WOMEN'S HEALTH

REVISED June 23, 2014

Dr. Sam Thenya: A Women's Health Pioneer

Teaching Case

> "The first step to success is understanding your dream and working towards achieving it. One must have passion for what they do as this is the only way to be motivated."
>
> Dr. Sam Thenya
> Group CEO, The Nairobi Women's Hospital[1]

At the beginning of 2011, Dr. Sam Dr. Thenya, founder and CEO of Nairobi Women's Hospital (NWH) in Kenya walked down the corridor of the maternity wing enroute to his office. Founded in 2001, the private hospital had since served over 300,000 patients with the mission "to be the unmatched provider of excellent personalized and affordable healthcare services to women and children in Eastern Africa."[2] (See **Exhibit 1** for a map of Kenya and **Exhibit 2** for basic NWH service statistics.) NWH employed 350 staff working across several different sites. The hospital offered a variety of services on a fee for service basis with a focus on women's health especially in the areas of Obstetrics and Gynecology. (**Exhibit 3** lists maternity packages that NWH offered to paying clients.)

NWH was in the midst of a rapid expansion with the goal of becoming the largest hospital group in East Africa. A third branch had recently opened in Nairobi and two more local sites were in the final stages of construction. Moreover, NWH had just opened a new medical training college. Dr. Thenya envisioned a dual purpose for the new school; it would generate revenue and simultaneously serve as a NWH employee pipeline. He anticipated that the school would train approximately 200 students annually and bring in approximately US$148,000. All of these projects had been made possible by a US$2.66 million equity and debt investment received from the Africa Health Fund (AHF) in 2010.

The AHF funding had provided NWH with many resources including technical expertise, expanded networks, and greater access to skilled personnel. While Dr. Thenya welcomed the AHF support and saw it as instrumental to the next stage of NWH's growth, he had discovered, "Sometimes I am at odds with AHF given our different priorities. As an institutional investor and an investor fund steward, AHF is duty-bound to be more conservative than me. My tolerance for risk is higher. Moreover, my long term outlook is longer than AHF's as its planned exit is in five to seven years whereas I am thinking about the institution's future far beyond that timeline."

In addition to NWH, Dr. Thenya devoted time to the Gender Violence Recovery Centre (GVRC). The GVRC provided free medical services and psychosocial support to gender based violence survivors (GBV) and their families. The GVRC defined GBV as "harm caused on someone by them being male or female. It includes but is not limited to, physical, sexual and psychological harm including intimidation, suffering, coercion, and/or deprivation of liberty within family, or within the general community. It also includes violence which is perpetrated or condoned by the state."[3] (See **Exhibit 4** for a list of frequently asked questions regarding

This case was originally developed by the Harvard Global Health Institute by Rachel Gordon, MBA, Case Studies Manager, and Paula A. Johnson, MD, MPH of the Brigham and Women's Hospital. It is used and distributed with permission by the Global Health Education and Learning Incubator at Harvard University. Cases are developed solely as the basis for class discussion. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management.

gheli@harvard.edu
617-495-8222

GBV.) According to a 2008-2009 Kenyan government health survey, 39% of women between the ages of 15-49 experienced some form of physical or sexual violence committed by a partner.[4]

The GVRC and NWH were closely affiliated as the GVRC had grown out of GBV services that Dr. Thenya had insisted NWH offer when it opened initially. The GVRC became an independent trust in 2005, but it was still physically based in each of the hospital's locations. GBV services, which NWH had previously offered free of charge were now delivered instead at the GVRC (making all services offered at NWH fee for service). The GVRC was one of the first such centers in Eastern Africa and was seen as a model of outreach and care delivery to GBV victims. The GVRC provided services to an average of 250 survivors per month (57% women, 35% girls, 3% men and 5% boys,) and since its founding had treated over 21,341 GBV survivors.

With the new AHF funding infusion, Dr. Thenya had decided to center his attention on NWH which meant that he would need to step back from GVRC's daily management and focus solely on its long-term sustainability. Originally, GVRC funding came from both NWH and donors; NWH now primarily provided in-kind services instead of financial support to the GVRC. Although NWH was still a major GVRC benefactor, the relationship between the two institutions was changing. A new GVRC board, with separate membership from the NWH, had been created. Dr. Thenya commented, "Although I sit on both boards, I want the new GVRC board to provide the public accountability for the center so that I may devote myself fully to NWH." Nonetheless, Dr. Thenya still saw the two institutions as intimately connected stating, "Wherever NWH puts a footprint so should the GVRC. The two will always walk together but should not necessarily converge." Dr. Thenya added, "For health providing institutions, it is not about profits but ensuring that you offer quality and affordable health services."[5]

Kenya

General Country Background

Located in Eastern Africa and bordered by Ethiopia, Somalia, South Sudan, Tanzania and Uganda, the Republic of Kenya (Kenya) had a climate that varied from tropical along its coast to arid within its interior. It had a total square area of just over 580,000 square kilometers which was slightly double the American state of Nevada. Divided into eight provinces with approximately 158 districts, the country had a population of just over 41 million that consisted of several different ethnic groups dominated by nine tribes.[6] Over 60 languages were spoken throughout the country but Swahili was the national language and English an official language. Christianity and Islam were the main religions in the country.

Kenya had a predominantly rural population as only 22% of Kenyans lived in urban areas. (Kenya's urban population was significantly lower than the regional average of sub-Saharan Africa of almost 39%.[7]) Urbanization was growing at a rate of 4.2% per year.[8] The majority of urbanites worked in the "informal" sector. [9] Roughly 2.1 million people lived in Nairobi, the country's capital and largest city. Other large cities included Mombasa, Nakaru, and Kisumu with populations respectively of approximately 661,000, 219,000 and 194,000.[10]

A regional trade hub, Kenya had the largest economy in the region in 2010 with a national GDP of US$31.4 billion and an anticipated growth rate of 5.6%.[11] Kenya's financial sector and transportation system were often considered the economic engine for much of East Africa and parts of Central Africa.[12] Services accounted for 65% of GDP. Although less than 10% of Kenya's land was arable, agriculture made up almost 20% of Kenya's GDP.[13] Three-quarters of the population worked in agriculture but primarily as subsistence farmers.[14] Coffee, tea and horticulture were the main agricultural exports. A variety of industries—consumer goods, plastics, textiles, metals, oil refining and tourism—made up the remaining 16% of the GDP.[15]

Despite Kenya's regional economic prowess roughly half of the population lived below the poverty line.[16] GDP per capita was $1,700 (PPP) and 60% of Kenyans subsisted on $2 a day or less.[17] Wealth was highly stratified with the political elite and a small middle class consuming a disproportionate amount of resources. The highest 10% of households earned 37.8% of resources compared to the bottom 10% of the population that earned only 1.8% of resources.[18]

The majority of Kenya's population was young as the median age was 19 and only 2.7% of the population was over the age of 65.[19] Life expectancy was approximately 63 years.[20] Over the past decade the infant mortality rate had decreased significantly from 70 per 1,000 live births in 2001 to 52 in 2009.[21] The average infant mortality rate for sub-Saharan Africa was significantly higher at 80.[22] Kenyan mortality rates for children under the age of five was 74 children per 1,000 which was considerably lower than the sub-Saharan Africa regional average rate of 128 per 1,000 children.[23] The maternal mortality ratio was 488 per 100,000 births.[24] Most Kenyan women (92%) received some antenatal care from a skilled provider (typically a nurse/midwife) but only 15% of women had an antenatal care visit by their fourth month as recommended by the World Health Organization (WHO). [25] Forty-three percent of births occurred at a health facility with the remaining 56% births taking place at home. (Socio-economic status was a strong predictor for whether women were likely to give birth at home with poor women likely to deliver at home. Those in the lowest quintile were three times more likely to give birth at home than those in the top quintile.[26]) Healthcare professionals—typically a nurse or a midwife—assisted in births 44% of the time. [27]

Kenya's average fertility rate had declined from 6.7 births per woman in 1989 to 4.6 in 2008-2009.[28] However, this rate varied considerably based on a mother's socio-economic status, educational levels and location. The wealthiest women had an average of 2.9 children while the poorest Kenyan women had 7.0 children. Women that completed secondary and higher education schooling had 3.1 children while those with no education had an average of 6.7 children. Urban women were more likely to have less children (2.9) compared to their rural counterparts (5.2). Roughly one third of Kenyan women married by the age 18. Contraceptive prevalence was 46%.[29]

In 2009, Kenya's disease burdens consisted both of communicable and non-communicable diseases. Kenya had the 11th highest HIV infection rate in the world with 6.3% of Kenyans infected with HIV. [30] HIV prevalence for women between the ages of 15-49 was 8%, which was almost double the prevalence rate of 4.3% among males between the ages of 15-49.[31] HIV was the country's leading cause of death.[32] Other communicable diseases included TB and malaria which were responsible for 14% and 5.8% of all deaths respectively.[33] At the same time, non-communicable disease rates in Kenya were rising especially for cardiovascular diseases, cancer and diabetes.[34]

The 2003 abolishment of school fees lowered a significant educational access barrier and approximately 92% of school age children attended primary school.[35] The average duration of time spent in school was approximately 11 years and in 2010 public expenditures on education accounted for 6.7% of the GDP and 17.2% of total government expenditures.[36] Although Kenya had an estimated literacy rate of 85.1%, education quality still remained an issue.[37]

Brief Political Background

A former British colony, Kenya gained independence in 1963. The Kenyan African National Union party dominated Kenyan politics until 2002 elections when the candidate of the newly formed National Rainbow Coalition became the country's third president. In 2007 presidential elections were held again pitting the president—who had formed a new political coalition party, the Party of National Unity—against former allies representing the Orange Democratic Movement (ODM) and Orange Democratic Movement-Kenya (ODM-K) parties. Although the president was declared the winner, many considered the election results fixed. Violence broke out in Kenya and over the next several months Kenya experienced significant ethnic

gheli@harvard.edu
617-495-8222

and gender violence as supporters of the president and the ODM opposition candidate, clashed. Eventually former UN Secretary General Kofi Annan oversaw the creation of a coalition government. He brokered a power sharing agreement between the two men that allowed the president to remain in office and created a new role of prime minister for the ODM opposition candidate. In April 2008, the new coalition government was sworn in.

In August 2010, a new constitution was approved via referendum and signed into law by the president. Intended to add checks and balances to presidential powers and lessen the influence of tribal politics (which had been especially pressing since the 2007 presidential elections) the constitution changed political power distribution and management. Changes included: parliamentary oversight of presidential appointments, separation of the judiciary and the government, and the creation of a citizen's Bill of Rights.

Healthcare Delivery in Kenya

Starting in the 1970's the Kenyan government had adopted a health strategy which emphasized disease prevention, management of common diseases, health education and promotion and rehabilitation of people with disabilities.[38] Kenya Vision 2030, the official development policy adopted in 2007, viewed improving healthcare and health outcomes as a cornerstone for transforming Kenya into a "newly industrializing middle income country providing a high quality of life to all its citizens in a clean and secure environment."[39] However, the 2007 political unrest had impacted healthcare delivery as the 2008 coalition government divided the agency which had formerly overseen healthcare issues into the Ministry of Public Health and Sanitation (MPHS) and Ministry of Medical Services (MMS). According to one analysis, this split occurred for political reasons and resulted in "politiciz[ed] healthcare… Duplication, and competition for resources, control, and influence may slow reforms, weaken management functions, and affect morale among senior planners and managers."[40] Often Kenyans lacked confidence in public facilities and an individual's healthcare access and quality of service depended on a variety of factors. [41] Many Kenyan health facilities, especially public facilities, lacked essential equipment and supplies to provide adequate care.[42] For example, less than half of all health facilities had a year-round supply of water, 75% of facilities did not have access to a constant electricity supply and 26% of health facilities had neither.[43] Many rural Kenyans traveled long distances to access care, and the care they received was not necessarily on par with the service provided in urban areas especially services provided for those with higher incomes.[44]

In 2008, the Kenyan government ran 48% of health facilities separating care into six different service delivery levels.[45] Basic (first level) care was delivered at the community level. Primarily preventive care along with modest curative care was delivered at dispensaries (second level) and health centers, maternity clinics and nursing homes (third level). Primary, secondary and tertiary hospitals, the fourth, fifth and sixth levels of care respectively, carried out more sophisticated and complicated care. The MPHS had responsibility for the first three levels of care while the MMS oversaw care at levels four through six. Facilities between the second and fourth levels were both private and public while the 14 hospitals at levels five and six were government owned.[46]

Private sector care played an important role in healthcare delivery. In 2008, private organizations ran almost 34% of Kenyan health facilities.[47] (NGOs and faith based organizations controlled 15% of the health facilities.[48]) According to 2006 World Bank indicators, 59% of the urban population and 49% of the rural population used a private, for-profit modern medical provider.[49] Almost 40% of out-of-pocket health funds were spent at private, for-profit hospitals and fees (beyond the nominal ones charged at public dispensaries and health centers) were often high.[50] Many patients paid out of pocket for essential drugs and care received in hospitals.[51] Indeed almost half of the Kenyans in the poorest fifth of the population had sought care at a private facility for a sick child.[52] Only 2% percent of Kenyans—typically those working in the formal sector and receiving high incomes—had private health insurance.[53]

gheli@harvard.edu
617-495-8222

In 2006, total women's health expenditures (delivery, antenatal, and family planning services) were approximately 8.8 billion KSh[a] with 61% of these funds spent on the public providers and 30% spent on private providers. [54] (The remaining 9% was unclassified.) Of the 2.7 billion KSh spent on women's health expenditures in the private sector, 45% was in private
for-profit hospitals, 26% was in not for-profit hospitals (primarily faith-based organizations) and approximately 20% was spent in private clinics. The private sector provided only 13% of antenatal services overall but this increased to 25% in urban areas.

An Interest in Women's Health

Dr. Thenya had found himself drawn to women's health during his medical training. During his general practice internship in 1994, Dr. Thenya worked in a government hospital in Nyeri, Central Kenya. Dr. Thenya recalled, "The work was hard but I saw joy in the women's wing. It was the happiest place in the hospital; babies were being born." In 1998, Dr. Thenya received a scholarship to be a teaching fellow at the University of Nairobi Hospital where he chose to specialize in obstetrics and gynecology.

At the University of Nairobi, Dr. Thenya worked on a domestic violence study run by two of his mentors and sponsored by Federation of Women Lawyers (FIDA) Kenya, the oldest women's rights organization in Eastern Africa.[b] The study examined community attitudes and practices towards domestic and sexual violence. Dr. Thenya worked closely with a young woman lawyer and criminal prosecutor, Njoki Ndungu, who specialized in women's rights advocacy issues.

While Dr. Thenya completed his studies in 2001, he supplemented his income by occasionally working in a Nairobi hospital. During an early evening shift in 2000 Dr. Thenya witnessed an argument between the Admitting Cashier at the Admissions Desk and a woman who although well-dressed appeared disheveled and distressed. He recounted his reaction to the exchange,

"I was furious that this woman who was clearly upset was not being treated with dignity or respect when I thought she had been a carjacking victim but even more so once I understood that she had been raped. My anger grew after I found out—as according to hospital procedure—the woman was required to pay out of pocket for any medications. This included short-term antiretroviral treatment or post-exposure prophylaxis[c] which could cost as much as a month's wages and were not covered by insurance. I paid the hospital fees so that she could be seen immediately."

That night Dr. Thenya discovered that the hospital offered little support of any kind to GBV victims. Care required payment. Even if care was received, there was no collection of potentially admissible physical evidence or system in place to take a victim's statement. While a victim was able to make a statement there was no guarantee it would be kept confidential and victims received no assistance in navigating the legal process on pressing charges against their assailants.

---

[a] Eight point eight billion KSh was approximately US$119,680,000 (0.0136 KSh=1US$ in August 2006). Case writer calculation based on historical conversion found at OANDA, http://www.oanda.com/currency/historical-rates/, accessed July 2012.

[b] FIDA-Kenya advocated for women's rights at the international, national and local levels. In Kenya, FIDA had supported and often helped draft legislation that improved women's status in Kenya. For more background see, http://fidakenya.org/about-fida/brief-history/ accessed August 2012.

[c] "Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse including through sexual assault." WHO definition as modified by case writer, http://www.who.int/hiv/topics/prophylaxis/en/, accessed January 2013.

gheli@harvard.edu
617-495-8222

Opening NWH and the GVRC

Outraged by what he perceived as a lack of services for assaulted women, Dr. Thenya repeatedly described the incident to his colleagues. Their reactions surprised him, "Everyone seemed to have the same response which was to ask, 'What can I do? Why should I bother? Do you really think that the police will do anything?'" Undeterred by these attitudes Dr. Thenya approached his hospital's CEO and urged him to open a special wing of the hospital that focused on the care of women with a specialty in treating sexual violence victims. Dr. Thenya remembered, "Although sympathetic, my CEO thought such an endeavor was financial suicide. He told me, 'Why don't you start your own hospital and give these free services.'"

While watching the news in October 2000, Dr. Thenya learned that a recently closed local hospital was to have its assets auctioned. Despite not having the financial resources Dr. Thenya turned to his wife and announced, "I am going to buy that hospital." He sold everything that he had—from clothing to even a car—to raise capital. He mused, "My wife and everyone else thought that I had gone mad because the hospital I wanted to buy had already closed down twice." Dr. Thenya laughed, "There was a big advantage to being naïve. I was passionate about the success of the hospital."

Dr. Thenya successfully raised the funds to purchase the hospital but quickly realized, "Even though I had a business plan I didn't have everything worked out. I forgot there was something called working capital." Dr. Thenya turned primarily to his professional medical network to get the needed money. Dr. Thenya ended up with 16 investors[55] consisting of both doctors and local healthcare figures who put in a total of US$250,000 and controlled approximately 60%.[56] He anticipated this collective investment would cover equipment, salaries, and other hospital related expenses for three years. Dr. Thenya was the majority shareholder with 40% percent. NWH was set up as a private, for-profit hospital. (NWH was a brand that was formally owned by Healthlink Matcare Ltd.)

On March 5, 2001, one month after Dr. Thenya completed his obstetrics and gynecology specialty boards, NWH opened with Dr. Thenya as its CEO. Dr. Thenya remembered, "I thought that NWH would be a Center of Excellence with small centers throughout the region. We would cater to the high-end of the Nairobi market and offer superior services and state-of-the-art equipment. Patients would learn about NWH through primary hospital referrals." However, the high-end healthcare market in Nairobi was extremely competitive; many hospitals served the same small wealthy population. Dr. Thenya quickly realized, "We'd be up against hospitals that had far greater resources." Dr. Thenya changed the NWH strategy to offer health services to middle and lower class women, segments that he felt were underserved. He explained, "An International Finance Corporation (IFC)[d] report showed that the 'so-called poor' were purchasing healthcare but weren't getting the quality. The high-end market is limited but here is a sector with seemingly insatiable demand that we could easily impact."

In 2001 the NWH began a policy of offering free services to GBV survivors with the goal of reporting all GBV incidents within 72 hours. No official nationally representative data were available but a study subsequently carried out by the Federation of Kenyan Women Lawyers in 2002 indicated 51% of women visiting antenatal clinics in Nairobi had been victims of violence during their lives, 65% from their husbands and 22% from strangers. (The remaining 13% did not indicate cause.).[57] Dr. Thenya recalled, "I told the NWH board that we had to provide free services even though we were struggling financially." This soon proved challenging; positive media coverage about these free services attracted a significant influx of new patients who needed medication to decrease HIV infection after possible exposure from sexual assaults but had no means to pay

[d] The entire report, "The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives," may be found at http://www.ifc.org/ifcext/healthinafrica.nsf/AttachmentsByTitle/IFC_HealthinAfrica_Final/$FILE/IFC_HealthinAfrica_Final.pdf, accessed September 2011.

for services. With no generics on the market, a standard course of HIV drugs cost approximately US$1,000 per month which created a huge burden on NWH. According to Dr. Thenya, "The board told me that we needed to stop offering these services but I told them, 'Over my dead body!'"

Despite Dr. Thenya's insistence to the board that the GVRC provide free care, he admitted, "I wondered, how can we do this when the medications are so expensive and not covered by insurance?" To relieve the financial pressure felt by NWH Dr. Thenya sought international donor support for the GVRC. Dr. Thenya remarked, "I realized we needed international donors if we were to carry out the GVRC mission."

In 2002 NWH received a grant from Canada International Development Agency (CIDA). This initially helped cover the cost of medical treatment including post exposure prophylaxis (PEP).[e] The five year grant covered 25% of expenses and provided capacity training for support groups and stakeholders. It also covered human resource expenses.

In 2004 Dr. Thenya officially established the GVRC as a charitable trust of NWH. The newly formed entity would continue to offer free services and also had expanded its mission to change attitudes and raise public awareness about GBV. He remarked,

> "GBV was not talked about when we started. People considered it a woman's issue. Even if a woman did report an incident to the authorities, she was asked inappropriate questions like, 'So what were you wearing?' or 'Did you enjoy it?' Another challenge for us was people's stance on domestic violence. Often times they considered it to be a marital issue to be settled between a wife and husband. This mindset was prevalent among the police and the community. Finally, many Kenyans viewed GBV as a foreign ideology that was being pushed by donors."

The lack of adequate financial resources continued to be an issue for the GVRC. In an effort to better manage donor relationships and broaden its donor base, the GVRC developed its first strategic plan which was again funded by CIDA in 2004. A fundraising committee was formed to increase funds from all sources—individual, corporate, foundation and international donors. An individual annual membership program, "Friends of the GVRC" was started. Membership dues supported services provided for rape survivors. Finally, the GVRC began to explore the viability of holding events like annual galas or sponsoring events to raise funds. However, in 2005 the GVRC owed NWH KSh9 million.[58]

In 2006, the GVRC staff developed training programs on sexual harassment and GBV issues for external audiences. Over the years the staff had continually noticed a lack of support for GBV survivors from the police as well as local communities. The police were typically insensitive while communities tended to be secretive about assaults. The staff trained the community leaders, local administration, the police, and healthcare workers. Dr. Thenya observed, "We had to get the police from the top involved so we trained the police. It is amazing how transformative just a couple of weeks of training can be. That is why we trained communities too." Dr. Thenya also developed an outreach strategy that involved working closely with the media to generate GBV awareness and engage the public. He estimated, "I have personally addressed thousands of people in all kinds of settings, such as churches, schools, mosques, local governing boards."

He also recognized, "I was running two very different organizations. NWH was a commercial business with a very clear profit motive while the GVRC did not have income and instead depended completely on donor support. On the one hand I had to fundraise for the GVRC and on the other I had to find people who could

[e] "Post-exposure prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse including through sexual assault." WHO definition as modified by case writer, http://www.who.int/hiv/topics/prophylaxis/en/, accessed January 2013.

gheli@harvard.edu
617-495-8222

pay NWH's fee-for-service." Eventually the GVRC hired a program manager to manage the daily operations while Dr. Thenya retained the Executive Director title.

Putting GBV on the Legislative Map

In late 2005 Dr. Thenya and his former colleague, now Honorable Njoki Ndungu, had an opportunity to work together again and build on the results of their original collaboration—the domestic violence study by FIDA Kenya.[f] The study results—which had been published in 2001—showed that women were often too poor to afford medical care and pursue counseling treatment after sexual assault. Moreover, many victims mistrusted doctors and the police and instead preferred to confide in and seek support from religious leaders. Dr. Thenya commented, "We found that 68% of women in the community reported some form of violence in their lives. Only 30% trusted a doctor and less than 5% trusted a police officer. The report confirmed the need for a holistic approach to sexual violence which considered not only the medical needs of sexual assault survivors but also their social and psychological needs. Most importantly though, the study was an early example of using empirical data to define a public health problem."

Hon. Njoki Ndungu, who had been nominated to the Kenyan parliament in 2003, had drafted and submitted the country's first gender-based violence bill, the Sexual Offences Act (SOA), to Parliament. The act defined rape, sexual assault and rape of children under age of 18 (defilement) punishable by imprisonment. In addition, the law mandated that rape be added to the required list of reportable conditions to the Ministers of Health and Department of Reproductive Health and created a sexual offenders registry. Moreover, the law attempted to create institutionalized frameworks to support victims. It called for establishing gender desks at police stations which would serve as official places where victims could safely file reports and seek care and introduced the concept of a rape shield into law such that it was illegal to mention a defendant's sexual history during trial unless it was directly relevant to the proceedings.

Statistics to support the need for the SOA were taken from the Gender Violence Monitoring Unit (GVMU)—a computerized management system of GBV data taken from survivors' experiences. Established in 2005 and UNFPA-funded, the GVRC had played a critical role in not only developing the GVMU but also supplying the data.

In an effort to pass SOA, Hon. Njoki Ndungu had organized a public advocacy campaign and asked Dr. Thenya to speak publicly in support of the legislation. He agreed and after SOA's successful passage in July, 2006, Hon. Njoki highlighted Dr. Thenya's role at a United Nations experts meeting on good practices in legislation on violence against women noting in a presentation that lobbying and advocacy strategies for SOA included finding "a solid male medical doctor as the male face of the Campaign: Dr. Sam Thenya."[59] In the same presentation she referred to NWH as one of the partnerships and networks that had supported successful SOA passage. [60]

A Call to Action: Post-Election Violence in Kenya

The 2007 post election violence destabilized parts of Kenya for a period of time. Several multi-lateral organizations estimated the impact and extent of the violence. A United Nations High Commissioner for Human Rights report published in February 2008 estimated that the violence had displaced approximately 260,000 people and killed over 1,500.[61] A rapid assessment of GBV during the post-election violence conducted by UNICEF, UNFPA and the Christian Children's Fund found that "sexual violence is not only

[f] FIDA-Kenya advocated for women's rights at the international, national and local levels. In Kenya, FIDA had supported and often helped draft legislation that improved women's status in Kenya. For more background see, http://fidakenya.org/about-fida/brief-history/ accessed August 2012.

occurring as a by-product of the collapse of social order in Kenya brought on by the post-election conflicts, but it is also being used as a tool to terrorize individuals and families and precipitate their expulsion from communities in which they live."[62]

Dr. Thenya described the violence: "Everything was paralyzed during that time. I couldn't even come to work, despite living so close." Although Dr. Thenya had helped publicize the scope of GBV he was initially reluctant to get involved. He commented, "I had limited staff and resources but when I asked my staff whether we should help, they told me 'We really have to do this. We'll prepare ambulances to get food and do an international appeal on the internet.[g] They were amazing.'" Dr. Thenya recalled, "We decided to be part of the solution so we worked with other leaders including other organizations such as the Kenyan Red Cross." Dr. Thenya made the decision to mobilize extra funds through an internet-based appeal for support so that NWH/GVRC could support medical staff and counselors across the country.[63] During late December 2007 through the end of March 2008, Dr. Thenya estimated, "We had over 1,000 volunteers from all over the country working with us." During this period of the crisis, over 650 women, men and children sought treatment for sexual assault at the NWH.[64]

In the summer of 2008, Dr. Thenya testified before the Commission of Inquiry on Post Election Violence (CIPEV), later known as the Waki Commission, on the sexual violence during the post election period. (The CIPEV was set up by former UN Secretary-General Kofi Annan.) Dr. Thenya stated, "We were inundated with patients during this period." Ultimately, NWH offered comprehensive services to over 653 patients but Dr. Thenya pointed out to the commission that the country's chaotic state made it difficult for many victims to receive appropriate treatment.[h] The final report acknowledged NWH's role during the crisis, "The void created by the lack of official response to sexual violence was partly filled by private hospitals, including Nairobi Women's Hospital." Moreover, the Waki Commission characterized GVRC/NWH's efforts as "offering invaluable humanitarian assistance. The Commission received evidence of the remarkable work of the NWH/GVRC. The NWH/GVRC served as a front line facility, which gave medical care and psychological support to victims of sexual violence and engaged in fundraising so that they could offer their services for free."[65]

After the post-election violence many more GBV survivors came to the GVRC which strained the NWH's already fragile finances as it still made significant contributions to GVRC operations. Dr. Thenya explained, "We had always had a policy that every GBV victim would be treated free of charge in the GVRC. When I developed this policy, I had no idea how expensive it would be to provide the necessary services and drugs. A passion to do the right thing had taken precedence over conceiving a clear NWH strategy in advance. But when I saw survivors returning with other survivors I knew that we had to continue." Despite Dr. Thenya's commitment to providing free services to GBV survivors, he often found himself "at opposition with NWH board to provide free services especially as the hospital experienced financial worries."

Many New Starts

In 2008, to bolster his business and leadership skills, Dr. Thenya attended a Master's Program in transformational leadership development at the United States International University (USIU) in Nairobi through a scholarship from the Coca Cola Foundation. He reflected, "I had stopped actively practicing

[g] For an example of one such appeal see, Charlene Smith, "We Never Thought It Could Happen Here," Thought Leader Mail and Guardian Online, January 24, 2008, http://www.thoughtleader.co.za/charlenesmith/2008/01/24/we-never-thought-it-could-happen-here/ accessed August 2011.

[h] To see the entire report as well as read Dr. Thenya's testimony see, "The Commission on Post-Election Violence Report," October 2008, http://www.nation.co.ke/blob/view/-/480850/data/46260/-/p6gqpv/-/WakiRep.pdf, accessed August 2011.

gheli@harvard.edu
617-495-8222

medicine and really felt I needed stronger managerial skills to push the organization further." In recognition of his work at NWH, Dr. Thenya received a fellowship from the Eisenhower Fellowship Program.[i] During his U.S.-based fellowship, Dr. Thenya learned about healthcare management, toured hospitals throughout the country to observe clinical practices and met with hospital CEOs. Additionally, he focused on best practices in non-profit management and the service provision for gender violence and HIV/AIDS programs. Finally, he studied entrepreneurial business models in healthcare delivery. For Dr. Thenya, the fellowship experience "lifted the lid on my leadership to think not only for Kenya and for Africa but also for the world at large."[66]

Dr. Thenya turned his attention to the NWH board. He commented, "When I initially sought NWH board members, I did so based on their community prominence and not on their commitment to the GVRC social mission. To many, NWH was merely an investment opportunity. " Additionally, Dr. Thenya had discovered that many members had direct conflicts of interest between their fiduciary duties as board members and their personal interests. For example, the NWH chose its initial bank based on a board member's recommendation. Only after the bank had closed suddenly and after the NWH had lost all of its funds did Dr. Thenya discover that the board member who had made the suggestion had a financial investment in the bank. Other board members sought hospital procurement contracts or employment opportunities for friends and family. Eventually Dr. Thenya decided to remove the board members who did not support the model of using the NWH to sustain the GVRC. He raised the funds and bought out all the board members and trustees by borrowing money from a local bank. After the board buyout, Dr. Thenya became the sole NWH shareholder in 2009.

A New Partner: The Africa Health Fund

Recognizing that he needed more cash to grow NWH, Dr. Thenya began to explore receiving an equity investment from four different venture capital funds. The leading candidate soon became the $57 million Africa Health Fund (AHF). (See **Exhibit 5** for the press release announcing the deal.) The AHF was formed in June 2009 with the objective "to increase access, affordability and quality of health-related goods and services for underserved Africans, especially those at the bottom of the income pyramid, [while] simultaneously providing investors with good long-term financial returns."[67] Aureos Capital (Aueros), a private equity firm that specialized in emerging markets, managed this new fund. AHF backers included such well-known donors as the African Development Bank, the Bill and Melinda Gates Foundation, the International Finance Corporation and the German Development Bank (DEG).

In January 2010, Dr. Thenya agreed to sell a 26% stake in NWH for US$2.6 million to the AHF.[68] (The NWH deal was AHF's first investment in the region.[69]) The quasi-equity[j] investment was to be applied towards a management buyout and the expansion of health facilities and services throughout Eastern Africa.[70] The Aureos partner leading NWH negotiations stated, "We are delighted to have NWH as the first investment because its growth strategy closely reflects the objectives of the AHF which seeks to support robust businesses that have a distinct goal of increasing the availability of quality healthcare to a broad population that has previously had limited choice."[71] Dr. Thenya commented,

> "The AHF was a key international player who brought us organizational creditability. Through its connections, the AHF could kick open doors in areas that we could not. It also offered us technical

[i] "The Eisenhower Fellowship was a selective leadership program that identified, empowered and linked outstanding leaders from around the world to helping them to achieve consequential outcomes across sectors and borders," Eisenhower Fellowships website, http://www.efworld.org/about/eisenhower_fellowships_whatwedo.php, accessed August 2012. Text modified slightly by casewriter.

[j] Quasi equity was "a form of company debt that could also be considered to posses some traits of equity, such as being non-secured by any collateral." Definition from Business.Dictionary.com, http://www.businessdictionary.com/definition/quasi-equity.html, accessed August 2011.

assistance grants for our team. I felt as though our visions were in sync; they wanted to expand not just in Kenya but throughout Eastern Africa and even beyond. They were also agreeable to the idea of the NWH seeking a listing on the stock exchange."

A New NWH Board

Four new NWH board members were appointed in 2010. Two new board members were Aureos staff (an AHF condition for its NWH investment). Dr. Thenya picked another member and remained on the board himself. The fifth and final member was a neutral chair. (See **Exhibit 6** for NWH board members.) Over the next year, Dr. Thenya worked closely with the new board. He commented, "They are engaged and they bring with them expertise in lots of different areas. I wanted to set up a governance system that could exist beyond me. We've been able to do that as we now have a very structured reporting system and meetings. We look at questions such as, 'What are our deliverables? Who are our target customers? What are our financial goals? What other outcomes are important to us?'" Indeed, the active role that the AHF board members had played in developing financial metrics for NWH had been unexpected for Dr. Thenya. He stated, "I thought that they were just going to look at the social dimensions. But there are financial deliverables that AHF expects which are not very realistic given our industry. This has been a bone of contention that we've discussed quite a bit."

The AHF's long-term commitment differed from Dr. Thenya's and he felt some pressure, "They could exit. This could happen in a couple of different ways. AHF could be bought out by a technical strategic partner who will continue to grow the hospital with me or AHF could exit through an IPO. At some point, AHF will leave and I will continue the journey but I don't know with whom. In two to three years we plan to look for a new strategic partner."

Indeed, Dr. Thenya was acutely aware that the AHF was an institutional investor. Dr. Thenya reflected on what this meant for the hospital,

> "If things go wrong, they are unlikely to be the main losers but on the other hand if things go right, then their investors also benefit. Any entrepreneur must understand this about private equity investors. They cover their own positions and minimize their losses. They're much more conservative than me, which is not necessarily a bad thing. I want to open a branch a month. If I was on my own, I'd probably have six or seven branches now. They are a little more cautious: "Oh, let's wait and see how this branch is going to do. Let's wait a little bit to see the macro and micro economic climate" whereas I'm ready to go. I want to see this footprint across Africa. But because they have experience and they have invested and managed growth before, they are saying, "Look, we have another four years—this is a marathon, not a sprint." They're probably a bit too cautious because they're handling other people's money. They sort of become the third eye, the devil's advocate saying, 'What if,' and I'm saying, "Look—we have a working model, let's go!"

Charting a GVRC Path

By 2010 the GVRC had treated over 20,000 GBV survivors for free (See **Exhibit 7** for GVRC service statistics.) The center's fifteen staff members worked on activities that included: training other service providers (health workers, police magistrates, policy makers, community opinion leaders) on GBV, collecting data daily on GBV, analyzing GBV statistics, advocating for GBV policy and raising community awareness of the impact of both GBV and HIV/AIDS and also providing legal support (preservation of evidence, medical reports and doctors' evidence at no cost).[72] In an effort to engage men in the fight against GBV, the GVRC organized a charity gala dinner, sponsored a golf tournament and developed a relationship with the Kenya Sevens Rugby Team. Team members appeared at several GVRC sponsored events throughout the year.

GVRC funding continued to be a challenge especially as staffing had not kept pace with many of the newly introduced activities. The GVRC had always received funding from both international donors and NWH. NWH funding had been dependent both on the hospital's financial performance and goodwill of the directors who decided how much to give to the GVRC as no formal support agreement between the two institutions existed. Historically, NWH had provided office space, administrative support, financial and even surgeries to GBV victims. NWH charged the GVRC for the surgeries performed on GVRC clients at a subsidized rate but "the GVRC has never been able to pay NWH," Dr. Thenya stated. He estimated that by the year 2010, "The GVRC owed NWH approximately US$600,000." Although NWH's financial position had changed with expansion, supporting the GVRC remained a top priority. GVRC services were provided in all NWH branches. However, the GVRC still depended on international and local donor support. (**Exhibit 8** shows selected GVRC donors and grants.)

Dr. Thenya continued to feel that it was time to separate himself more formally from the GVRC. The former GVRC Program Manager replaced Dr. Thenya as the new center's Executive Director in May 2010. He remarked, "I want the brand to be GVRC not Dr. Sam Thenya. An entrepreneur must accept that an organization must separate completely from the founder to be sustainable and therefore have a succession plan." He continued, "There was a perceived conflict of interest in that this private entity, NWH was running the GVRC." As part of this effort, Dr. Thenya worked with the new NWH board directors to appoint a new GVRC board of Trustees. He explained,

> "Integrity is good, but people must also be able to see that integrity. It should not only be there, but it must be seen to be there. It's just like justice in that way. Right now we control the funds that have been donated, and simultaneously, I'm running the for-profit arm. It works because the donors trust me, everybody else trusts me but if you had somebody who doesn't have that kind of integrity, it's very easy to have the two completely muddled with other people's money going into the for-profit. We could lose our focus of why the two institutions started."

The new seven member GVRC board held its first meeting on May 27, 2010. (**Exhibit 9** lists GVRC board members.) Dr. Thenya commented, "The board's mandate was to ensure that GVRC remained true to its mission of providing free medical and psychosocial support to survivors of gender based violence in East and Central Africa. They were responsible for the daily running of the GVRC and a way for donors to see clearly that any donated funds went to the GVRC and not NWH." Agenda topics included introducing the board of trustees, a brief on the GVRC/NWH, adopting proposed terms of reference, and electing the chair of the board.[73] One of the first actions the new GVRC board undertook was determining how the GVRC might generate income so that it would be less dependent on donor funding.

Creating a New Revenue Source

In May 2011, NWH in partnership with the German company GIZ[k] entered the medical waste business and purchased an incinerator. Medical waste could be highly infectious and improper disposal put communities at risk for biohazards and also created environmental dangers. However, many small to mid-size facilities in Kenya did not have the resources to purchase the incinerators necessary for proper disposal. Dr. Thenya commented, "We decided to get a larger capacity than we needed so as to assist small clinics and hospitals that may not have capacity. It is important to note that proper waste management makes business sense."[74] NWH purchased the incinerator and covered staff training time and costs. GIZ offered project coordination, consulting services, financial resources for training and public education and promotion of best practices in

[k] GIZ was a federal German enterprise that "worked primarily with the German Government in achieving its objectives in the field of international cooperation for sustainable development." For more information see, http://www.giz.de/en/aboutgiz/profile.html, accessed January 2013.

the health sector.[75] Thirty-four mid-sized hospitals participated in the program and hazardous waste had been reduced by 75% when compared to pre-project levels.[76]

Looking into the Future

During the first half of 2011, the NWH and the GVRC boards worked to define a new working relationship for their respective institutions that considered the unique relationship connection between NWH and GVRC. Under the new plan, NWH and GVRC had a shared purpose. Dr. Thenya explained, "NWH takes care of the entire life cycle of women while the GVRC provides protection to women if this cycle becomes disrupted through GBV. Our success depends on the two working together. As such we have a common purpose, 'We care for and protect the health of our women in Africa.' We also share some critical success factors." (See **Exhibit 10** for a chart of success factors for the GVRC and NWH and **Exhibit 11** each organization's respective vision and mission.)

The GVRC board had met again in April 2011 and developed a strategic plan for the GVRC that would enable it to generate enough income to cover its own costs or, at the very least, make it less dependent on donor funds. Dr. Thenya explained the GVRC could potentially become more self sufficient with , "Income generating activities included charging other organizations for the use of the GBV data that the GVRC had collected and developing training programs that made a profit." Yet Dr. Thenya admitted, "I still worry whether the GVRC mission of offering free medical care and medications to GBV survivors will be in jeopardy if financial pressures become too great. It's important that the GVRC remain a socially driven organization and not become a commercial enterprise."

While the GVRC board charted an organizational direction, the NWH continued its expansion efforts. (See **Exhibit 12** for selected NWH financials.) Dr. Thenya believed that NWH was well positioned to take advantage of Kenya's growing healthcare sector—estimated to have expanded by 6% in 2011.[77] In an interview with *Reuters* in February 2011, the doctor had commented, "It's a growing sector with a huge potential especially with the growing middle class."[78] For Dr. Thenya the next few years offered great opportunities but also potential missteps, "Our services are in such high demand and we do not have enough resources to do it all. We have to be careful to manage public expectations."

By 2012 NWH had continued with its expansion and had six different branches as well as the original Hurlingham location. (**Exhibit 13** describes each site briefly.) The additional facilities brought NWH's bed capacity to 226. NWH was recruiting heavily and had many open positions ranging from medical officers to all levels of nursing and administrative staff. Plans were underway to open branches not only in all major Kenyan cities but also in all of Africa. Moreover, NWH's medical waste incineration program was serving over 10 medical facilities in the Nairobi metropolitan area and had recently broken even.[79]

Exhibit 1 – Map of Kenya

Source: Courtesy of the University of Texas Libraries, the University of Texas at Austin, http://www.lib.utexas.edu/maps/ accessed October 2011.

Exhibit 2 – Selected NWH Statistics

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
# of Sites	1	1	1	1	1	1	1	2	2	3	7
# of RNs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	54	72	113	133
# of MDs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	16	37	49	53
# of Beds	61	61	61	61	61	61	61	149	149	226	226
Annual Inpatient Admissions	1,626	n/a	n/a	2,078	2,519	2,681	3,257	3,107	4,344	5,768	4,210
Annual Outpatient Admissions	19,511	n/a	n/a	27,710	35,419	45,047	58,237	61,594	76,885	93,857	68,679

Notes: Statistics as of December 31 of each year with the exception of 2005 (April – December) and 2012 (January – August). MD includes 8 permanent staff and 45 part-time. Totals do not include specialists.

Source: Company documents.

Exhibit 3 – NWH Maternity Packages (2011)

Our maternity packages are tailor-made to meet the maternity needs of different women. These packages are ideal for cash-paying clients since they are prepaid. They are also easy on the pocket and we allow the client to pay in installments and only expect full payment by the 8th month of the gestation period. As for the clients whose medical care is handled either directly by their company or by an insurance company, we will still offer maternity care but give an itemized bill since direct and insurance companies deal with the hospital on a post-paid basis.

For all of the packages offered below: NHIF card is accepted under ALL the above packages Withdrawal penalties: – Week 1—28 weeks of gestation: Ksh. 1,000 Week 28 weeks and above: 5% of TOTAL package.

Package	Eligibility	Package Costs include:	Package does not include the costs of:	Additional Information
Shortmat	Clients who are almost sure of a normal delivery.	• 2 days hospital stay • Use of delivery pack and delivery room • Obstetrician ward review • Pediatrician for first examination • Ward drugs and disposables • Initial immunization as per the KEPI schedule: BCG & Polio	• -Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Antenatal services will be charged separately. • Medication, feeds and nursery care for sick babies • Induction for the mother • For clients choosing to be delivered by an obstetrician , an extra Ksh.24,000/= will be charged on discharge • Additional services provided billed & paid for separately. • Clients who undergo an emergency caesarean section will receive an itemized bill payable at discharge	This package is payable in full before admission.
Regular	Clients who are almost sure of normal delivery & is fully payable at least one month (30 days) before the expected date of delivery. Eligibility – 14 weeks gestation, with no pre-existing medical or obstetric complications .	• Ten antenatal consultations • One routine antenatal lab profile • Two ultrasound scans 2 days hospital stay Use of delivery pack and delivery room • Pediatrician for first examination • Obstetrician's ward review • Ward drugs and disposables • Supplements: Folic acid (3 month dose) & Pregnacare/ Vitiron (2month dose) • Initial immunization as per the KEPI schedule: BCG& Polio	• Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Medication, feeds or care for sick babies • Induction of the mother • For clients choosing to be delivered by an obstetrician , an extra Ksh.24,000/= will be charged on discharge • Additional services provided billed & paid for separately. • Clients who undergo an emergency caesarean section will receive an itemized bill payable at discharge	A deposit of Ksh. 20,000 is payable on booking for the package. Total payment for the package is due at least one month (30 days) before the expected date of delivery).
Ultimate	Covers both the antenatal and delivery services, including emergency Caesarean Section.	• Ten antenatal consultations • One routine antenatal profile • Antenatal & postnatal exercises: • 3 sessions each Supplements: Folic acid (3month dose) and Pregnacare/Vitiron (2month dose) • Two ultrasound scans • 2 days (normal delivery) OR 4 days (C/S) ward stay	• Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Medication, feeds or care for sick babies • For clients choosing to be delivered by an obstetrician , an extra Ksh.24,000/= will be charged on discharge	A deposit of Ksh. 30,000 is payable on booking for the package. Full payment at least one month (30 days) before the

gheli@harvard.edu
617-495-8222

	Eligibility – 14 weeks gestation, with no pre-existing medical or obstetric complications .	• Use of delivery pack& delivery room OR theatre Fees • Pediatrician first time examination and Obstetrician ward review • Mother's post natal consultation after 6 weeks • Initial immunization as per the KEPI schedule: BCG & Polio • Ward drugs and disposables	• Any additional services provided are billed and paid for separately	expected date of deliver.
Superb	Clients who are to deliver through an elective caesarean section	• Theatre charges 4 days ward stay • One day nursery stay • Obstetrician ward review • Pediatrician for first examination of baby • Ward drugs & disposables • Initial immunization as per the KEPI schedule: BCG& Polio	• Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Antenatal services will be charged separately. • Medication, feeds or care for sick babies • Additional services provided billed & paid for separately.	This package is payable in full before admission.
Superb with ANC	Clients who are to deliver through an elective caesarean section and is fully payable at least one month (30 days) before the expected date of delivery.	• Ten Antenatal consultations • One Routine antenatal profile • Antenatal & postnatal exercises: • 3 sessions each · Supplements: Folic acid (3month dose) and Pregnacare/Vitiron (2month dose) • Two ultrasound scans • Theatre charges 4 days ward stay • One day nursery stay • Obstetrician ward review • Pediatrician for first examination of baby • Ward drugs & disposables • Immunization as per the KEPI BCG& Polio	• Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Medication, feeds or care for sick babies • Additional services provided billed & paid for separately	
Private Patient (Normal)	Clients who have their own private doctor and are sure of a normal delivery.	• 2 days hospital stay • Use of delivery pack and delivery room • One day nursery stay • Ward drugs and disposables • Initial immunization as per the KEPI schedule: BCG & Polio	• Doctor's charges, • Antenatal services • Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Medication, feeds and nursery care for sick babies • Induction for the mother • Additional services provided billed & paid for separately • Clients who undergo an emergency caesarean section will receive an itemized bill payable at discharge.	This package is payable in full before admission.
Private Patient Caesarean	Clients who have their own private doctor and are to undergo an elective caesarean section.	• Theatre charges • 4 days ward stay • One day nursery stay • Ward drugs & disposables • Immunization as per the KEPI schedule: BCG& Polio	• Doctor's charges • Antenatal services • Pre-existing medical conditions of mother and/or child during pregnancy and/or after delivery • Medication, feeds and nursery care for sick babies • Additional services provided billed & paid for separately	This package is payable in full before admission.

Source: NWH website, http://www.nwch.co.ke/maternity-packages-2/ and company documents.

Exhibit 4 – GBV Frequently Asked Questions

What are forms of GBV?

Women and girls suffer from numerous forms of violence and these include acts that cause physical harm such as female genital mutilation. Other forms of violence include stalking, blaming without reason, neglect, and sexual harm such as rape and forced prostitution. Often, these groupings only reflect the nature of the violence and not the effects.

Who is at risk and why?

All women face the risk of violence- despite their economic status, race, physical appearance, education level or age- as violence against them both reflect and reinforce inequalities between men and women that exist in virtually every culture around the globe. Men are also known to suffer from (GBV) but the magnitude is much smaller compared to that of women. Women suffer most because of patriarchal values which accord them lower social status.

What are the effects of GBV?

a) *Physical effects:* This includes pain, contracting of STI's and HIV in cases where the assailant is infected, mutilated genitalia, potentially a range of other injuries which can even result in death, unintended pregnancy, abortion or infanticide, and unwanted children.

b) *Psychological effects:* Psychological trauma is also known to result from GBV and this range from paralysis and terror to emotional pain; sense of denial, depression, mental disorder, and sometimes suicide. The victim can also experience nightmares and be haunted by fears and feelings of shame or guilt.

c) *Social effects:* Social costs to survivors of GBV include rejection, stigmatization, further sexual exploitation and severe punishment. The development and wellbeing of children and families is also affected. Boys who witness battery are likely to be of violent disposition while girls may grow into victims. GBV inhibits girl's access to schooling, may result in poor performance at school and deprives society of the full participation of women in development. Most research confirms that;

   "Early sexual victimization may leave women less skilled in protecting themselves, less sure of their worth and their personal boundaries, and more apt to accept victimization as part of being female hence increasing chances of future victimization like battery, rape, domestic violence, high risk behavior in adolescence and adulthood like unprotected sex with multiple partners, alcohol/substance abuse, teen pregnancy and prostitution among others."

d) d) *Economic effects:* Victims bear enormous financial costs in accessing justice and health services. Organizations also bear costs when they commit resources to provisions of legal and health services to survivors.

Violence against women and girls is a global scourge that affects the health and economic stability of women, their families and their communities. Women who are victims of violence are often unable/ afraid to seek health and other forms of care, such that the violence in their lives can not only have long standing physical and psychological effects for the survivors, it can also undermine national development because it handicaps women's ability to participate in the social and economic life of their communities. Gender based violence also serves to perpetuate male power and control. It is sustained by a culture of silence and denial of the seriousness of the myriad consequence of abuse.

gheli@harvard.edu
617-495-8222

GBV violates several recognized human rights such as the right to life, freedom from torture, equal protection before the law, liberty and security of person, the highest attainable standard of physical and mental health, and the right to be heard. It also violates women's right to control their sexuality.

Source: Excerpt from GVRC website, http://www.gvrc.or.ke/index.php?option=com_jefaq&view=faq&Itemid=59, accessed June 2012. Text modified by case writer.

gheli@harvard.edu
617-495-8222

Exhibit 5 – Press Release of AHF/NWH Deal

The Africa Health Fund invests US$2.66 million in Nairobi Women's Hospital

January 4, 2010: The Africa Health Fund (the Fund), which was launched in June this year, has made its first investment, acquiring a stake in the Nairobi Women's Hospital for US$2.66 million.

The Africa Health Fund is managed by Aureos Capital, a leading private equity fund management company specialising in investing in small to medium-sized businesses in emerging markets.

The Fund is backed by the International Finance Corporation (IFC), the African Development Bank, DEG and the Bill & Melinda Gates Foundation, who have jointly invested US$57 million. The target is to raise a total of US$100 million, with a final close in 2010.

The objective of the Africa Health Fund is to increase access to, increase affordability and increase quality of health-related goods and services for underserved Africans, especially those at the bottom of the income pyramid, simultaneously providing investors with good long-term financial returns.

Nairobi Women's Hospital (NWH) provides healthcare services for women and children. It focuses on providing inpatient, outpatient and specialized services for women, including antenatal, gynaecology, obstetrics, breast cancer detection and surgery. It also has what is believed to be the first Gender Violence Recovery Centre in East Africa.

A proportion of the sum invested in NWH will be used to help fund a management buyout, with the balance going to the expansion of facilities such as clinics, beds, ambulances and operating theatres in the East Africa Region.

Sev Vettivetpillai, CEO of UK-based Aureos Advisers says: Whilst we were setting up a unique HIV/AIDS risk management programme for our East African portfolio companies in 2008 we started to realise just how fragmented and under-capitalised the healthcare sector is in Africa.

Many of the causes of the high costs and inefficiencies of the healthcare sector in Africa are essentially business issues that we hope the Fund, and the input of Aureos executives, will help to resolve.

We believe the Africa Health Fund will make a valuable contribution to helping low-income Africans get access to affordable, high-quality healthcare services whilst at the same time providing satisfactory returns to our investors.

We are delighted to have completed this investment in NWH and look forward to helping them reach a larger portion of the underserved population in East Africa.

Aureos has one of the longest-standing track records of private equity investment in Africa and an unparalleled expertise investing in small to mid-cap business and in healthcare.

Through the Africa Health Fund, we look forward to helping populate Africa s private healthcare sector with growing, profitable businesses, well positioned to attract further domestic and foreign investment.

Dr Sam Thenya, Group CEO of NWH, comments: We are delighted to have attracted the backing of the Africa Health Fund and to receive the support of Aureos. Their experience in the African health sector will help us better reach those in need.

Source: Excerpt from NWH website, http://www.nwch.co.ke/index.php?option=com_content&view=article&id=48:funding&catid=52:newsandevents&Itemid=87 accessed July 2012.

Exhibit 6 – NWH Board of Directors (2010)

Dr. Sam Thenya is a medical doctor by profession, and the Group CEO and founder of the Nairobi Women's Hospital. He holds an MBCHB and MMed (Obs/Gyn) degrees, both from the University of Nairobi and an Executive Master of Science (Organizational Development), EMOD, at the United States International University (USIU).

Mrs. Patricia Ithau is a Senior Executive, possessing 20 Years experience growing some of the world's leading consumer household and alcoholic brands across a variety of different and challenging markets both locally and internationally. She is further experienced in general management leading some of the top businesses in the East African region including creating new business ventures in new geographies.

She has a proven track record of success in growing overall business, brand equity share and turnover; creating brands; training; inspiring and influencing teams to deliver against stretching targets; and generation of step change thinking. She is experienced in strategic visioning, planning and P&L management (Company, brand and Society). She is the chair of the Nairobi Women's Hospital Board of Directors.

Dr. Lawrence Ndombi is the Leader at Business Partner Consulting (BPC) and immediate former Vice - President, Human Resources, Unilever East and Southern Africa. He is a seasoned business leader, a champion of HR and has worked with other senior business leaders to turn around businesses and achieve desired business results.

Mrs. Wendy Mukuru is a Senior Associate with Aureos Kenya Managers. Prior to her joining Aureos, Wendy worked for the East Africa Portfolio Associate for Acumen Fund focused on building deal pipeline, conducting diligence on new investment opportunities and managing investments in the Health sector. She has over seventeen years of working experience in a variety of positions within the financial services industry such as; CFC Stanbic Kenya and Standard Chartered Bank. She holds a B.Sc. Business Administration, Finance Option from California State University, Los Angeles.

Mr. Shakir Merali is an experienced investment professional with eight years of deal evaluation and portfolio management in both a Trans-Atlantic venture capital fund as well as a leading Emerging Markets private equity fund, coupled with four years of strategy and operational consulting to multinational corporations. Mr. Merali is skilled in negotiating, structuring and executing investment deals. He has a broad platform of business experience from working with a range of companies.

Source: NWH website, http://www.nwch.co.ke/index.php?option=com_content&view=article&id=81&Itemid=70, accessed October 2011. Test modified by case writer.

Exhibit 7 – GVRC Services (FY 2002-2011)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
# of GBV survivors seen	326	1046	1756	1970	2,338	2,750	2,805	2,487	2,909	2954
# of court cases presented evidence*	N/A	N/A	N/A	N/A	86	85	153	75	178	123
# of clients referred to other organizations	N/A	N/A	N/A	N/A	465	385	138	174	109	94

Notes: Financial constraints prevented GVRC staff from attending cases that took place outside of Nairobi.

Source: GVRC Annual Reports from 2005-2005, 2005-2006, 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011 available at http://www.gvrc.or.ke/index.php/reports/annual-reports# accessed July 2012.

Exhibit 8 – Selected List of GVRC Donors

Year	Donor	Award Amount (KSh)
2002-2004	MSF Belgium (medical donations)	215,628
	Canadian International Development Agency (Gender Equity Support Project)	4,149,083
	Ford Foundation	9,240,000
2005	MS Kenya (Danish Association for International Corporation)	300,000
	Swiss Agency for Development	600,000
	Safaricom Foundation	22,500,000
2006	Individual donations	1,568,832
	Other corporate donations: Coca-Cola East and Central Africa Foundation, MSF Belgium, Nairobi Women's Hospital, Action Aid International Kenya, Kenya Charity Sweepstakes	5,867,775
	Safaricom Foundation	7,255,762
2007	Individual donations	2,906,107
	Safaricom Foundation	7,744,238
	Other corporate donations: Terres Des Hommes, Coca-Cola East and Central Africa Foundation, Nairobi Women's Hospital, Action Aid International Kenya, British High Commission, UNFPA, UAP Insurance	17,721,870
2008	Individual donations	1,290,664
	Safaricom Foundation	7,500,000
	Other corporate donations: Terres Des Hommes, Coca-Cola East and Central Africa Foundation, The Nairobi Women's Hospital, Action Aid International Kenya, British High Commission, UNFPA, UAP Insurance	45,384,713
2009	Individual donations	42,800
	Safaricom Foundation	3,750,000
	Other corporate donations	21,876,466
2010	Individual donations	62,300
	Safaricom Foundation	7,500,000
	Other Corporate donations	18,092,426

gheli@harvard.edu
617-495-8222

Exhibit 8 – Selected List of GVRC Donors Excluding NWH (continued)

Year	Donor	Award Amount (KSh)
2011	Unilever Kenya LTD	39,200
	Childline Kenya	85,278
	Housing Finance Corporation of Kenya	133,400
	Terres Des Hommes (TDH)	148,400
	Kenya Airport Authority	200,000
	Coca-Cola East and Central Africa Foundation	262,772
	DED	991,450
	Output Based Approach	1,012,214
	UNFPA	1,392,673
	GIZ	2,952,573
	Plan International	8,295,468
	Safaricom Foundation	8,500,000
2012	Childline Kenya	171,924
	Plan International	543,244
	Output Based Approach	895,572
	GIZ	1,014,000
	Terres Des Hommes (TDH)	2,402,231
	Safaricom Foundation	8,500,000
	GIZ Drought Response Programme	11,357,518
	Royal Media Services	52,000,000

Source: Company documents.

Exhibit 9 –GVRC Board of Trustees Members (2010)

- **H. E. Geert Aagaard Anderson**, Danish Ambassador to Kenya
- **Mr. Les Baillie**, Chairman, Safaricom Foundation, formerly Chief Investor, Relations Officer, Safaricom Limited.
- **Wangechi Grace**, Executive Director GVRC, Board of Trustees Secretary
- **Mrs. Wendy** Mukuru, Senior Associate, Aureos Kenya Managers and Director NWH Board
- **Norah Matovu Mwinyi**, Consultant on Gender and Development, formerly Executive Director, FEMNET (African Women's Development and Communication Network)
- **Dr. James Nyikal**, Permanent Secretary of Gender, Children and Social Development, Government of Kenya.
- **Honourable Lady Justice Njoki Ndung'u**, Judge of the Supreme Court, EBS, formerly Committee of Experts, Constitutional Review, Chairlady, GVRC.
- **Ms. Norah Odwesso**, Public Affairs and Communications Director, Coca-Cola East and Central Africa Limited.

Source: GVRC website, http://www.gvrc.or.ke/index.php/about-us/board-of-trustees#!prettyPhoto, accessed August 2012.

Exhibit 10 – Success Factors Comparison between NWH and GVRV

Success Factor	NWH	GVRC
We delight our customers.	X	X
With our processes we passionately keep our promises.	X	X
We are accountable as a team.	X	X
We run a sustainable organization by delivering value to our stakeholders.	X	
We deliver a planned expansion.	X	
Our services are demand driven.		X
We are the leaders and source of credible data in the sector.		X
We are a strong and unique brand.		X
Our organization is built on trust and integrity.		X

Source: Company documents.

Exhibit 11 –NWH/ GVRV Missions and Visions

	NWH	GVRC
Vision	We are trusted with the healthcare of our women in Africa.	A society free of gender based violence.
Mission	With a passion we deliver healthcare.	We are the centre of excellence in the prevention and management of GBV in Africa.

Source: Company documents.

gheli@harvard.edu
617-495-8222

Exhibit 12 –NWH Financials for Years 2009 – 2010

HEALTHLINK MATCARE LIMITED

STATEMENT OF COMPREHENSIVE INCOME
FOR THE YEAR ENDED 31 MARCH 2010

	Notes	2010 Sh'000	2009 (Restated) Sh'000
INCOME		437,843	361,863
DIRECT EXPENSES		(228,284)	(186,233)
GROSS PROFIT		209,559	175,630
OTHER INCOME		4,504	6,490
OPERATING EXPENSES		(276,724)	(148,742)
INTEREST INCOME	4 (a)	135	746
FINANCE COSTS	4 (b)	(7,110)	(394)
(LOSS)/PROFIT BEFORE TAXATION	5	(69,636)	33,730
TAXATION CREDIT/(CHARGE)	7(a)	22,857	(12,513)
(LOSS)/ PROFIT FOR THE YEAR		(46,779)	21,217
OTHER COMPREHENSIVE INCOME FOR THE YEAR		3,226	-
TOTAL COMPREHENSIVE (LOSS)/ INCOME FOR THE YEAR		(43,553)	21,217

Source: Company documents.

Exhibit 13 –Brief Descriptions of NWH Sites and Services Offered

Facility Name	Founded	# of beds	Services Offered	Notes of Interest
Hurlingham	2001	60	• Labs • Imaging • Pharmacy • Two operating theatres • Neonatal nursery • Maternity ward • Surgical wards	• Original NWH location • Attracts clients from many parts of Nairobi
Adams	2009	88	• Group's ICU unit • Dentistry and a dental unit	• Location for incinerating machine • The only mobile mammography unit in Kenya
Ongata Rongai	2011	77	• Maternity ward • Medical ward for men & women • Surgical wards for men & women • Fully equipped dental unit	• Hosts the NWH-Medical Training College which opened doors in 2008 and had trained and certified over 300 students by December 2012.
Kitengela	2012	N/A	• 24hr Outpatient Services • 24hr Laboratory Services • 24hr Pharmacy Services • 24hr Imaging Services • Specialized Clinics • Counseling Services	• Fully fledge 24hr outpatient centre designed to accommodate all outpatient needs
Eastleigh	2012	N/A	• 24hr Laboratory Services • 24hr Pharmacy Services • 24hr Imaging Services • Counseling Services	• Part of the planned expansion • Equipped to handle emergent cases including deliveries with 12 hours observation
Nakuru	2012	30	• 24hr Accident & Emergency Services • 24hr Laboratory Services • 24hr Pharmacy Services • 24hr Imaging Services	• Part of the planned expansion
Kiambu Pharmacy	2012	N/A	• Pharmacy operates from 8am to 8pm for seven days in a week	• First satellite pharmacy of its kind and part of planned expansion. • Three staff members--pharmacist in-charge, the pharmacy technologist and a cashier. • Plan to steadily monitor the demand for a late night pharmacy and/or a 24hr pharmacy.

Source: Company website, http://www.nwch.co.ke/branches-2/, accessed January 2013.

Endnotes

[1] Immaculate Karambu, "Violence victims offered a shoulder to lean on," *Business Daily Africa*, June 9, 2010, http://www.businessdailyafrica.com/-/539444/934548/-/item/0/-/4pncmyz/-/index.html, accessed September 2011.
[2] "Our Hospitals," NWH website, http://www.nwch.co.ke/index.php?option=com_content&view=article&id=9:ourvisionamission accessed July 2012.
[3] GVRC website, http://www.gvrc.or.ke/index.php?option=com_jefaq&view=faq&Itemid=59, accessed June 2012.
[4] 2008-2009 Kenya Demographic and Health Survey (KDHS), www.measuredhs.com/pubs/pdf/FR229/FR229.pdf, accessed August 2011.
[5] Immaculate Karambu, "Violence victims offered a shoulder to lean on," *Business Daily Africa*, June 9, 2010, http://www.businessdailyafrica.com/-/539444/934548/-/item/0/-/4pncmyz/-/index.html, accessed September 2011.
[6] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011 and "Kenya Demographic and Health Survey, 2008-09," www.measuredhs.com/pubs/pdf/FR229/FR229.pdf, accessed August 2011.
[7] "Kenya Health System Assessment 2010," USAID, August 2010, URL, accessed July 2012.
[8] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011, accessed September 2011.
[9] "Kenya Overview," USAID Kenya, October 5, 2010, http://kenya.usaid.gov/country-profile, accessed June 2012.
[10] Area and Population (Kenya), in Europa World online. London Routledge. Harvard University, accessed October 2011.
[11] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html accessed September 2011.
[12] "Food Security Analysis: Kenya," USDA Foreign Agricultural Service, Office of Global Analysis, March 2009 http://www.fas.usda.gov/itp/Kenya/KenyaFoodSecurity09.pdf accessed June 2012.
[13] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011
[14]"Background Note: Kenya," Bureau of African Affairs, U.S. Department of State, May 7, 2012, http://www.state.gov/r/pa/ei/bgn/2962.htm, accessed June 2012.
[15] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011 and "Kenya Health Assessment 2010," USAID August 2010, http://www.healthsystems2020.org/content/resource/detail/2760/, accessed July 2012.
[16] "Kenya," IndexMundi, http://www.indexmundi.com/kenya/, accessed October 2011.
[17] "Kenya Overview," USAID Kenya, October 5, 2010, http://kenya.usaid.gov/country-profile, accessed June 2012.
[18] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011.
[19] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011.
[20] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011.
[21] "Kenya," IndexMundi, http://www.indexmundi.com/g/g.aspx?c=ke&v=29, accessed October 2011.
[22] "Kenya Health Assessment 2010," USAID August 2010, http://www.healthsystems2020.org/content/resource/detail/2760/, accessed July 2012.
[23] "Kenya Health Assessment 2010," USAID August 2010, http://www.healthsystems2020.org/content/resource/detail/2760/, accessed July 2012.
[24] "Kenya Health Assessment 2010," USAID August 2010, http://www.healthsystems2020.org/content/resource/detail/2760/, accessed July 2012.
[25] Kenya National Bureau of Statistics and ICF Macro. 2010. "2008-09 Kenya Demographic and Health Survey: Key Findings," http://www.measuredhs.com/pubs/pdf/SR178/SR178.pdf, accessed July 2012.
[26] Kenya, Private Health Sector Assessment," World Bank Working Paper Series, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[27] 2008-2009 Kenya Demographic and Health Survey (KDHS) NEED URL FOR LONG VERSION, accessed August 2011.

gheli@harvard.edu
617-495-8222

[28] Unless otherwise noted, data from this paragraph based on Kenya National Bureau of Statistics and ICF Macro. 2010. "2008-09 Kenya Demographic and Health Survey: Key Findings," http://www.measuredhs.com/pubs/pdf/SR178/SR178.pdf, accessed July 2012.
[29] "Kenya Health Assessment 2010," USAID August 2010, http://www.healthsystems2020.org/content/resource/detail/2760/, accessed July 2012.
[30] "CIA World Factbook, Kenya," CIA website, https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html, accessed September 2011.
[31] Kenya National Bureau of Statistics and ICF Macro. 2010. "2008-09 Kenya Demographic and Health Survey: Key Findings," http://www.measuredhs.com/pubs/pdf/SR178/SR178.pdf, accessed July 2012.
[32] "Kenya," U.S. Global Health Initiative, October 14, 2010, http://www.ghi.gov/country/kenya/, accessed August 2012.
[33] National Coordinating Agency for Population and Development (NCAPD) [Kenya], Ministry of Medical Services (MOMS) [Kenya], Ministry of Public Health and Sanitation (MOPHS) [Kenya], Kenya National Bureau of Statistics (KNBS) [Kenya], ICF Macro. 2011. Kenya Service Provision Assessment Survey 2010. Nairobi, Kenya: National Coordinating Agency for Population and Development, Ministry of Medical Services, Ministry of Public Health and Sanitation, Kenya
National Bureau of Statistics, and ICF Macro. http://measuredhs.com/pubs/pdf/SPA17/SPA17.pdf.
[34] Kenya Service Provision Assessment 2010.
[35] "USAID and Kenya: Education and Youth," USAID, http://kenya.usaid.gov/programs/education-and-youth, accessed July 2012.
[36] The WorldBank, "EdStats: Country Profiles, Kenya," http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTEDUCATION/EXTDATASTATISTICS/EXTEDSTATS/0,,contentMDK:22614780~menuPK:7196605~pagePK:64168445~piPK:64168309~theSitePK:3232764,00.html?KEN,105, accessed July 2012.
[37] "USAID and Kenya: Education and Youth," USAID, http://kenya.usaid.gov/programs/education-and-youth, accessed July 2012.
[38] National Coordinating Agency for Population (NCAPD) [Kenya], Ministry of Medical Services (MOMS) [Kenya], Ministry of Public Health and Sanitation (MOPHS) {Kenya}, Kenya National Bureau of Statistics (KNBS) [Kenya], ICF Marco. 2011. *Kenya Service Provision Assessment Survey 2010*. Nairobi, Kenya: National Coordinating Agency for Population and Development, Ministry of Medical Services, Ministry of Public Health and Sanitation, Kenya National Bureau Statistics, Ministry of Public Health and Sanitation, Kenya National Bureau of Statistics, and ICF Macro, http://measuredhs.com/pubs/pdf/SPA17/SPA17.pdf, accessed September 2011. (Kenya Service Provision Assessment)
[39] Kenya Service Provision Assessment 2010.
[40] Richard G. Wamai, "The Kenyan Health System—Analysis of the situation and enduring challenges," *Japan Medical Association Journal (JMAJ)*, March/April 2009, Vol. 52, No.2, http://www.med.or.jp/english/journal/pdf/2009_02/134_140.pdf, accessed October 2011.
[41] Africa Health Dialogue Blog, "Will the poor in Kenya enjoy the 'Right to Health?", November 1, 2010, http://africahealth.wordpress.com/2010/11/01/will-the-poor-in-kenya-enjoy-the-%E2%80%9Cright-to-health%E2%80%9D/, accessed October 2011.
[42] Africa Health Dialogue Blog, "Will the poor in Kenya enjoy the 'Right to Health'?", November 1, 2010, http://africahealth.wordpress.com/2010/11/01/will-the-poor-in-kenya-enjoy-the-%E2%80%9Cright-to-health%E2%80%9D/, accessed October 2011.
[43] Press Release, "New report to be released on quality of health care services in Kenya," Measure DHS Demographic and Health Surveys, May 24, 2011, http://www.measuredhs.com/Who-We-Are/News-Room/Research-on-quality-of-health-care-services-in-Kenya.cfm, accessed September 2011.
[44] Africa Health Dialogue Blog, "Will the poor in Kenya enjoy the 'Right to Health'?", November 1, 2010, http://africahealth.wordpress.com/2010/11/01/will-the-poor-in-kenya-enjoy-the-%E2%80%9Cright-to-health%E2%80%9D/, accessed October 2011 and "Kenya, Private Health Sector Assessment," USAID, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[45] Richard G. Wamai, "The Kenyan Health System—Analysis of the situation and enduring challenges," *JMAJ*, March/April 2009, Vol.52, No. 52.
[46] "Kenya, Private Health Sector Assessment," USAID, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.

[47]Richard G. Wamai, "The Kenyan Health System—Analysis of the situation and enduring challenges," *JMAJ,* March/April 2009, Vol.52, No. 52.
[48]Richard G. Wamai, "The Kenyan Health System—Analysis of the situation and enduring challenges," *JMAJ,* March/April 2009, Vol.52, No. 52.
[49] As quoted in, International Finance Corporation World Bank Group, "The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives," http://www.ifc.org/ifcext/healthinafrica.nsf/Content/FullReport, accessed October 2011.
[50] "Kenya, Private Health Sector Assessment," USAID, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[51] Africa Health Dialogue Blog, "Will the poor in Kenya enjoy the 'Right to Health'?", November 1, 2010, http://africahealth.wordpress.com/2010/11/01/will-the-poor-in-kenya-enjoy-the-%E2%80%9Cright-to-health%E2%80%9D/, accessed October 2011.
[52] "Kenya, Private Health Sector Assessment," World Bank Working Paper Series, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[53] "Kenya, Private Health Sector Assessment," World Bank Working Paper Series, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[54]Unless otherwise noted data from this paragraph taken form "Kenya, Private Health Sector Assessment," World Bank Working Paper Series, August 2009, pdf.usaid.gov/pdf_docs/PNADS739.pdf, accessed September 2011.
[55] Owen Dyer, "In search of a sustainable philanthropy," *Bulletin of the World Health Organization*, Volume 84, Number 6, June 2006, 425-504, http://www.who.int/bulletin/volumes/84/6/news20606/en/index.html, accessed September 2011.
[56] Owen Dyer, "In search of a sustainable philanthropy," *Bulletin of the World Health Organization*, Volume 84, Number 6, June 2006, 425-504, http://www.who.int/bulletin/volumes/84/6/news20606/en/index.html, accessed September 2011.
[57] As quoted in, Catherine Maternowska, Jill Keesbury and Nduku, "Sexual Violence: Setting the Research Agenda for Kenya," Bixby Center for Global Reproductive Health, Population Council, and LVCT, November 2009, http://www.popcouncil.org/pdfs/2009RH_SGBVKenya.pdf, accessed June 2012.
[58] Clay Muganda, "Kenya Turning a Blind Eye," *allAfrica.com*, July 5, 2005, http://allafrica.com/stories/200507140994.html, accessed August 2012.
[59] Presentation, "Lobbying The Sexual Offences Act 2006," Hon. Njoki S. Ndungu, EBS, MP, undated, presented at "UN Expert Group Meeting on good practices in legislation on violence against women," Vienna, Austria, 26 to 28 May 2008" http://www.un.org/womenwatch/daw/egm/vaw_legislation_2008/vaw_legislation_2008.htm#expert, accessed January 2013.
[60] Presentation, "Lobbying The Sexual Offences Act 2006," Hon. Njoki S. Ndungu, EBS, MP, undated, presented at "UN Expert Group Meeting on good practices in legislation on violence against women," Vienna, Austria, 26 to 28 May 2008" http://www.un.org/womenwatch/daw/egm/vaw_legislation_2008/vaw_legislation_2008.htm#expert, accessed January 2013.
[61] "Report from OHCHR Fact-finding Mission to Kenya, 6-28 February 2008," United Nations High Commissioner For Human Rights, February 2008, http://responsibilitytoprotect.org/OHCHR%20Kenya%20Report.pdf, accessed August 2011.
[62] "A Rapid Assessment of Gender-Based Violence During the Post-Election Violence in Kenya conducted January-February 2008," UNICEF, UNFPA and Christian Children's Fund, March 2008, http://www.unfpa.org/emergencies/docs/gbv_assessment_kenya.pdf, accessed August 2011.
[63] Charlene Smith, "We Never Though It Could Happen Here," *Thought Leader Mail and Guardian Online*, January 24, 2008, http://www.thoughtleader.co.za/charlenesmith/2008/01/24/we-never-thought-it-could-happen-here/, accessed August 2011.
[64] "A Rapid Assessment of Gender-Based Violence During the Post-Election Violence in Kenya conducted January-February 2008," UNICEF, UNFPA and Christian Children's Fund, March 2008, http://www.unfpa.org/emergencies/docs/gbv_assessment_kenya.pdf, accessed August 2011.
[65] Waki Commission, "The Commission on Post-Election Violence Report," October 2008, http://www.nation.co.ke/blob/view/-/480850/data/46260/-/p6gqpv/-/WakiRep.pdf, accessed August 2011
[66] Dr. Samuel Thenya as quoted in undated video of Eisenhower fellowship. For the full video see, http://www.efworld.org/programs/eisenhower_fellowships_current_international_fellowships%20TEST.php, accessed September 2011.

[67] Emily Perryman, "Africa Health Fund invests USD2.66m in Nairobi Women's Hospital," *Private Equity Wire*, April 1, 2010, www.privateequitywire.co.uk, accessed August 2011.
[68] Beatrice Gachenge, "Kenya's health sector draws private equity interest," *Reuters*, http://www.reuters.com/article/2011/02/24/kenya-health-privateequity-idUSLDE71N1MP20110224, February 24, 2011 and George Omondi, "Kenya: Country Gears Up for Major Health Sector Reforms," *allAfrica.com*, http://allafrica.com/stories/201003020911.html, March 3, 2010, accessed August 2011 both accessed August 2011.
[69] George Omondi, "Kenya: Country Gears Up for Major Health Sector Reforms," *allAfrica.com*, http://allafrica.com/stories/201003020911.html, March 3, 2010, both accessed August 2011.
[70] Emily Perryman, "Africa Health Fund invests USD2.66m in Nairobi Women's Hospital," *Private Equity Wire*, April 1, 2010, www.privateequitywire.co.uk and "Investment in Nairobi Women's Hospital in Kenya," International Finance Corporation," undated,
[71] Mr. Shakir Merali as quoted in, George Omondi, "Kenya: Country Gears Up for Major Health Sector Reforms," *allAfrica.com*, http://allafrica.com/stories/201003020911.html, March 3, 2010, accessed August 2011.
[72] Information from this paragraph based on the presentation by Dr. Samuel Thenya, "Healthcare As Part Of Integrated GBV Services: The potential need of a network of expertise and knowledge," 5th GTZ Health Sector Network Meeting, February 25, 2010, http://docs.google.com/viewer?a=v&q=cache:0s-3c6TLQ1gJ:www.gtzkenyahealth.com/SNM/Thursday%252025TH%2520February/Morning/HEALTHCARE%2520AS%2520PART%2520OF%2520INTEGRATED%2520GBV%2520SERVICES.ppt+Healthcare+As+Part+Of+Integrated+GBV+Services&hl=en&gl=us&pid=bl&srcid=ADGEESgkHB4YhM69PqOI0FkS-lQ2TcRsQ1vwByMLamgjAP1s7c1A5pPyssELkU4S2TIbG88CvRH0BXStjuC5QS-Wd9rnOnYpJi4I174AWuRa-m9YIqGHFEURVgdZqaAsqvfigWeIeahf&sig=AHIEtbQyWchJt3WdDujjv6u44KFskTpwXw, accessed August 2011.
[73] Nkirote Mwiti, "Gender Violence Recovery Centre Inaugural Board of Trustees Meeting," *GIZ Health Sector Programme in Kenya: A web log on activities of GIZ Health Programme in Kenya*, http://www.gtzkenyahealth.com/blog3/?p=4388, June 2, 2010, accessed September 2011.
[74] Dr. Sam Thenya as quoted in, Immaculate Karambu, "Nairobi Women's Hospital seeks to tap new revenue in medical waste," *Business Daily Africa*, May 5, 2011, http://www.businessdailyafrica.com/-/539552/1156456/-/688833z/-/index.html, accessed January 2013.
[75] "Health – Kenya: Biomedical Waste Management in Hospitals," http://www.giz.de/Themen/en/dokumente/giz2011-en-kenya-psb-biomedical-waste.pdf.
[76] "Health – Kenya: Biomedical Waste Management in Hospitals," http://www.giz.de/Themen/en/dokumente/giz2011-en-kenya-psb-biomedical-waste.pdf.
[77] Beatrice Gachenge, "Kenya's health sector draws private equity interest," *Reuters*, http://www.reuters.com/article/2011/02/24/kenya-health-privateequity-idUSLDE71N1MP20110224, February 24, 2011
[78] Dr. Samuel Thenya as quoted in Beatrice Gachenge, "Kenya's health sector draws private equity interest," *Reuters*, http://www.reuters.com/article/2011/02/24/kenya-health-privateequity-idUSLDE71N1MP20110224, February 24, 2011.
[79] John Muchangi, "Hospital with Kenya's most modern incinerator," *The Star*, January 17, 2012, http://www.the-star.co.ke/news/article-33904/hospital-kenyas-most-modern-incinerator, accessed August 2013.

gheli@harvard.edu
617-495-8222