Civil society organizations: Capacity to address the needs of the urban poor in Nairobi

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Abstract

Background: Civil society organizations proliferate in areas underserved by governments. This study aims to describe the CSO landscape in three Nairobi slums and assess their capacity to deliver services that impact on the health of residents.
Methods: Data on core business, financial management, governance structures, and monitoring and evaluation systems of 952 CSOs were collected and descriptive analyses done.
Results: Out of 952 CSOs assessed, 47% reported HIV/AIDS as their core business, 45% savings & credit, 34% environment, 27% water & sanitation, 19% child health and 15% sexual & reproductive health. Most CSOs reported good financial management, governance structures and M&E systems. 43% have received technical support from other organizations, and 24% reported receiving funding in the previous five years. Only 27% were represented in district health stakeholder forums.
Conclusions:There is need to validate the CSO self-reports and assess the quality of services provided. CSOs and health governance structures need to work closely to improve health outcomes.

Key words: **Civil Society Organisation, Informal Settlement, Nairobi**

Introduction

Since the beginning of the twentieth century, the role of civil society organizations (CSOs) in national development has been notable through their advocacy for the less privileged and vulnerable members of society and provision of essential services to underserved populations ([1, 2]). They include non-governmental organisations, faith-based institutions, community groups, professional associations, research institutes and think tanks [[3, 4]]. CSOs can also be categorised according to their spheres of influence into global, regional, national, and local entities. CSOs are known to step into areas where government has not been able to meet the needs of citizens. They are involved in representation of citizens, advocacy and technical input for initiatives to reduce poverty, capacity building, service delivery and community organisation [5]. CSOs have been reported to have a large impact on global health initiatives by influencing policy and program implementation, and rising up to be recognized as "the voice of the poor" [6-9]. Their numbers have drastically accelerated over the last two decades. For instance in Tunisia the number of registered NGOs increased by more than two-fold between 1988 to 1991 from 1800 to 5000. [[10]]. Funding from bilateral and multilateral organisations also increased during this period with major donors contributing enormously towards education, water and sanitation and HIV/AIDS programmes run by CSOs [[3, 11, 12]]. CSOs actively participating in advocating for reforms in national policies and influencing decision making [[13]] are on the rise especially as the number of underserved poor populations increases in many Sub Saharan African countries. They have positioned themselves to monitor Government and to demand accountability for the use of funds

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especially in countries with high dependence on donor funding such as Uganda [2]. In Kenya where this study was done, the important role of CSO in community development and health promotion has been recognized in the current National Health Sector Sector Strategic Plan (NHSSP). CSOs are recognised as a vehicle for strengthening health service delivery at the community and local district level. The role of CSOs and other health service providers has been outlined in a community strategy which aims to revitalise community health services in Kenya and to strengthen service delivery at community level ([14]). The NHSSP outlines mechanisms that enable CSOs to participate in the planning, management and delivery of health services. These mechanisms include representation in health stakeholder forums through which they are expected to plan, implement and monitor health programs jointly with local health authorities and other stakeholders [15]. In spite of the efforts of government to create platforms for CSOs to be more actively engaged in planning of health services, the high rates of urbanisation in Nairobi, Kenya's capital city, create a challenge for the health sector to address the health needs of the informal settlements where close to 60% of its residents live [16]. The urban poor who live in these informal settlements continue to deal with high levels of poverty and poor health outcomes [6, 17, 18] due to limited access to social services. There is little or no presence of public social services such as schools, health facilities, roads, and water and sanitation infrastructure. Unsurprisingly, with such low levels of government presence in these underserved areas, there is a plethora of CSOs in the informal settlements [17, 18].

However, despite the proliferation of CSOs and their best efforts to implement programs to improve the wellbeing of slum dwellers, residents continue to experience poor access to essential social services and poor health and other outcomes. It is unclear what factors limit the CSOs from making observable impact on health outcomes among the residents they serve. The objective of this study is therefore to describe the CSO landscape in Korogocho, Viwandani and Kibera, three large informal settlements in Nairobi City and to assess their capacity to deliver services that impact on the health of residents.

Methods

The data used in this study were from a situation analysis of services rendered to residents of three large informal settlements in Nairobi. The situation analysis was done to inform the design of a comprehensive program to provide better access to quality health services to the residents of the three informal settlements of Kibera, Korogocho and Viwandani. Data were collected from 952 CSOs within the three informal settlement involved in providing social services that had a direct impact on health such as water, sanitation, health care, psychosocial support and, nutrition among others. Data collected included the organizational structure, core business, services rendered, target population, geographical reach and data management capacity, monitoring and evaluation systems, technical assistance needs, governance, leadership, management of financial resources partnerships and networking, involvement in community health governance structures such as village health committees and health stakeholder forums among others. Ethical clearance for the study was obtained from the Kenya Medical and Research Institute and data collection took place between November 7, 2008 and December 4, 2008. Trained field workers who resided in the community and had previous working experience in the informal settlements visited CSOs and conducted interviews with the person in-charge or the most senior manager of the organisation. Frequencies and proportions were generated to examine the characteristics of the CSOs in each of the three informal settlements STATA 10 ([20]) was used for the analysis.

Results

Table 1-Characteristics of CSOs operating in three informal settlements in Nairobi 2008.

	All informal settlements				
TYPE OF ORGANIZATION	N	(%)	Kibera (%)	Korogocho (%)	Viwandani (%)
Self-help group/Association/Youth Group	548	57.6	49.2	61.7	61.6
Community Based Organisation	254	26.7	37.4	22.2	20.5
Faith Based Organisation	90	9.5	6.2	7.3	13.8
Non- Government Organisation	55	5.8	6.5	6.9	2.9
Other*[1]	5	0.5	0.3	1.2	0.3
Total (N)	**952**	**100**	**321**	**261**	**370**
CSO CORE BUSINESS					
HIV/AIDS (Including VCT, ART, PMTCT)	447	46.9	45.5	35.6	41.4
Savings & Credit	431	45.2	40.2	26.8	45.1
Environment	323	33.9	45.5	20.3	33.5
Water and Sanitation	256	26.9	34.6	16.5	27.6
Child Health	185	19.4	26.8	16.5	15.1
Gender Issues	166	17.4	17.5	16.5	18.1
Sexual and Reproductive Health (FP, STI)	139	14.6	23.1	16.9	5.7
Drug Abuse	133	13.9	17.1	16.9	9.2
Violence Against Women	110	11.6	18.4	11.1	5.9
Street Children	106	11.1	18.4	8.4	6.8
Sex Workers	57	5.9	12.2	3.8	2.2
Juvenile Delinquency	41	4.3	6.5	5.4	1.6
Education	72	7.6	11.8	3.8	6.5
Sports	26	2.7	5.9	1.9	0.5
PARTNERSHIPS AND NETWORKS					
The organisation is active	938	98.5	98.1	99.6	98.1
Worked with other partners in implementing activities	572	60.1	72.6	54.4	53.2
Has received funding from donors in last five years	224	23.5	30.2	25.3	16.5
Has received technical support from other organisations in last five years	405	42.5	54.8	34.5	37.6
GOVERNANCE, LEADERSHIP AND ADVOCACY					
Have an elected Management Committee	913	95.9	96.9	98.9	92.9
Constitution/written rules seen	500	52.5	76.0	52.1	32.4
Organization is guided by a strategic plan	723	75.9	92.2	49.4	80.5
Organization's work plan seen	396	41.6	71	25.3	27.6
Organization is represented in Community Health Committee	615	64.6	66.9	48.3	74.1
Organization is represented in Divisional Health Stakeholder Forum	324	34.0	33.9	13.4	30.0
Organization is represented in District Health Stakeholder Forum	255	26.8	47.4	16.5	34.9
MANAGEMENT AND USE OF DATA SYSTEMS					
Organization has own office in the informal settlement	476	50.0	65.1	42.5	42.2
Organization has own office outside the informal settlement	85	8..9	5..3	9.6	11.6
Organization has no office	391	41.1	29.6	47.9	46.2
Organization has own office computer	21	2..2	3.1	2..3	1.4
Organization collects data every month	163	17.1	31.2	10.7	9.5
Organization uses data when writing proposals for funding	401	42.1	60.1	41.0	27.3
Organization has bank account	644	67.7	67.3	81.6	58.1

[1]Other includes adult education centres, clubs and societies

Results

Out of the 952 CSOs assessed, the majority were self-help groups and community based organizations (CBOs) as shown in Table 1. Less than 1% were clubs and societies that also included an adult education centre. Viwandani had the highest number of CSOs and Korogocho had the least number of CSOs. The predominant core business for the CSOs was health related activities with HIV/AIDS (47%) being the most reported. The other top areas covered also included financial (45%), and environmental (34%) issues . The least common areas of focus were violence against women (11%), street children (11%) and juvenile delinquency (4%). Among the informal settlements, Kibera had a higher number of CSOs focusing on sex workers and street children compared to the other two settlements. Almost all of the organizations reported that they were active and the majority collaborated with other partners. Few CSOs had received funding from either local or international donors with only 24% reporting receiving funding in the last five years. More CSOs in Kibera (30%) received funding than in the other two informal settlements (25% in Korogocho and 17% in Viwandani). Similarly less than half of the CSOs received technical support from other partners and out of the three informal settlements Kibera had the highest number of CSOs that reported working with other partners, and receiving funding and technical support in the last five years (Table 1). The majority of CSOs reported having established management structures. More than 90% reported having an elected management committee, and an approved constitution. Kibera had the most CSOs where a written constitution and the organisational work plan were seen by the field worker. More than half of the CSOs reported representation in the community health committee. However representation in the divisional and district health stakeholder forums was low with only 34% and 27% reporting representation respectively. In comparison to Kibera, Viwandani followed by Korogocho had lower representation among the division and district health stakeholder forums (Table 1). Regarding management and running of the CSOs, half of the organizations had offices in the informal settlements, 41% did not have any offices and only 9% had offices outside the informal settlements where they operate. The majority had bank accounts (68%) and 42% reported using data when writing proposals. Less than 20% reported collecting data on a monthly basis and only 2% had a computer in the office. Kibera had the most CSOs with offices in the informal settlements while CSOs in Korogocho were most likely to report having a bank account.

Discussion

The purpose of the study was to describe the profile of CSOs in Nairobi informal settlements, the services they render to the residents and assess their capacity to effectively offer these services. The key findings show that the majority of CSOs in informal settlements are self help groups and CBOs that are primarily involved in HIV/AIDS-related and microfinance activities. Representation in governance structures through which CSOs are supposed to influence management and provision of health services is minimal. Collection of data by CSOs on a regular basis is almost non-existent. Our findings showed that the CSOs core business is similar to what has been found in previous studies where health, education, finance and social services including water and sanitation are predominant areas of service provision for CSOs [1]. The CSOs predominantly focused on HIV/AIDS issues as their core business, and this can be attributed to deliberate efforts by multilateral and bilateral donors to increase the engagement of CSOs in the response against the pandemic.[7, 21] The Global Fund to Fight AIDS, Tuberculosis and Malaria which provide large-scale financing to HIV hard- hit countries has a dual-track financing model. In Kenya for instance the Ministry of Finance and CARE Kenya-a CSO were the recipients of round seven funding and in round one, two CSOs: Sanaa Art Promotions and Kenya Network of Women With AIDS were the sole principle recipients of funds for program implementation.[22] The availability of donor funds has strengthened civil society and organizations are

more engaged in the design, implementation, and oversight of HIV programs. This could explain the mushrooming of HIV related CSOs at all levels including the slums.[23] In addition, there have been concerted efforts at mainstreaming HIV/AIDS in all development sectors such as education and agriculture. This has increased the awareness of civil society to the need change to or prioritise HIV/AIDS as their core business due to the wide reaching effects of the pandemic. Relatively few CSOs focus on child health, juvenile delinquency and gender issues. Viwandani had the most CSOs, Kibera had CSOs with more health-related services such as environment, child health and sexual and reproductive health issues, while Korogocho had CSOs with the least involvement in environmental issues, and participation in leadership and advocacy forums. Overall, Kibera CSOs did better in terms of partnerships and networking, governance structures, and management and data use. This may be a reflection of more resources being allocated to Kibera due to the high population density and the fact that there is widespread publicity surrounding the "largest slum in Eastern Africa". Representation of CSOs in governance structures is poor as shown by the lack of CSO involvement in divisional and district health stakeholder forums where key decisions and annual operation plans for the health sector are designed. The study was subject to several limitations including lack of validation and respondent's bias. Survey participants may have embellished their responses to portray a picture of a viable CSO. For instance, in a follow-up activity involving the 60 most viable[2] CSOs selected from the 952 assessed in this study, only five could produce data that had been collected in the previous six months and yet all had reported that they collect data on a monthly basis.

Conclusion

Programs that aim at building the capacity of CSOs in management, fundraising and networking may go a long way in enhancing CSOs capacity to have more meaningful impact on the lives of slum dwellers. CSOs and health governance structures such as district health stakeholder forums need to work more closely together if the former are to have more relevance and impact on health outcomes among the urban poor. Linkages with governance structures need to be strengthened since involvement in the divisional and district health stakeholder forums will enhance the relevance of CSOs.

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[2] Viable CSOs were defined as those that were active, registered with the local administration, had a constitution, collected routine data and had a bank account

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