 | 76.1 |
| CDC | 14 | 15.2 | 91.3 |
| Bill Gates Foundation | 8 | 8.7 | 100.0 |
| **Total** | **92** | **100.0** | |

From Table 4.2, it was observed that 60.9% of the respondents indicated that USAID was the USA international health organization that ensured public health service delivery in Kibra subcounty, Kenya. Another 15.2% of the respondents indicated that PERFAR and CDC were the USA international health organization that ensured public health service delivery in Kibra subcounty and only 8.7% of the responded indicated Bill Gates Foundation. A chi-square test of variation was also performed $(X^2(3) = 64.174, p = 0.000)$showed that there was a

statistically significant difference between the USA state agencies partnerships with the organizations.

The findings show that well-known international agencies like USAID primarily enhance US public diplomacy. This is accurate given that USAID collaborates with numerous private sector organizations to help youngsters who have lost both parents due to the HIV/AIDS pandemic and those who come from economically disadvantaged homes finish their education and take on leadership roles in their communities. Additionally, USAID collaborated in a Global Development project with Equity Bank, Equity Group Foundation, MasterCard Foundation, and UKaid thanks to financing from the President's Emergency Plan for AIDS Relief (PEPFAR). A health program officer said in an interview:

> USAIDs also has a Water, Sanitation and Hygiene (WASH) program that assists the Governmentof Kenya and communities to increaseaccess to improved water and sanitationfacilities and improve hygiene in Kibra area.

These sentiments reflect USA objective by way of public health diplomacy to care for foreign publics in Kenya.This finding reflects USIAD/Kenya (2013) report that public diplomacy focuses on helping communities access more and betterwater, the WASH activity:improveshealthbyreducing water-borne andotherdisease;reducestheburden,which usually falls onwomen and children, oftrekking long distancesfor water, leaving moretime for study and othertasks;createscommunitymanagedwatersystemsthat will endure without further interventions . The researcher also needed to understand the nature of partnership as discussed next.

### 4.4.1 Kind of Partnership

Respondents were asked to describe the kind of partnership their organization had with USA international health organizations. The findings are as shown in Figure 4.1

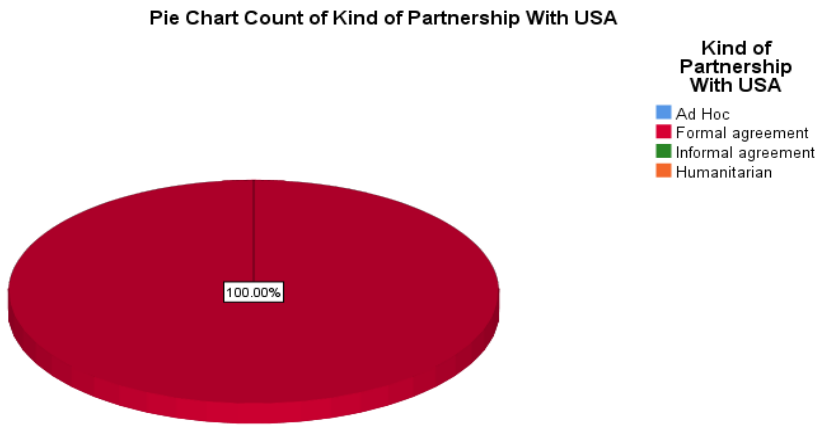



**Figure 4.1 : Nature of Partnership**

From Figure 4.1, it was observed that 100% of the respondents indicated that the kind of partnership their organizations had with the USA international health organizations was formal. In thiscase, formality means that the NGOs that provide health services in Kibra had formal agreements with USA organizations championing health public diplomacy on various programs. The details of contract however was mostly dictated by these international organizations. For instance, the Kenya AIDS NGOs Consortium (KANCO) has an agreement with USAID to support abstinence, faithfulness education and life skills to 56,840 youth, young adults and train 197 people to deliver AB interventions in Kibra. This findings were collaborated by FGDs discussion

> In most cases, our organization has partnered with local CBOs to realize madate of out benefactor USAID. We working with a network model of six partners namely: Kibera Community Self Help Project, the National Organization of Peer Educators, Kenya Medical Association, *MaendeleoyaWanawake* Association and Community Capacity Building Initiative who work collaboratively to implement the RAY (Responding to AIDS among youth) project.

This sentiment means that USAID as an organization focus on public diplomacy is far much removed from the programs themselves. It is left to local health NGOs to ensure compliance

which in itself is complex. However, formal agreements agree but this excludes other critical players such as the County government and institutions that are directly at the centre of these services such as the Ministry of Health in Kenya. In an interview, a health program officer equipped:

> As *Lea Toto, a local NGO*we have a cooperative agreement with USAID on community-based outreach program.

The postulation by the program officer indicates the endevour by USA organization to reach grassroot people in provision of the said services. However, this may not be effective since an appleal to Kenyan republics lacks accountability when government is not involved. Therefore, the researcher interrogated USA interests as discussed below.

### 4.4.2 USA public health diplomatic interests

Respondents were asked to state whether they thought USA public health diplomatic interests are at the center of their nature of partnership. Their responses are as summarized in Figure 4.2

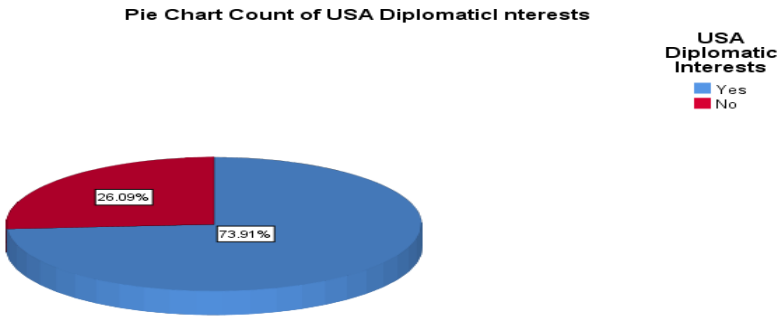



**Figure 4.2: USA Diplomatic Interests**

From Figure 4.2, it was observed that 73.91% of the respondents agreed that they thought USA public health diplomatic interests are at the center of their nature of partnership while 26.09% of the respondents disagreed. To establish what kind of interest the USA organizations had, respondents were asked to describe the kind of interest, this was presented as shown in Figure 4.3.

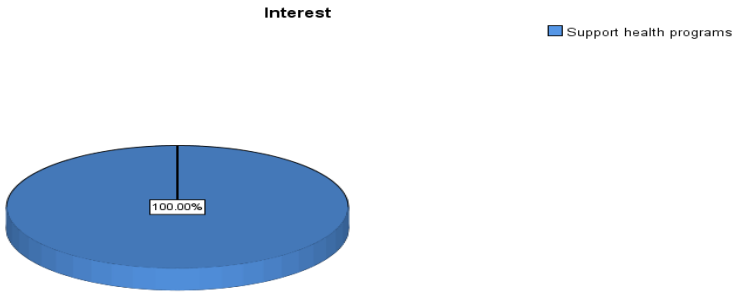



**Figure 4.3: Health Support Programs**

From Figure 4.3, it was observed that 100% of the respondents indicated that the interest was to support health programs.This finding indicate that USA organizations are platforms through which USA government champions her foreign policies to foreign republics. In as much as respondents indicated that the focus is on health programs, USA aim to promote her culture and appeal to Kenyan republics is not lost in this context. In an interview, a CEO equipped:

The aim is to provide health services to poor population directly, however, this can only be done through proxies that have grassroot organization and thus we reach the locals through the media adverts.

This claim embodies the fundamentals of public diplomacy. Public diplomacy may also be viewed as propaganda for a nation state by enhancing its image overseas in a way that will be

advantageous to the state. Public diplomacy focuses at promoting its culture for long-term goals while short-term when it comes to current foreign policies (Berridge,2005). In an FDG, a health worker appeared to concur that the image of the United States is present on nearly every item as a tactic to sway recipients' perceptions of the type of treatment that the USA as a state has provided to underprivileged communities in Kibra.

This finding agrees with Ross's (2010) observation that the requirement for diplomatic representation for organized non-state entities has been referred to by a variety of words. Multi-stakeholder diplomacy covers a wider range of contacts between state actors and non-state entities who don't often engage in international relations. The number of long-term alliances between governments and non-governmental organizations (NGOs) to carry out health services delivery, capacity-building projects, and research has increased along with the growth of global health assistance during the past two decades. The Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance (originally the Global Alliance for Vaccines and Immunization), Stop TB, Roll Back Malaria, and the Global Polio Eradication Initiative are just a few of the global health partnerships that are supported by both public and private sector organizations. These public-private partnerships add a unique dimension to the area of public health diplomacy because they are typically run by boards of directors rather than through the consensus-building procedure more typical of traditional multilaterals.

Therefore, the researcher was keen on effectiveness of public diplomacy and thus went ahead to interrogate other support programs advanced to local health NGOs in Kibra as discussed next. On this, respondents were asked to state other support offered by the USA organizations to the health facilities apart from funding. This was presented as shown in Table 4.3.

**Table 4.3: Kind of Health Support by USA organizations**

| | Frequency | Percent | Cumulative Percent |
|---|---|---|---|
| Capacity Building | 59 | 64.1 | 64.1 |
| Joint Monitoring and Evaluation | 8 | 8.7 | 72.8 |
| Joint Research | 9 | 9.8 | 82.6 |
| Logistical Support | 9 | 9.8 | 92.4 |
| Health Education | 7 | 7.6 | 100.0 |
| **Total** | **92** | **100.0** | |

From Table 4.3, it was observed that majority 64.1% of the respondents indicated that apart from funding, The USA organizations offered capacity building. Another 9.8% of the respondents indicated that these organizations offered joint research and logistical support. 8.7% of the respondents stated that these organizations offered joint monitoring and evaluation while 7.6% of the respondents indicated that USA organizations offered health education. A Chi-square test $(X^2(4) = 112.132, p = 0.000)$of variation revealed that there was a statistically significant difference between other support offered to the organizations by the USA state agencies.

**As** findings illustrate, monitoring and evaluation has a percentage of 8.7% while joint research and logistical support 9.8%. These percentages are indicative of ineffectiveness of USA public diplomacy on health. There is little collaboration as regards monitoring of the processes which points to the fact that unless other stakeholders are brought on board public diplomacy may not be effective in some areas such as health. And so, this explains how donors' shifting priorities with regard to public health policy have unexpected consequences such as

compromising the consistency of national health policy and increasing transition costs in a severely underfunded system (Mehlikaet al., 2004). This means that the provision of public healthcare services is adversely impacted by the conflict between the health operations of foreign organizations and national health policy in host nations. This draws attention to the type of particular initiatives on which US international organizations concentrate.

### 4.4.3 Programs in Partnership with USA state agencies

Respondents were also asked to state which programs do USA state agencies or USA private based organization are in partnership with their organizations. Here they were required to tick appropriately (YES or NO). Their responses are as shown in Table 4.4

Table 4.4: Health Programs by USA Agencies

| | | Frequency | Percentage |
|---|---|---|---|
| Productive Health Care | Yes | 92 | 100.0% |
| | No | 0 | 0.0% |
| | **Total** | **92** | **100.0%** |
| Immunization Against Polio and Measles | Yes | 6 | 6.5% |
| | No | 86 | 93.5% |
| | **Total** | **92** | **100.0%** |
| Diet and Nutrition Enhancement | Yes | 85 | 92.4% |
| | No | 7 | 7.6% |
| | **Total** | **92** | **100.0%** |
| Sanitation Improvement | Yes | 44 | 47.8% |
| | No | 48 | 52.2% |
| | **Total** | **92** | **100.0%** |
| Sexual Transmitted Disease | Yes | 55 | 59.8% |
| | No | 37 | 40.2% |
| | **Total** | **92** | **100.0%** |
| Communicable Diseases and Cholera | Yes | 29 | 31.5% |
| | No | 63 | 68.5% |
| | **Total** | **92** | **100.0%** |
| Non-Communicable Diseases | Yes | 15 | 16.3% |
| | No | 77 | 83.7% |
| | **Total** | **92** | **100.0%** |

From Table 4.4, it was observed that 100% of the respondents indicated that USA state agencies partnered with them in productive health care. Only 6.5 % of the respondents indicated that the USA agencies partnered with them in Immunization Against Polio and Measles. It was also observed that 92.4% of the respondents indicated that they partnered in Diet and Nutrition Enhancement. Another 47.8% of the respondents stated that these organizations partnered with them in Sanitation Improvement. 59.8% of the respondents agreed that the USA organizations partnered with them in Sexually Transmitted Disease. It was also observed that 31.5% of the respondents stated that the USA organizations partnered with them in Communicable Diseases and Cholera while only 16.3% agreed that the USA state agencies partnered with them in Non-Communicable Diseases.

This finding are indicative of USA organization resolve to prioritize some programs which may at sometimes not serve health interests of the poor populations in Kibra. In an interview, a health worker lamented:

> It is true that some critical health issues are not given consideration but since donor organization are in control of the type of health programs there is little we can do to change that.

This lamentation clearly indicates the dilemma that local NGOs experience where programs sponsored may not resonate with health needs of the poor populations in Kibra. From the findings, reproductive health scores 92% since there is a feeling by donor organization to reduce population in the global South. Other health programs like non-cummunicativedeseases are not considered as much. Thus, public health diplomacy may serve interests of the USA and not the recepients as from illustrated findings. This in itself reflects the ineffectiveness of the programs.

The results here were at odds with data from USAID and PEPFAR, two US government agencies that work with regional organizations in Kenya. For instance, this organization collaborates with faith-based organizations (FBOs), utilizing their volunteers and staff to enhance their organizational structure and take use of the FBOs' special roles and functions (PERFAR, 2015). This NGO has pledged to adopt the Fast-Track methodology alongside UNAIDS. Together, they deliver a sizable amount of HIV care, particularly in sub-Saharan Africa, and have a long history of earning the trust of the neighborhood. A World AIDS Day 2018 event at one of the original PEPFAR sites, a picture exhibit on gender-based violence, and a documentary commemorating the HIV experience in Kenya were among the events that the U.S. Department of State sponsored (Mehlikaet al., 2004).

Additionally, since 1979, CDC has worked with other organizations on research programs examining innovative malaria preventive and treatment methods. In addition, the following achievements from the 2018 fiscal year were reported by CDC Kenya and its implementing partners: More than 7.7 million people in Kenya are HIV-positive. 92% of people with HIV who are receiving treatment have the HIV virus under control (or viral suppression). More than 400,000 women were aware of their pregnancy. Babies can be born HIV-free because 99% of people who tested positive for HIV are receiving treatment. In 2018, CDC Kenya worked with the Kenya Medical Research Institute (KEMRI), the National AIDS and STI Control Program (NASCOP), and other organizations (CDC, 2018).

To ascertain this, cross-tabulations between the USA state organizations and health programs was also performed, this is presented in Table 4.5.

**Table 4.5: Cross Tabulation**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | p-value |
| Productive Health Care | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | - | - |
| Immunization Against Polio and Measles | 10.7% | 89.3% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | **4.126(3)** | **0.248** |
| Diet and Nutrition Enhancement | 100.0% | 0.0% | 50.0% | 50.0% | 100.0% | 0.0% | 100.0% | 0.0% | **42.212(3)** | **0.000** |
| Sanitation Improvement | 39.3% | 60.7% | 100.0% | 0.0% | 14.3% | 85.7% | 75.0% | 25.0% | **25.589(3)** | **0.000** |
| Sexual Transmitted Disease | 98.2% | 1.8% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | **87.195(3)** | **0.000** |
| Communicable Diseases and Cholera | 51.8% | 48.2% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | **27.224(3)** | **0.000** |
| Non-Communicable Diseases | 0.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | 12.5% | 87.5% | **85.558(3)** | **0.000** |

From Table 4.5, it was observed thatthere was a statistically significant variation between the USA state agencies and Diet and Nutrition Enhancement, Sanitation Improvement, Sexually Transmitted Disease, Communicable Diseases and Cholera and Non-Communicable Diseases.

### 4.5 Effects of the USA international health organizations towards capacity building in Public Healthcare in Kibra Sub County.

The second objective of this study was to assess effects of the USA international health organizations towards capacity building in Public Healthcare in Kibra Sub County. To assess the effects of the USA international health organizations towards capacity building in Public Healthcare in Kibra Sub County, healthcare workers were asked to state the areas of capacity building which the USA organization partnered with their organizations. Their responses are as shown in Figure 4.4.

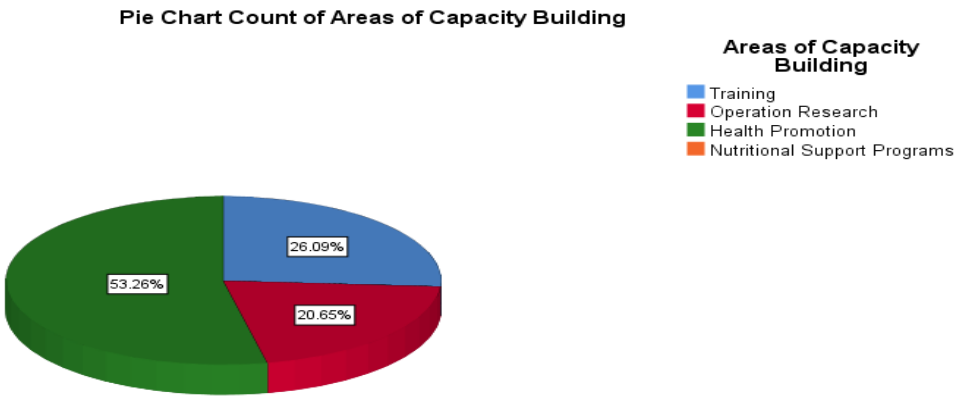



**Figure 4.4: Areas of Capacity Building**

From Figure 4.4, it was observed that majority 53.26% of the respondents indicated that the USA state agencies partnered with them in Health care promotion. Another 26.09% of the respondents stated that they partnered with them in training while 20.65% of the respondents

indicated that the USA state agencies partnered with them in operation research. None of the respondents indicated that there was partnership in nutritional support programs.

This discovery highlights instances in which USAID collaborated with the Ministry of Health Services and other partners to develop competency-based emergency obstetric and newborn care training curricula. According to a CEO interview, the five regional service delivery programs funded by USAID increased access to maternity, neonatal, and child health care at both the institution and community levels. Additionally, 6,395 community health workers were educated by USAID in maternal and/or neonatal health. Community health workers are crucial to reducing maternal and infant mortality because more than 50% of Kenyan women still give birth at home without access to trained care.

This result is consistent with a USAID/Kenya report from 2013 that notes community health workers should also encourage women to take advantage of early antenatal services, which include HIV testing—a crucial first step in the prevention of mother-to-child HIV transmission—and preventative treatment for malaria during pregnancy. Additionally, community health professionals encourage the use of latrines, hand washing with soap, and vaccinations.

These early initiatives, however, were only partially effective. USAID and other funders soon realized that the Kenyan government lacked the technical know-how and experience necessary to staff and manage new projects. Thus, to implement family planning projects, USAID, the World Bank, and other donors devised a strategy in the early to mid-1980s that involved the establishment of new governmental bodies supported by a specially chosen advisory team. The National Council on Population and Development, under the Ministry of Home Affairs, and the National Family Welfare Center ("NFWC"), under the Ministry of Health, were both

founded as a result of this approach. At an effort to decentralize the health system, the former coordinated efforts between public and private organizations working on family planning, and the latter trained community nurses and clinical officers to work in dispensaries, health centers, and sub-centers across Kenya (Mehlikaet al., 2004). This is a blatant example of how public health diplomacy can fall short of its goals in the absence of a good public health policy.

Also, the focus on health promotion is indicative of USA public diplomacy interests which are to boost her image abroad and attitude among foreign publics in Kibra. As findings illustrate, it is clear that empowering the local NGOs in terms of training, nutrition support programs are not a prority since dependency on donor technical know how and funding is the cog in public diplomacy agenda of USA. Thus, the researcher went further to find out which programs are funded by USA organization on matters of public health in Kibra as discussed next.

### 4.5.1 USA state agencies Effects on funded healthcare programs

Respondents were asked to state their opinions on whether they thought that USA state agencies funded healthcare programmes in Kibra Sub County had led to increased access to health, reduced cost of healthcare, increased hygiene and availability of funding. They were required to tick appropriately (YES or NO). Their responses are presented as shown in Table 4.6.

**Table 4.6: USA Funded Health Programs**

| | | Frequency | Percentage |
|---|---|---|---|
| Increased Access to Health | Yes | 67 | 72.8% |
| | No | 25 | 27.2% |
| | **Total** | **92** | **100.0%** |
| Reduced Cost of HealthCare | Yes | 71 | 77.2% |
| | No | 21 | 22.8% |
| | **Total** | **92** | **100.0%** |
| Increased Hygiene | Yes | 72 | 78.3% |
| | No | 20 | 21.7% |
| | **Total** | **92** | **100.0%** |
| Availability of Funding | Yes | 72 | 78.3% |
| | No | 20 | 21.7% |
| | **Total** | **92** | **100.0%** |

From Table 4.6, 72.8% of the respondents stated that the USA state agencies funded programs increased access to health, 77.2% of the respondents indicated that the USA state agencies funded programs reduced cost of health care. Another 78.3% of the respondents stated that the programs increased hygiene while 78.3% of the respondents stated that the programs ensured availability of funding.

It was found that USAID efforts included strengthening the Ministry of Health Reproductive Health Logistics Unit and upgrading the Ministry of Health Rural Health Training Centers. On the NGO side, USAID earmarked funds to help FPAK, CHAK become financially stable. In an interview, a health program officer argued:

The dependency on donor funded programs means control of the entire process in healthcare in Kibra. There is need for more collaborative engagement even on training, however, this only possible if key actors get involved in genuine negotiations.

There was need for cross-tabulations of opinions on the effect of USA state agency funded programs on the health sector and the tabulations are presented in Table 4.7.

**Table 4.7: Cross Tabulation on Effects**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | p-value |
| Increased Access to Health | 100.0% | 0.0% | 78.6% | 21.4% | 0.0% | 100.0% | 0.0% | 100.0% | **80.089(3)** | **0.000** |
| Reduced Cost of Health Care | 100.0% | 0.0% | 100.0% | 0.0% | 7.1% | 92.9% | 0.0% | 100.0% | **86.729(3)** | **0.000** |
| Increased Hygiene | 78.6% | 21.4% | 92.9% | 7.1% | 78.6% | 21.4% | 50.0% | 50.0% | **5.513(3)** | **0.138** |
| Availability of Funding | 100.0% | 0.0% | 100.0% | 0.0% | 14.3% | 85.7% | 0.0% | 100.0% | **81.924(3)** | **0.000** |

From Table 4.7, it was observed that there was a statistically significant variation between the USA state agencies and health care workers opinions that it increased access to health, reduced cost of health care and availability of funding. However, there was no statistically significant variation between USA state agencies and health workers opinions that the funded programs increased hygiene.

### 4.5.2 Public Health Care Services Delivery as a Result of Capacity Building

To assess the effect of capacity building programs funded by USA state agencies on public healthcare services delivery, respondents were asked to rate the public healthcare services delivery as a result of capacity building programs funded by USA in their organizations. The responses are presented as shown in Table 4.8.

**Table 4.8: Capacity Building of Health Programs**

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

According to Table 4.8, the majority of respondents—62.0%—rated the situation as good, and 20.7%—very good. This demonstrates unequivocally that timely service delivery was made

possible by capacity building initiatives made available by US state agencies. Another 52.2% of respondents gave a very or very good rating, indicating that staff members were providing improved patient care as a result of the capacity building programs. The availability of finances was assessed as good by 38.0% of the respondents, and very good by another 43.5%, while staff motivation was regarded as good by 31.5% of the respondents, reasonably good by 64.1% of the respondents, and very good by 38.0% of the respondents.

Findings show that increasing capacity has improved health service delivery overall, although drug availability still presents a problem. However, it was highlighted that access to health is not particularly good due to other problems, as evidenced in an interview where a program health officer bemoaned Kibra locals' lack of awareness and openness to health-related issues. Thus, there is a need for more health care program sensitization of the local population. As a result, public diplomacy has gaps when the sending state is the only one involved and the host state's position is not explicitly stated.

Cross-tabulations of capacity building programs funded by USA state agencies on public healthcare services delivery was performed and presented in Table 4.9.

**Table 4.9: Cross Tabulation**

| | | USA Organizations Partners | | | | | |
|---|---|---|---|---|---|---|---|
| | | USAID | PERFAR | CDC | Bill Gates Foundation | $X^2$ | **p-value** |
| Timely Delivery of Services | Poor | 0.0% | 0.0% | 0.0% | 100.0% | **165.784(9)** | **0.000** |
| | Fairly Good | 0.0% | 0.0% | 66.7% | 33.3% | | |
| | Good | 98.2% | 1.8% | 0.0% | 0.0% | | |
| | Very Good | 0.0% | 68.4% | 31.6% | 0.0% | | |
| Care of Patients by Staff | Poor | 0.0% | 0.0% | 0.0% | 0.0% | | |
| | Fairly Good | 100.0% | 0.0% | 0.0% | 0.0% | **87.495(6)** | **0.000** |
| | Good | 52.1% | 29.2% | 18.8% | 0.0% | | |
| | Very Good | 0.0% | 0.0% | 38.5% | 61.5% | | |
| Availability of Drugs | Poor | 0.0% | 0.0% | 50.0% | 50.0% | | |
| | Fairly Good | 0.0% | 0.0% | 90.9% | 9.1% | **115.868(9)** | **0.000** |
| | Good | 45.7% | 40.0% | 2.9% | 11.4% | | |
| | Very Good | 100.0% | 0.0% | 0.0% | 0.0% | | |
| Staff Motivation | Poor | 0.0% | 0.0% | 0.0% | 100.0% | **100.976(9)** | **0.000** |
| | Fairly Good | 0.0% | 37.9% | 44.8% | 17.2% | | |
| | Good | 94.9% | 5.1% | 0.0% | 0.0% | | |
| | Very Good | 0.0% | 0.0% | 33.3% | 66.7% | | |

From Table 4.9, cross-tabulations revealed thatthere was a statistically significant variation between capacity building programs funded by USA state agencies and public service delivery (timely delivery of services, care of patients by staff, availability of drugs and staff motivation).

### 4.5.3 Programs Preference for Budgetary Support

Respondents were asked to state their opinions on which healthcare programmes that they would prefer the USA global health agencies provide budgetary support, they were also required to tick appropriately (Tick YES or NO). Their responses to this question are presented in Table 4.10

**Table 4.10: Health Programs Funded**

| | **Yes** | | **No** | |
|---|---|---|---|---|
| | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Malaria | 75 | 81.5% | 17 | 18.5% |
| Pregnancy Test | 42 | 45.7% | 50 | 54.3% |
| HIV and AIDS Tests | 78 | 84.8% | 14 | 15.2% |
| Sexual Transmitted Diseases | 74 | 80.4% | 18 | 19.6% |
| Covid19 | 78 | 84.8% | 14 | 15.2% |

From Table 4.10, 81.5% of the respondents indicated that they would prefer malaria to be funded by USA state agencies. Another 84.8% of the respondents stated that they would prefer HIV and AIDS tests to be funded by the USA state agencies. 80.4% of the respondents were in support for funding of sexually transmitted diseases and another 84.8% of the respondents supported that Covid19 should be funded by the USA state agencies. Only 45.7% of the respondents supported that pregnancy tests should be funded by the USA state agencies.

The order of choice shows that HIV/AIDS, STDs, and malaria are still major health concerns in Kibra; hence, more public diplomacy is required to address these issues in Kibra's informal

settlements. The results are consistent with USAID Kenya's (2015) study, which found that the presence of US agencies in Kibra led to the extension of services for those with HIV, strengthened human resource ability to provide those services, and improved referral networks for HIV care. The established network referral center at Kenyatta Hospital, AMREF-supported PMTCT programs, adult treatment services, pediatric treatment services, and the Kibera Community Self Help Program (KICOSHEP) are just a few of the community services that AMREF supports. Adults living in Kibera who are HIV-positive are included in the demographic targeted by this activity and will be assisted by these initiatives. However, a health professional claimed that financing is required for community sensitization initiatives to raise awareness among slum dwellers, both men and women. As a result, there is a discrepancy between program financing, awareness, and availability in Kibra. This disproves the idea that public diplomacy can be used to directly engage foreign publics through initiatives supported by the health sector.

To assess variation between the programs preferred for funding by the USA state agencies between the USA state agencies, cross-tabulations were computed and presented as shown in Table 4.11.

**Table 4.11: Cross Tabulation**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | p-value |
| Malaria | 100.0% | 0.0% | 64.3% | 35.7% | 14.3% | 85.7% | 100.0% | 0.0% | **59.282(3)** | **0.000** |
| Pregnancy Test | 16.1% | 83.9% | 100.0% | 0.0% | 92.9% | 7.1% | 75.0% | 25.0% | **51.767(3)** | **0.000** |
| HIV and AIDS Tests | 100.0% | 0.0% | 100.0% | 0.0% | 28.6% | 71.4% | 50.0% | 50.0% | **54.353(3)** | **0.000** |
| Sexual Transmitted Diseases | 100.0% | 0.0% | 28.6% | 71.4% | 42.9% | 57.1% | 100.0% | 0.0% | **52.058(3)** | **0.000** |
| Covid19 | 100.0% | 0.0% | 100.0% | 0.0% | 57.1% | 42.9% | 0.0% | 100.0% | **65.425(3)** | **0.000** |

From Table 4.11, it was observed that all the Chi-square values returned statistically significant values this means that there was a statistically significant variation between the programs preferred for funding by the USA state agencies in the USA state agencies themselves. The findings here are indicative of the differences on preferences and which programs need to be funded. Thus a disconnect between USA interests and needs at the local level which again points to the need of other actors being brought on board.

### 4.5.4 Involvement in the implementation of health care programs

Respondents were asked to state ways in which they want to be involved in the implementation of the healthcare programs offered by the international organizations in their areas. Respondents were required to tick appropriately (Tick YES or NO). Their responses are presented in Table 4.12

**Table 4.12: Community Participation**

| | Yes | | No | |
|---|---|---|---|---|
| | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Awareness Campaigns | 83 | 90.2% | 9 | 9.8% |
| Community Participation | 71 | 77.2% | 21 | 22.8% |
| Programme Implementation | 65 | 70.7% | 27 | 29.3% |
| Resources Mobilization | 35 | 38.0% | 57 | 62.0% |
| Proposal Development | 87 | 94.6% | 5 | 5.4% |

From Table 4.12, it was observed that 90.2% of the respondents would want to be involved in awareness campaigns, 77.2% of the respondents indicated that they would wish to be involved in community participation. Another 70.7% of the respondents stated that they would want to be involved in programme implementation and 94.5% of the respondents stated that they would want to be involved in proposal development. Only 38.0% of the respondents indicated that they would want to be involved in resource mobilization**.**

Findings indicate the gaps that exist in USA public health diplomacy. As findings indicate, there is need for awareness of existence of these programs to locals in Kibra. In an FDG, a health worker lamented that most locals are ignorant andrelactant to partake of some health programs such as family planning and vaccinations this is because of the perception that they may be affected negatively by them. This brings to the fore aspects of community participation in USA public health diplomacy programs where needy programs are mounted by USA sate agencies. The gap here is that public diplomacy may not be effective unless there is rigorous community participation, since some actors are forgotten in public diplomacy as a sub-

discipline of diplomacy in general. In fact, resources are wasted as a result of them not achieving the goals intended.

To ascertain this, cross-tabulation between the various ways in which the respondents would wish to be involved and the USA state agencies was also performed in order to understand the level of variation, this is presented as shown in Table 4.13.

**Table 4.13: Cross Tabulation on Community Participation**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | p-value |
| Awareness Campaigns | 100.0% | 0.0% | 100.0% | 0.0% | 35.7% | 64.3% | 100.0% | 0.0% | **55.580(3)** | **0.000** |
| Community Participation | 100.0% | 0.0% | 14.3% | 85.7% | 50.0% | 50.0% | 75.0% | 25.0% | **53.885(3)** | **0.000** |
| Programme Implementation | 66.1% | 33.9% | 42.9% | 57.1% | 100.0% | 0.0% | 100.0% | 0.0% | **14.921(3)** | **0.002** |
| Resources Mobilization | 33.9% | 66.1% | 0.0% | 100.0% | 92.9% | 7.1% | 37.5% | 62.5% | **26.846(3)** | **0.000** |
| Proposal Development | 100.0% | 0.0% | 100.0% | 0.0% | 64.3% | 35.7% | 100.0% | 0.0% | **29.458(3)** | **0.000** |

From Table 4.13, cross-tabulations values returned statistically significance values, this shows that there was a statistically significant variation between the USA state agencies in program involvement. As mentioned, the need to bring on board other actors like benefitting community through public participation and awareness is important to the general practice of public diplomacy.

### 4.5.5 Level of satisfaction of capacity building programs

The researcher was interested to explore the level of satisfaction of the respondents with the capacity building programs. To achieve this, respondents were asked to state their level of satisfaction about the capacity building programmes offered by USA International Organization in their health facility. There responses are as shown in Figure 4.5.

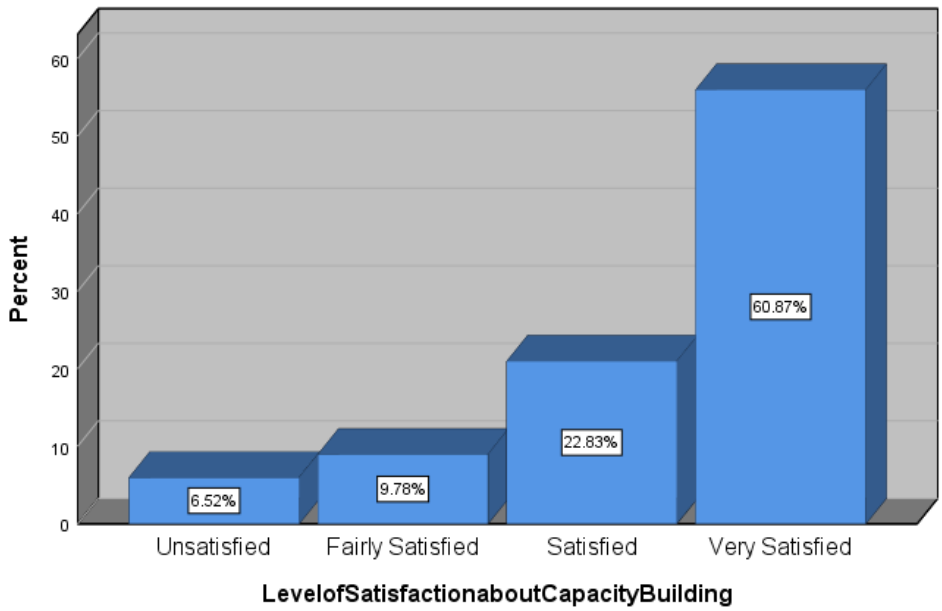



**Figure 4.5: Level of Satisfaction**

From Figure 4.5, it was observed that majority 60.87% of the respondents were very satisfied with the capacity building programs offered by USA international organizations. Another 22.83% of the respondents indicated that they were satisfied with the capacity building programs, 9.78% of the respondents stated that they were fairly satisfied while only 6.52% of the respondents indicated that they were unsatisfied.

The satisfaction of the mentioned capacity building is limited to NGOs and the USA funding organizations. In an FDG interview, a health worker however, pointed out that the same may not apply to the general public in Kibra. This relates to lack of awareness on the side of the public and the perception that some programs are a plot by USA to harm them. Thus, perception is a key aspect of public diplomacy that makes it ineffective if the receipients perceive the intentions negativels as is the case with some of the health programs promoted by USA health organizations in Kibra.

To asses the level of variation of the levels of satisfaction between the USA state agencies and levels of satisfaction among the health care workers, a cross-tabulation was performed and this is presented in Table 4.14.

**Table 4.14: Tabulation on Satisfaction**

| | | USA Organizations Partners | | | | | |
|---|---|---|---|---|---|---|---|
| | | USAID | PERFAR | CDC | Bill Gates Foundation | $X^2$ | p-value |
| Level of Satisfaction about Capacity Building | Very Unsatisfied | 0.0% | 0.0% | 0.0% | 0.0% | | |
| | Unsatisfied | 0.0% | 0.0% | 0.0% | 100.0% | | |
| | Fairly Satisfied | 0.0% | 0.0% | 77.8% | 22.2% | **186.556(9)** | **0.000** |
| | Satisfied | 0.0% | 66.7% | 33.3% | 0.0% | | |
| | Very Satisfied | 100.0% | 0.0% | 0.0% | 0.0% | | |

From Table 4.14, the Chi-square test value $(X^2(9) = 186.556, p = 0.000)$ revealed that there was a statistically significant variation between the levels of satisfaction about the capacity building programs offered by the USA international organizations.

### 4.5.6 Benefits of the Capacity Building Programs to the Local Community

Respondents were asked to state ways in which the capacity building programme were of benefit to the community. Their responses are as shown in Figure 4.6.

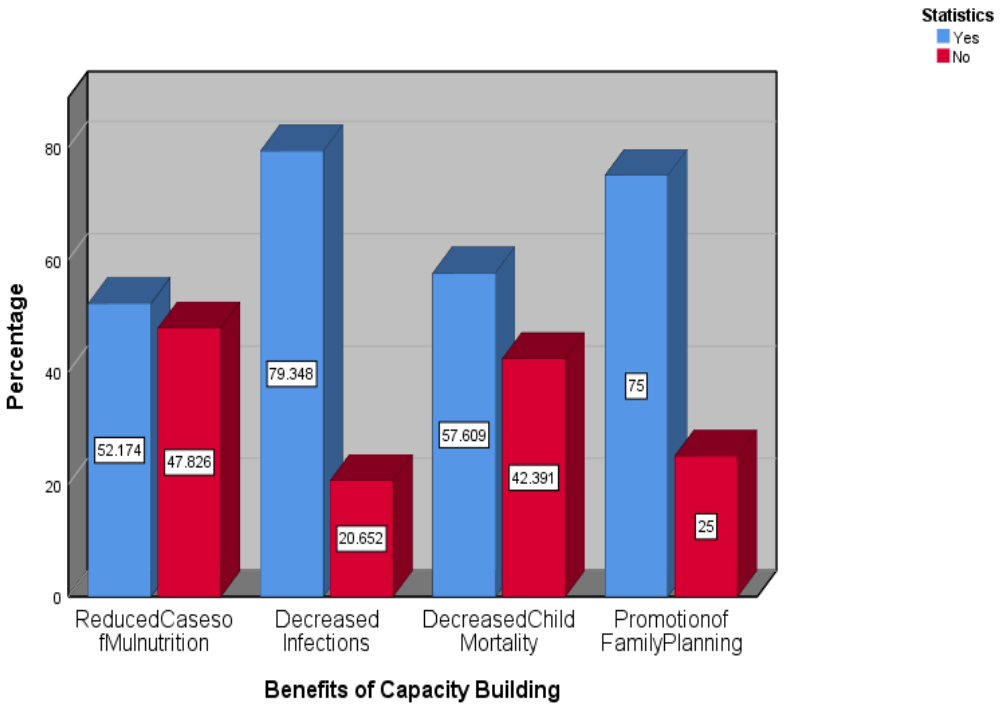



**Figure 4.6: Benefits of Capacity Building**

From Figure 4.6, it was observed that 52.17% of the respondents indicated that capacity building programs reduced cases of malnutrition in the community, 79.34% of the respondents stated that the capacity building programmes decreased infections. Another 57.60% of the respondents stated that the programmes decreased child mortality and 75% of the respondents indicated that the programmes promoted family planning. This clearly shows that the capacity building programmes had a positive influence to the communities.

A cross-tabulation was also performed to determine variation of the benefits of capacity building programmes in the USA international organization, this is presented in Table 4.15.

**Table 4.15: Benefits of Capacity Building**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | $X^2$ | p-value |
| | Yes | No | Yes | No | Yes | No | Yes | No | | |
| Reduced Cases of malnutrition | 80.4% | 19.6% | 0.0% | 100.0% | 0.0% | 100.0% | 37.5% | 62.5% | **49.062(3)** | **0.000** |
| Decreased Infections | 100.0% | 0.0% | 64.3% | 35.7% | 0.0% | 100.0% | 100.0% | 0.0% | **72.385(3)** | **0.000** |
| Decreased Child Mortality | 41.1% | 58.9% | 100.0% | 0.0% | 100.0% | 0.0% | 25.0% | 75.0% | **30.358(3)** | **0.000** |
| Promotion of Family Planning | 96.4% | 3.6% | 0.0% | 100.0% | 64.3% | 35.7% | 75.0% | 25.0% | **56.571(3)** | **0.000** |

From Table 4.15, all the Chi-square values returned statistically significant values indicating that there was a statistically significant variation between the benefits of the capacity building programmes in the USA international organizations.

## 4.6 Evaluation of the Effect of USA International Organizations Funding and Budgeting on Public Healthcare Services Delivery

The third objective of this study was to evaluate the effect of USA international organizations funding and budgeting on public healthcare services delivery in Kenya. To achieve this, respondents were asked to state challenges their organization encountered in regard to partnering with USA health organizations. Their responses are presented in Table 4.16.

**Table 4.16: Challenges for NGOs**

| | Yes | | No | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| Restricted Funding | 63 | 68.5% | 29 | 31.5% |
| Stringent Requirements for Funding | 75 | 81.5% | 17 | 18.5% |
| Diplomatic Interests | 33 | 35.9% | 59 | 64.1% |
| Donor Supervision | 51 | 55.4% | 41 | 44.6% |

From Table 4.16, it was observed that 68.5% of the respondents experienced challenges of restricted funding, 81.5% of the respondents experienced challenges of stringent requirements for funding, another 55.4% of the respondents experienced donor supervision as a challenge while only 35.9% of the respondents indicated that they experienced diplomatic interests as a challenge.

As findings indicate, most local health NGOs reported challenge with regard to funding that is advanced tied to the donor interests. Even while Kenya is nonetheless responsible under international law for protecting its residents' right to health, the USA's diplomatic interests in other areas show how Kenya's control over the delivery of healthcare is undercut. Donor funding has changed in favor of NGO delivery of health care services and away from block funds at the federal level. As a result, government organizations like the Ministry of Health have lost donor financing, while regional health NGOs profit. Similar to many other poor nations, local NGOs in Kenya distribute financing and budgets rather than national governments.

Although this reliance on NGO's may have led to an effective use of donor money, it is less apparent whether it has led to a more effective use of health care funds overall. More crucially, the tactic contributed to the development of a system that is especially susceptible to constraints imposed by the US. With regard to the regulation of family planning, USAID's reproductive health policymaking was distinguished by a position of political neutrality. In the 1967 Guideline for Assistance to Population Programs, for instance, it was noted that USAID does not support any particular population strategy for other countries, including family planning and other health issues. But the goal is to offer aid when it is required so that everyone can enjoy the fundamental right to manage their own reproductive, health, and welfare decisions (WHO, 2000).

To determine variation of the challenges faced by health facilities across the USA international organizations, a cross-tabulation between the challenges encountered and the USA international organizations was performed and presented as shown in Table 4.17.

**Table 4.17: Cross Tabulation on NGOs Challenges**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | **p-value** |
| Restricted Funding | 98.2% | 1.8% | 0.0% | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% | **87.450(3)** | **0.000** |
| Stringent Requirements for Funding | 100.0% | 0.0% | 100.0% | 0.0% | 28.6% | 71.4% | 12.5% | 87.5% | **67.224(3)** | **0.000** |
| Diplomatic Interests | 58.9% | 41.1% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | **33.080(3)** | **0.000** |
| Donor Supervision | 26.8% | 73.2% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | 0.0% | **47.546(3)** | **0.000** |

From Table 4.17, all Chi-square values returned statistically significant values indicating that there was a statistically significant variation between challenges encountered in the USA international organizations. In summary, dependency on donor funding in many categories of health programs can be ineffective for actors involved. the donors, for instance, as indicated in an interview with an administrator in one of the health NGO, is that donor agencies are keen on service delivery and once done there is no assurance that contract sould be renewed. Therefore, issues of sustainability of these health programs are a focus when dependency aspect creep in. In an interview with a CEO of international organization, it was found that there is need for a linkage between permanent structures within the government and these NGOs for matters of sustainability of health programs. The researcher thus focused on issue of funding sustainability as discussed next.

### 4.6.1 Sustainablity of Funding

Respondents were asked to state whether there a time when funding was cut or suspended, here they were required to respondent by ticking appropriately (YES or NO). Their responses are as shown in Figure 4.7.

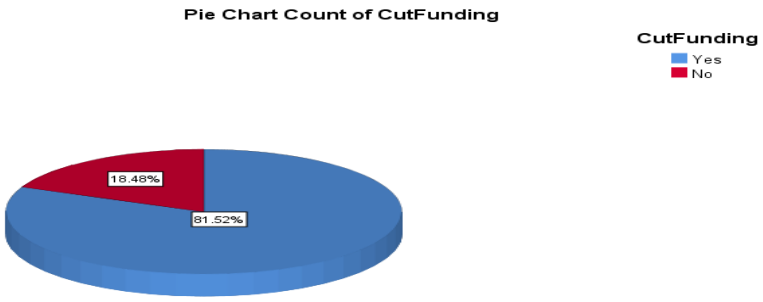



**Figure 4.7: Cutting Funding**

From Figure 4.7, majority 81.52% of the respondents indicated that they experienced funds being cut down. The aspect of cutting funds is not new in the Kenyan experince. For instance,Mehlika*et al*., (2004) saysUS health policy which was later became to be known as the Mexico policy affected healthcare service in Kenya negatively. Notes that when President Bush reinstated the Mexico City Policy in 2001, two NGOs, Marie Stopes International (MSI) and the Family Planning Association of Kenya (FPAK), who had previously been significant partners of USAID in Kenya, refused to sign the required pledge. Observes that as a result, both NGO's suffered severe financial losses and were compelled to shut down clinics, scale back services, charge higher fees or impose new ones, and limit outreach and education initiatives. Faced with this substantial loss of funds, FPAK had to make difficult decisions about eliminating staff and services.This explains how donor diplomatic intrests affect health diplomacy of recipient countries caused by the stoppage and reduction of funds due to change of donor policies.

The FPAK Eastleigh clinic opened in 1984 in a heavily populated slum that is now home to numerous refugees from the Democratic Republic of the Congo, Ethiopia, and Somalia. It closed its doors in 2002. Due to the lack of government health facilities in the area, residents were forced to seek out additional health services, including family planning, STD testing, and medical care. The clinic also provided care for women who lived in Mathare Valley, one of Nairobi's most underdeveloped urban regions. Due to its close proximity to the Eastleigh Youth Counseling Center (YCC), the Eastleigh clinic offered crucial services to teenagers. Numerous health services were cut after these clinics closed as a result of a decrease in donor funding, and the staff members who worked there were laid off.

Cosequently ,the clinics which remained started to impose fees for their services and most of their health workers lost their jobs. According to the study, a fee structure was put in place so

that residents of disadvantaged areas would pay market prices for services and utilize the money to subsidize services for the poor because USAID funding was not available. After the cuts, FPAK discovered that the cross-subsidization program does not produce enough cash to support clinics in rural and underdeveloped urban areas. As indicated in this study, donor states forced their health policy down the recipient countries even if they were not able to respond to health needs of the people.The dangers of donor dependency can be interpreted diplomatically in terms of state interest. First, issues of accountability and monitoring gaps in public diplomacy emerge since some key actors are cut off the diplomatic channel. To determine variation of cutting funding in the health facilities across the USA international organizations, a cross-tabulation between cutting funding and the USA international organizations was performed and presented as shown in Table 4.18.

**Table 4.18: Cut on Funding**

| | USA Organizations Partners | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | USAID | | PERFAR | | CDC | | Bill Gates Foundation | | | |
| | Yes | No | Yes | No | Yes | No | Yes | No | $X^2$ | p-value |
| Cut Funding | 100.0% | 0.0% | 28.6% | 71.4% | 64.3% | 35.7% | 75.0% | 25.0% | **41.738(3)** | **0.000** |

From Table 4.18, the Chi-square test value of $(X^2(3) = 41.738, p = 0.000)$ indicates that there was a statistically significant variation between cutting funds in the facilities in the USA

state agencies. The reason for cutting funding was basically due to end of contract. However, scaling down on health programs is another reason due to reduced funding. In both cases, the effects are loss of jobs, reduced health programs and other related issues. In an interview, a health program officer argued that sometimes withdrawal of funds, reduction or cutting are due to politics that can be deliberate in nature. This statement points to politics as a reason for cutting funding to purnish the beneficiary state when it fails to comply with donor funding requirements.

This finding concurs with Peter (1997) assertion that even domestic politics in the donor country can affect level of funding. For instance, following the U.S. policy statement in Mexico City, USAID promulgated agency guidelines to administer the new funding restrictions which eventually affected the way donor funding was being done.

#### 4.6.1. 2 Effect of reduction on funding

For those who experienced cuts in funding respondents were required to state how the reduction in funding affected their operations. The respondents were required to tick appropriately and their responses presented as shown in Table 4.19.

**Table 4.19: Effects of Reduced Funding**

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Scaled down operations | 37 | 40.2 | 40.2 | 40.2 |
| Closed some units | 15 | 16.3 | 16.3 | 56.5 |
| Closed down | 10 | 10.9 | 10.9 | 67.4 |
| Retrenched some employees | 30 | 32.6 | 32.6 | 100.0 |
| **Total** | **92** | **100.0** | **100.0** | |

From Table 4.19, majority 40.2% of the respondents indicated that they scaled down operations due to funds cut, 32.6% of the respondents stated that they had to retrench some employees due to funds cut. It was also observed that 16.3% of the respondents stated that they had to close down some units due to the funds cuts while only 10.9% of the respondents indicated that they closed down due to funds cut. Therefore, some NGOs close doors completely due to lack of funding. The effect of this is that access to the very health services cease to exist in Kibra as a result which calls to question donor funded programs that are unsustainable when other actors are not on board.

To determine variation of the effects of cutting funding in the health facilities across the USA international organizations, a cross-tabulation between effects of cutting funding and the USA international organizations was performed and presented as shown in Table 4.20.

**Table 4.20: Cross Tabulation on Funding**

| | | USA Organizations Partners | | | | | |
|---|---|---|---|---|---|---|---|
| | | USAID | PERFAR | CDC | Bill Gates Foundation | $X^2$ | **p-value** |
| Effects of Funding Reduction | Scaled down operations | 24.3% | 16.2% | 37.8% | 21.6% | | |
| | Closed some units | 100.0% | 0.0% | 0.0% | 0.0% | **54.288(9)** | **0.000** |
| | Closed down | 100.0% | 0.0% | 0.0% | 0.0% | | |
| | Retrenched some employees | 73.3% | 26.7% | 0.0% | 0.0% | | |

From 4.20, the Chi-square test value of $(X^2(9) = 54.288, p = 0.000)$ indicates that there was a statistically significant variation between the effects of funding reduction in the USA state

agencies. The effects of freezing donor funds also have socio-economic effects as indicated in table 4.20. Public diplomacy as a result may not be effective in the long run when traditional diplomatic channel are absent completely as discussed next.

### 4.6.3 Level of government involvement

Finally, the respondents were asked to state the level of the government involvement concerning funded programs in their facilities. The respondents were required to rate between very involved, involved, not involved and I do not know. Finding indicate that majority 83.70% of the respondents indicated that the government was not involved while 16.30% of the respondents stated that the government was involved. Central government involvement is cut off at stages of contract agreements between the local NGOs and USA health organizations. Since public diplomacy focus is about the involvement of the donor contries hence limiting the role of host to advisory and surpvisory from a remote point of view. This stand point was collaborated by CEO in one of the government health institutionwho argued that the responsibility funding and surpervision of health programs is therefore considered the function of major players such as health NGOs and international funding agencies.As mentioned earlier,the effectiveness of public diplomacy becomes a major issue when the stakeholders have not dealt with the gaps concerning public health diplomacy more particulary among the recipient countries.

# CHAPTER FIVE

# SUMMARY, CONCLUSION AND RECOMMEDNATIONS

## 5.1 Introduction

This chapter presents an overview of the study's results, draws a conclusion, and offers suggestions. This is carried out in accordance with the three distinct goals.

## 5.1 Summary of Findings

The firstobjectiveexamined the nature and extent of USA international organizations partnership in public healthcare services delivery in Kenya. It was observed that 100% of the respondents indicated that the kind of partnership their organizations had with the USA international health organizations was formal. In thiscase, formality means that the NGOs that provide health services in Kibra had formal agreements with USA organizations championing health public diplomacy on various programs. The details of contract however was mostly dictated by these international organizations. This leaves out the host government as an actor. The aim is to provide health services to poor population directly, however, this can only be done through proxies that have grassroot organization and thus we reach the locals through the media adverts. This assertion reflects essence of public diplomacy. Public diplomacy may also be viewed as propaganda for a nation state by enhancing its image overseas in a way that will be advantageous to the state. Public diplomacy focuses at promoting its culture for long-term goals while short-term when it comes to current foreign policies (Berridge,2005). It was noted that 100% of the respondents said they had cooperated with US state authorities to provide effective healthcare. Only 6.5% of the respondents said that the USA agencies collaborated with them on polio and measles vaccination campaigns. It was also observed that 92.4% of the respondents indicated that they partnered in Diet and Nutrition Enhancement.

Another 47.8% of the respondents stated that these organizations partnered with them in Sanitation Improvement. 59.8% of the respondents agreed that the USA organizations partnered with them in Sexually Transmitted Disease. It was also observed that 31.5% of the respondents stated that the USA organizations partnered with them in Communicable Diseases and Cholera while only 16.3% agreed that the USA state agencies partnered with them in Non-Communicable Diseases. This finding are indicative of USA organization resolve to prioritize some programs which may not serve health needs of the poor populations in Kibra.

The second objective evaluated the impact of American foreign organizations on Kenyan public healthcare service delivery capacity building. The Ministry of Health's Reproductive Health Logistics Unit was discovered to be strengthened, and the Ministry of Health's Rural Health Training Centers were upgraded. On the NGO front, USAID set aside money to support FPAK and CHAK's transition to financial stability. Findings show that increasing capacity has improved health service delivery overall, although drug availability still presents a problem.Also, access to health is not realy positive as a result of other factors as indicated in an interview where a program health officer lamented of little awareness and receptiveness by Kibra local to issues of health. It was observed that 90.2% of the respondents would want to be involved in awareness campaigns, 77.2% of the respondents indicated that they would wish to be involved in community participation. Another 70.7% of the respondents stated that they would want to be involved in programme implementation and 94.5% of the respondents stated that they would want to be involved in proposal development. Only 38.0% of the respondents indicated that they would want to be involved in resource mobilization**.**

The third objective evaluated how the USA international organizations funding and budgeting affect public healthcare services delivery in  Kenya.it was observed that 68.5% of the respondents experienced challenges of restricted funding, 81.5% of the respondents experienced challenges of stringent requirements for funding, another 55.4% of the respondents experienced donor supervision as a challenge while only 35.9% of the respondents indicated that they experienced diplomatic interests as a challenge. As findings indicate, most local health NGOs reported challenge with regard to funding that is advanced tied to the donor interests. Such interests affect level of funding asmajority 40.2% of the respondents indicated that they scaled down operations due to funds cut, 32.6% of the respondents stated that they had to retrench some employees due to funds cut. It was also observed that 16.3% of the respondents stated that they had to close down some units due to the funds cuts while only 10.9% of the respondents indicated that they closed down due to funds cut. Therefore, some NGOs close doors completely due to lack of funding.

**5.2 Conclusions**

From the finding of objective one, finding are indicative of USA organization resolve to prioritize some programs which may at sometimes not serve health interests of the poor populations in Kibra.Thus, public health diplomacy may serve interests of the USA and not the recepients as from illustrated findings. This isreflects the ineffectiveness of some of the programs.

According to goal two's findings, building capacity is only for NGOs, which excludes educating Kibra inhabitants about health programs. When left to the sending state and when the local community's role is not clearly defined, public diplomacy has shortcomings.

From findings of objective three, scaling down on health programs is another reason for reduced funding. Effects are loss of jobs, reduced health programs and other related issues. In conclusion, politics as a reason for cutting funding to purnish the beneficiary state when it fails to play along interest of donors

### 5.3 Recommedations

The first objective states that there must be synergy between Kenya's national health strategy and the health initiatives of international organizations. This draws attention to the need for public diplomacy to involve more actors in order to be effective.

The second purpose states that residents of Kibra must be made aware of the existence of these health programs, therefore community involvement is crucial in addition to the work of NGOs' health workers.

Accordingto the third objective, for sustainable access to health services in Kibra donor funded programs need to sustainable and void of politics of donor and receiving state.

### 5.4 Suggestions for Further Research

1. How can donor agencies increase collaboration and partnership globally.
2. Research on the monitoring, evaluation and implementation procedures and how they affect the efficiency of internationally funded projects.
3. What are the factors that influence funding of particular health projects

## REFERENCES


Abbott F. (2005). The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health. *American Journal of International Law*.Volume 58, Issue (317).

Adams V, Novotny T, Leslie H. (2008).Global Health Diplomacy.*Journal of Medical Anthropology*.; Volume(4), Issue 23.

Adedimeji, A.A, Omololu. F and Odutolu, O (2007), "HIV risk perception and constraints to Allan Bryman, A. (2008*), social research methods* published in the United States by Oxford University press, 3rd Edition.

Alvaro B. (2004).HIV/AIDS in Africa*:* International Responses to the Pandemic, 11 *Journal of New Economy*Volume 5, Issue 66

Amis, P. and C. Rakodi (1994),. "Urban poverty: issues for research and policy", *Journal of International Development* Vol.6,.No.5. 3.

Amorim C, Douste-Blazy P, Wirayuda H, Støre JG, Gadio CT, Dlamini-Zuma N, Pibulsonggram N. (2007). Oslo Ministerial Declaration—Global Health: *A Pressing Foreign Policy Issue of Our Time*. The Lancet Publication, Oslo

Beth R. Crip. Hal Swerissed, Stephen J. Duckett (2000), four appearances to capacity building in health: consequences for measurement and accountability. *Journal of Health Promotion International*. Volume 15, Issue 2.

Bonventre, E. V., Hicks, K. H., and Okutani, S. M. (2009).US National Security and Global Health: An Analysis of Global HealthEngagement by the U.S. Department of Defense. Washington, DC

Botes, L and Reneburg, D.V. (2000).Community participation in development; nine plaques and twelve commandments community participation in *Development Journal*, Volume 2, issue 10

Brian Pratt, John Hailey, MachelaGailo, Rebecca Schadwick and Rachel Hayman, (2012).CDC (Centers for Disease Control and Prevention) Annual Report 2006. 2006 Available at http://www.cdc.gov/globalhealth (accessed October 15, 2010) [Google Scholar]

CDC (Centers for Disease Control and Prevention) Annual Report (2008). 2008 Available at http://www.cdc.gov/globalhealth (accessed October 15, 2010) [Google Scholar

Charles W. Freeman III and Xiaoqing Lu Boynton (2011., *China's Emerging Global Health and Foreign Aid Engagement in Africa*. City: Center for Strategic and Internationsl Studies (ESIS).

Congressional Research Service. Foreign Aid (2009): An Introduction to U.S. Programs and Policy. (CRS Report for Congress R40213). Washington, DC: US GPO; 2009. [Google Scholar]

Davies, S. E. (2010). *Global Politics of Health* 1st Edition. Cambridge, London

Denzin W. K. and Linccolin, Y.S. (1994), Introduction; Entering the field of Quantitative Department Sydney.MartynHammersly Qualitative Research Controversies and Context. Sage Publications Ltd, Oliver Yard 55 City Road London.

Kothari R. (2010), Research methodology, methods and techniques, 2nd Edition; published by New age international ltd, India.

Debasih C. (2012), Research Methodology published by Saurash, New Delhin.

Miriam O.StepheneJ. Wanja, R. (2016). Comparative Study of Kenya US, EU and China Trade and Investment Relations Published by Institute of Economic Affairs, Nairobi, Kenya.

Encyclopedia of Public International Law 368 (2000) (discussing self-determination). ICJ Judge Mohammed Bedjaoui states that "[t]herightto development flows from the right to self-determination and is of the same kind

Faid M. (2012).Tackling cross-sectoral challenges to advance health as part of foreign policy. Oslo

Fidler D. (2010).Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5N1 and Pandemic Influenza H1N1.

Frishman A. (2009).Major Reason for Nigerian Boycott of Polio Vaccine.Health Affairs. 2009;28(6):1860–61. [PubMed] [Google Scholar

Gates Foundation.(2010). Foundation Fact Sheet. Available at http://www.gatesfoundation.org/about/Pages/foundation-fact-sheet.aspx (accessed January 30, 2011)

Global *Journal of Advanced Research* (2015). The Dilemma in Sustainable of Community Based, Volume 3, Issue 12

Goyet, C. (1999).Stop propagating Disaster myths. Pan America http:// www.pano.org

HealyhFinacing in Kneya (2011), the Case of RH/FP. Publisher, German Foundations for World Population (DSW) and Institute for Education if Democracy (IED).in Applied Statistics Research;.New York, USA.

Javan, I. O and Ongondo, C. O. (2011).*QualitativeResearch, an introduction to principles and techniques*,Moi University press, Eldoret, Kenya.

Kates J, Katz R. (2010). US Participation in International Health Treaties, Commitments, Partnerships, and Other Agreements. Washington, DC.

Kates J., Wexler A., Valentine A. (2011). Donor funding for health in low- & middle-income countries, 2002-2009 [Internet]. Menlo Park (CA): Kaiser Family

Foundation; 2011 Nov. [cited 2012 Oct 5]. 27 p. Available from: http://www.kff.org/globalhealth/7679.cfm [Google Scholar]

Kauffmann J, Feldbaum H. (2009).Diplomacy and the Polio Immunization Boycott in Northern Nigeria.Health Affairs. 2009;28(4):1091–1101. [PubMed] [Google Scholar

Kickbusch I, Silberschmidt G, Buss P. (2007). Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health. Bulletin of the World Health Organization. 2007;85(3):230–32. [PMC free article] [PubMed] [Google Scholar

Kickbusch, I. (2009). "Making Global Health Governance Forward,"in Kent Buse, Wolfgang Hein, and Nick Drager (eds) *Making Senseof Global Governance: A Policy Perspective*. New York: PalgraveMacmillan, 320–39.

Kirigia JM, Gbary AR, Muthuri LK, Nyoni J, (2006). Seddoh A. The Cost of Health Professionals' Brain Drain in Kenya.BMC Health Services Research. 2006;6:89. [PMC free article] [PubMed] [Google Scholar

Leslie HH, Sun Z, Kruk ME (2017). Association between infrastructure and observed quality of care in 4 healthcare services: A cross-sectional study of 4,300 facilities in 8 countries.

Lu C., Schneider M. T., Gubbins P., Leach–Kemon K., Jamison D., Murray C. J. (2010).Public financing of health in developing countries: a cross-national systematic analysis. Lancet. 2010;375(9723), 1375–1387 10.1016/S0140-6736(10)60233-4 [PubMed] [CrossRef] [Google Scholar]

Lyndon B. Johnson, Special Message to Congress on the Foreign Aid Program ( 1966).in Public Papers of the Presidents of the United States,Lyndon B. Johnson, Vol. I at 119 (1967)

Makino T. (2011). New Era for International Health Law?Health Security vs. Equity. Washington, DC: 2011. Stimson Center. Available at http://www.stimson.org/spotlight/new-era-for-international-health-law-health-security-vs-equity-/

Maryann Lansk8ang and Rodo to Dennis (2004), Building capacity in Health Research in the Development World published by the World Health Organization.

Massoud MR, Kimble L. (2018). The USAID ASSIST Project's approach to improving health care in low and middle-income countries. *Technical Report*.Published by the USAID ASSIST Project. Chevy Chase, MD: University Research Co., LLC (URC)

MatrynHammerley and Anna Traianou (2012).Ethics in Quantitative Research, controversies and contexts.Age publication ltd. Oliver yard ss City Road, London.

McNinnes, C. and Lee, K. (2012).*Global Health and InternationalRelations*. Cambridge UK: Polity.

MehlikaHoodbhoy, Martin S. Flaherty and Tracy E. Higgins (2004): Exporting Despair, The Human Rights Implications of U.S. Restrictions on Foreign Health Care Funding in Kenya. The Crowley Program, in International Human Rights

Michaud J., Kates J. (2012). Raising the profile of diplomacy in the U.S. global health response: a backgrounder on global health diplomacy [Internet]. Menlo Park (CA): Kaiser Family Foundation; 2012 Sep. [cited 2012 Oct 5]. 8 p. Available from: http://www.kff.org/globalhealth/8360.cfm [Google Scholar]

Moran, M. (2014). Private Foundations and Development Partnerships: American Philanthropy and Global Development Agenda. New York: Routledge.

Mugenda and Mugenda (2003), Research Methods Quantitative and Qualitative Approaches Published in Nairobi, Kenya.

Mwatsuma K. Mwamuye,I And Nyamu,H.M(2014) Devolution Of Health Care System in Kenya: A Strategic Approach And Implementation In Mombasa County,Kenya.International Journal of Advanced.Research, Volume 2 Issue 4, 263-268.

Nachmias, C. F. (1996), Research Mehtods in the Social Sciences; London; St, Martins Press inc.

NSW Health (2001), k8A Framework for Building Capacity to improve Health. NSW Health

Nye, J. S. Jr. (2004). *Soft Power: The Means to Success in WorldPolitics*. New York: Public Affairs.

Organisation for Economic Co-operation and Development (2007).Recent Trends in Official Development Assistance to Health. Paris, France: Organisation for Economic Co-operation and Development; 2007. ( http://www.oecd.org/dataoecd/1/11/37461859.pdf). (Accessed November 24, 2009) [Google Scholar]

Parmar, I. (2012). *Foundations of the American Century: TheFord, Carnegie, & Rockefeller Foundations in the Rise of AmericanPower*. New York: Columbia University.

PEPFAR (2012). "Public-Private Partnership Announces Immediate40 Percent Cost Reduction for Rapid TB Test," PEPFAR website,http://www.pepfar.gov/press/releases/2012/196090.htm

Peter J. Spiro, *The States and International Human Rights,* 66 Fordham L. Rev. 567, 574-75 (1997).

Philip A. Gerard Q. (1986).*The Nature and Scope of State Parties' Obligations Under the ICESCR*, 9 Hum. Rts Q. 156, 186 (1986).

Ravenholt, R. (1967).*The A.I.D. Population and Family Planning Program—Goals, Scope, and Progress*, 5 Demography 561, 562 (1968) (quoting U.S. Agencyfor Int'l Dev., Guidelines for Assistance to Population Programs, M.O. 1612.57 (1967)).

Rachlis B, Naanyu V, Wachira J, Genberg B, Koech B, Kamene R. (2016) CommunityPerceptions of Community Health Workers (CHWs) and Their Roles in Management for HIV, Tuberculosis and Hypertension in Western Kenya. PLoS ONE 11(2): e0149412. doi:10.1371/journal.pone.0149412

Ranjt Kumar (2014), Research Methodology by Sage Publications, California.

Singh A.S. and Masuku, M.B. (2014), Sampling Techniques and Determination of Sample size Research.In Handbook of Qualitative Research Londo Sage.

Stefan Al (2014), villages in the city; a guide to south USA's informal settlements.The constitution of Kenya 2010.

U.S. President's Emergency Plan for AIDS Relief (2015). *Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between PEPFAR and Faith-based* U.S. Department of State. *Organizations to Build Capacity for Sustained Responses to HIV/AIDS.*Washington, DC: 1518 Clifton Rd, NE

USAID Health-Related Research and Development Progress Report.(2014). Bureau for Global Health. Washington, D.C.

USAID Kenya (2015), Health Population and nutrition, Kenya.USAID website, "Mission, Vision and Values," webpage, https://www.usaid.gov/who-we-are/mission-vision-values; Obama Administration, Office of the White House Press Secretary, "Statement by the President on Global Health Initiative*,"* May 5, 2009; Obama Administration, *National Security Strategy*, 2010; Obama Administration, *National Security Strategy*, 2015; White House, *National Security Strategy*, 2017.

USAID. (2015). U.S. Agency for International Development 1300 Pennsylvania Avenue, NW Washington, DC 20523 Tel: (202) 712-0000 Accessedon02/03/2020 from https://www.usaid.gov/sites/default/files/documents/1864/HSS-Vision.pdf

USAID. (2019). Strengthening Health systems to support HIV and AIDS prevention, care and treatment September 18, 2019 Accessed on 25/02/2020 from https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/strengthening-health-systems-support-hiv-and

USAID.(2012). USAID's global health strategic framework better health for development executive summary. Retrieved on 24th/ January 2020,

fromhttps://www.usaid.gov/sites/default/files/documents/1864/gh_framework_es2012.pdf

USAID/KENYA Integrated Strategic Plan 2001-2005, at 111 (2000),

USAID/Kenya, Annual Report FY 2004, at 4 (2004).*available at* http://pdf.dec

Walter Rodney (1974), How Europe underdeveloped Africa. Howard University Press

WHO (2002), Community Participation in Loacl a Helath and Sustainable Development

Wolffel G. (1997), Media and Political Conflict: News From the Middle East Cambridge; Cambridge University Press.

World Health Organization (2013), state of Health Financing in the African Region.

World Health Organization (2015).Improving environmental health conditions in low income settlementsKom and where it goes.

World Health Organization, Global Strategy for Health for All by the Year 2000, 71-77 (1981), *available at* http://whqlibdoc.who.int/publications/9241800038.pdf.

World Health Organizations (2015), "Framework of Engagementwith Non-State Actors Report by Secretariat," http://www.who.int/about/who_reform/non-state-actors/en/.

Youde, J. (2012). *Global Health Governance*. Cambridge UK:PolityPress.

Zikmund W. (1999), *Business Research Metods*, Chicago: The Dryden Press.

# APPENDICES

## APPENDIX I: Introduction letter

**Dear Respondent,**

I am a student pursuing a masters of Arts degree in international relations at Kisii University, Nairobi Campus. I am carrying out a research on the topic of the analysis of the contribution of USA International Organizations to Public Health Service delivery in Kenya, the case of Kibra Sub-county. The study will examine the extent of USA Internal Organizations partnership with other actors to provide Public Health Care Services and assess their contriubution on capacity building in Public Health Care Development and evaluate how internal funding requirements affect Public Health Service Delivery in Kenya. Your response will be treated with high regard and confidentiality. I therefore, kindly ask for your acceptance and contribution to this work by answering the questionnaire.

Thank you very much.

**Benson NyagakaOntieri**

**APPENDIX II:Questionnaire for Directors (KEMRI, NASCOP, Ministry of Health), administrators and Managers of health based organizations**

**Section A: General: Information Questionnaire**

This questionnaire is meant for Masters Project Research study. The information required is purely for academic and not for any other purposes. The information provided shall be treated as confidential. Please feel free and answer the questions below. Thank you for accepting to participate.

Please mark with a tick ( ) the appropriate answer to the following questions

1. Please indicate your Gender

Male ( ) Female ( ) Other ( )

2. Please indicate your age?

18-30 yrs ( )
31- 43 yrs ( )
44-56 yrs ( )
57-60 yrs ( )

3. Your highest level of education?

Certificate ( )

Diploma ( )

Undergraduate ( )

Post graduate ( )

Others ( )

4. How long have you worked in this organization?

Less than 1 years ( )

1-3 years ( )

4-6 years ( )

7-10 years ( )

More than 10 years ( )

**Section B**

**Objective 1: Nature and extent of USA international health organizations towards Public Health service delivery in Kibra Sub County.**

i)Which of the following USA organizations partner with your organization in delivery of health care services in Kenya?(Tick YES or NO)

a) USIAD b) PERFAR c) CDC d) Bill Gates Foundation

ii) a) How can you describe the kind of partnership your organization has with USA international health organizations

b) ad hoc ii) formal agreement iii) informal agreement iv) humanitarian

iii) Do you think USA public health diplomatic interests are at the center of your nature of partnership? Yes/No

b) If yes, describe these interest _____

_____

iv) Apart from funding, which of the following support do these USA organizations give to your organization?

a) Capacity building b) joint monitoring c) joint research d) logistical support

Other_____

vii)Which of the following programs do USA state agencies or USA private based organization are in partnership with your organization? Tick Appropriate (Tick YES or NO)

a. Productive Healthcare [ ]
b. Immunization against Polio and Measles [ ]
c. Diet and Nutrition Enhancement [ ]
d. Sanitation Improvement [ ]
e. Sexual Transmitted Disease [ ]
f. Communicable Diseases/Cholera [ ]
g. Non-Communicable Diseases [ ]

**Objective 2: To assess effects of the USA international health organizationstowardscapacity building in Public Healthcare in Kibra Sub County.**

i) Which areas of capacity building does the USA organization partner with your organization?

a) Training b) Operation research c) Health promotion d) Nutrition programmes

Other:_____

ii) Do you think USA state agencies funded healthcare programmes in Kibra Sub County have led to any of the following? Tick Appropriate (Tick YES or NO)

a. Increased access to health care [ ]
b. Reduced cost of health care [ ]
c. Increased hygiene [ ]
d. Availability of funding [ ]

_____

_____

iii) How do you rate the service offered by American funded healthcare centers in terms of:-

| | | Very Good | Good | Fairly Good | Poor |
|---|---|---|---|---|---|
| a. | Timely Delivery of Services | | | | |
| b. | Handling by their staff | | | | |
| c. | Availability of Drugs | | | | |
| d | Staff motivation | | | | |

iv) In your opinion, which healthcare programmes will you prefer the USA global health agencies provide budgetary support? Tick Appropriate (Tick YES or NO)

a. Malaria [ ]
b. Pregnancy Test [ ]
c. HIV and AIDS Tests [ ]
d. Sexual Transmitted Diseases [ ]
e. Covid19 [ ]

v)In which ways do you want to be involved in the implementation of the healthcare programs offered by the international organizations in your area? Tick Appropriate (Tick YES or NO)

a. Awareness Campaigns [ ]

b. Community Participation [ ]

c. Program implementation [ ]

d. Resources Mobilization [ ]

e. Proposaldevelopment

vi) What is your level of satisfaction about the training and awareness programs you have chosen above? Tick Appropriate (Tick YES or NO)

a. Satisfied [ ]

b. Very Satisfied [ ]

c. Fairy Satisfied [ ]

d. Unsatisfied [ ]

e. Very Unsatisfied [ ]

vii)In which ways does this involvement benefit the community? Tick Appropriate (Tick YES or NO)

a. Reduced Cases of Malnutrition [ ]

b. Decreased Infections [ ]

c. Decreased Child Mortality [ ]

d. Promotion of Family Planning [ ]

e. Better Usage of Condoms [ ]

**Objective 3: evaluate USA international organizations on funding and budgeting towards health services delivery**

i) Which of the following challenges does your organization encounter in regard to partnering with USA health organizations?

a) Restricted funding b) Stringent requirements for funding c) USA diplomatic interests d) poor USA-Kenya diplomatic relations limit funding

ii) Is there a time funding was cut or suspended? Yes/No

if Yes, explain reasons why_____
_____
_____

iii) How did the reduction in funding affect your operations? Pick

a) Scaled down operations b) closed some units c) closed down d) retrenched some employees

iv) How did your scaling down or closure affect healthcare in the area? Pick

a) Some health services were suspended

b) Health issues increased

c) More deaths/suffering

Other_____

vi)What are some of the challenges you encounter to obtain healthcare services from the US funded healthcare centers? Tick Appropriate (Tick YES or NO)

a. Long Waiting Hours [ ]
b. Lack of Drugs [ ]
c. Corruption [ ]
d. Poor Relations [ ]
**e.** Others,
Specify……...…

## APPENDIX III: Interview Schedule for Director of USA international health organizations/NGOs

1. Do you think USA based organizations operations in Kenya are independent of USA diplomatic interests?
2. Do you think USA based organizations operations on health are tied to any other diplomatic interests?
3. Do you think any diplomatic tiff between Kenya and USA affect USA based organizations health operation in Kibra?
4. Do you have and cooperative agreements with local NGOs and Kenyan Government of issues of Health in Kibra?
5. To what extent if any is the Kenyan government involved in receiving donor funds for health care services in Kibra slums?
6. What are some of the gains acquired by your organization a result of the health care services in Kibra slums?
7. Do you think Kenyan government does not own donor funded health care projects in Kibra slums by your organization?
8. Can you highlight on some of the challenges you encounter diplomatically either in receiving funds or in the implementation of health care projects in Kibra slums?
9. What measures do you have in place to address the stated diplomatic challenges?

## APPENDIX IV:Focus Group Discussion Schedule (Health workers)

1) What types of projects do you have?

a) HIV/AIDS[ ]

b) Malaria[ ]

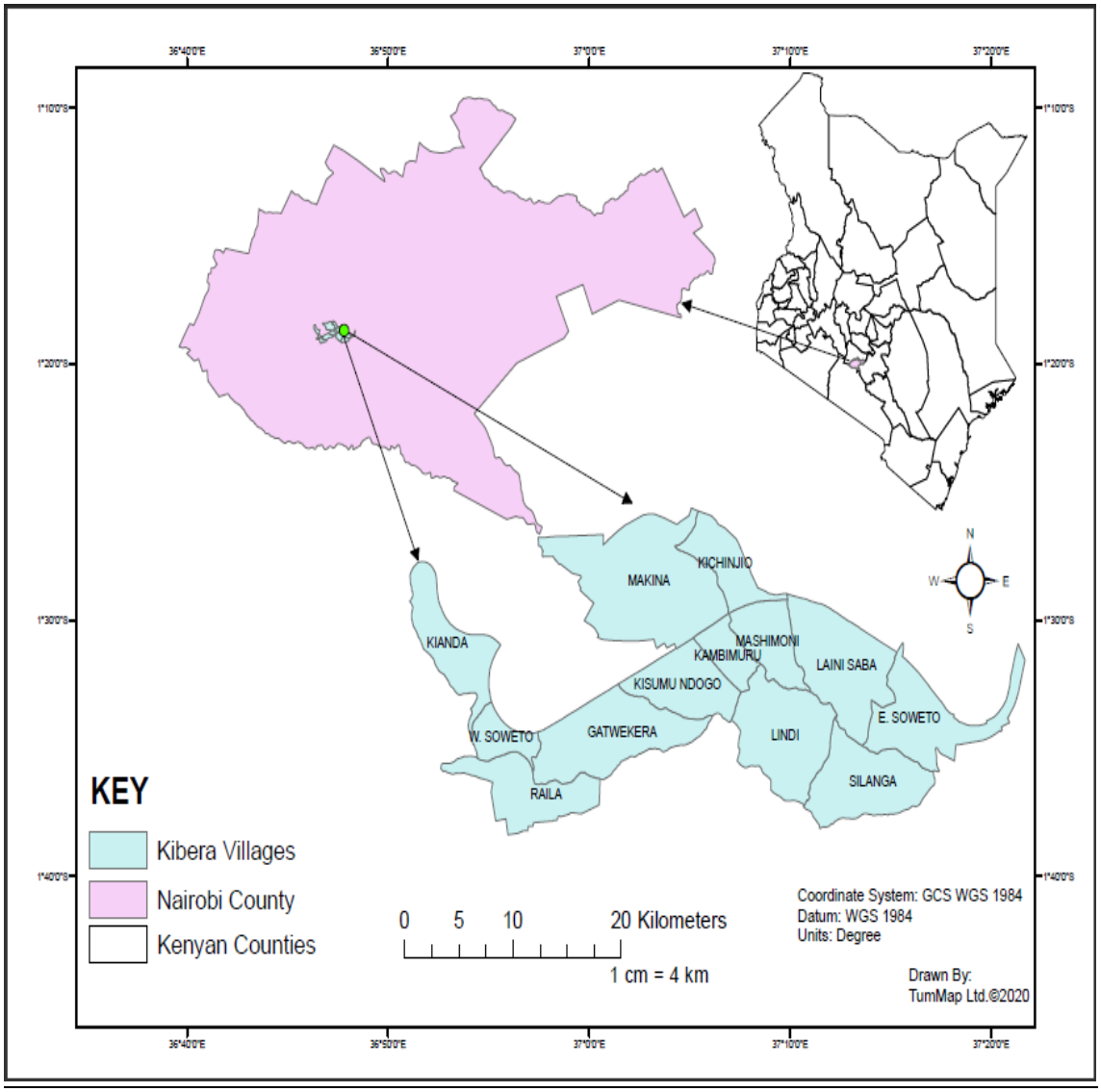
c) Water and Sanitation[ ]

d) Pre-natal health care

Others.(specify)…….....…….....……
…….....……
……..

| Item/issue | Descriptive Notes |
|---|---|
| Number of health care activities | |
| Nature of health care activities | |
| Number of beneficiaries | |
| Number of centers | |
| Number of visits/field work | |
| Number of homecare health services | |
| Reduction of healthcare services | |
| Increase in healthcare services | |
| Effects of your healthcare activates on general public | |
| Any healthcare activities stopped due to lack of funding | |
| Effects of these activities to healthcare workers | |

## Appendix V: Kibra Map



## Appendix VI: Letter From NACOSTI

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 906797

Date of Issue: 02/February/2021

**RESEARCH LICENSE**

This is to Certify that Mr.. BENSON NYAGAKA ONTIERI of Kisii University, has been licensed to conduct research in Nairobi on the topic: Contribution of USA International Organizations to public health services delivery in Kibra Sub-County, Kenya. for the period ending : 02/February/2022.

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Director General
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## Appendix VII: Letter from Kisii University


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**OFFICE OF THE REGISTRAR RESEARCH AND EXTENSION**

**REF:** KSU/R&E/ 03/5/505 **DATES:** 22nd January, 2021

**The Head, Research Coordination**
**National Council for Science, Technology and Innovation (NACOSTI)**
**Utalii House, 8th Floor, Uhuru Highway**
**P. O. Box 30623– 00100**
**NAIROBI - KENYA.**

Dear Sir/Madam

**RE: BENSON NYAGAKA ONTIERI MAS17/60050/15**

The above mentioned is a student of Kisii University currently pursuing a Degree of Master of Arts in International Relations . The topic of his research is, ***"Contribution of USA International organizations to public health services delivery in Kibra sub-county, Kenya".***

We are kindly requesting for assistance in acquiring a research permit to enable him carry out the research.

Thank you.

for Prof. Anakalo Shitandi, PhD
**Registrar, Research and Extension**

**Cc:** DVC (ASA)
Registrar (ASA)
Director SPGS

## Appendix VIII: Plagiarism Report

CONTRIBUTION OF USA INTERNATIONAL ORGANIZATIONS TO PUBLIC HEALTH DIPLOMACY IN KIBRA, KENYA

ORIGINALITY REPORT

| 20% | 19% | 5% | 5% |
|---|---|---|---|
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