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VICTOR MASBAYI

*Interviewed by: Marcia Bernbaum
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INTERVIEW

Early years, education, and values

Q: Tell me about where you were born and raised

MASBAYI: I was born in Nairobi, Kenya in 1951.

When I was a year and a half my mother, sister and I had to go back to my father's village, Emauko in Busia county, because my father was put into detention by the colonial government. The colonial government claimed that he was supporting the freedom fighters.

We went to Emauko and lived with our grandmother. Busia County is located in Western Kenya near the Kenya/Uganda border. When I lived there Emauko was a village of about 2,000 people, far from a large city. Most of the people that lived there were peasant farmers and cattle herders. They farmed mostly sorghum (millet), cassava, sweet potatoes and maize.

There was no electricity and no water. There were no health services. We had to travel 10 kilometers to the nearest mission health facility in Butula. Later on, the government created a health center in Bumala, closer to Emauko.

Most people who lived in Emauko were either uneducated or had low education levels. A few people, like my father and others, had gone to secondary school, most in Uganda where the schools were considered better. My father went to the Makerere University and enrolled for an engineering course which he never completed because he was put in detention while on internship. My mother attended most of primary school and could read and write.

For my first eight years I attended a school about 3 miles from my home. It had eight grades with about 20 students in each grade. We would run over and back from our house. Since we couldn't go home at lunchtime we would go into the bush and get fruits to eat.

My father was in detention for 5 years until 1957. My grandfather died a year later after my father returned from detention. For the first couple of months he was a restricted person. He was not allowed to leave his village and he couldn't be in the company of more than 3 people at any time.

His treatment while in detention wasn't bad because the colonial government found him useful because he was an engineering student. They used his skills to build roads and bridges. He spent part of his detention in Athi River outside of Nairobi. The other part was spent on Island Mageta on Lake Victoria.

When the ban was lifted my father was able to get a job with East African Breweries in Nairobi where he worked for three years. When his brother, who was the village chief of Marachi location in Busia County, was promoted to be a district commissioner my father was asked to come back to fill this position which he did for four 4 years. For the first time I got to know him well.

While he was chief, he had run ins with his superiors who kept trying to move the ethnic boundary lines which he felt compelled to defend. Out of frustration, after serving as Village Chief for four years, my father returned to East African Breweries in Nairobi where he rose to the position of Marketing Manager.

Being the restless man, he was, he decided he wanted to be a Member of Parliament. In 1969, when I was 18, he returned to Busia where he was elected as a Member of Parliament for the Busia East Constituency. My father expanded his family to include a total of five wives, my mother being the first. In total I had 28 brothers and sisters.

My high school days were split between two schools that were distinctively different. St Paul's Amukura School where I completed my secondary school exams was a rural school that catered for average Kenya children. Children in this school came from modest family backgrounds. Sadly, the school rules and regulations were not strictly enforced and there was much indiscipline among students. I learned early at this school that if I was going to be successful, I needed to discipline myself. It worked for me because I was among only two students who got the top grade at the national examinations out of 120 students who sat the exam. My two-year high school was at Lenana School in Nairobi. This was a school previously exclusive for white students during the colonial days. It changed its colonial name Duke of York to Lenana School after Kenya's independence. Here the rules were well enforced. Most students came from well off families. Here good performance and standards were highly encouraged and competition to perform well was stiff. This school further reinforced my belief in the value of self-discipline to succeed in life.

I joined the University of Nairobi in 1973 to study sociology and government. Here I learned the value of using empirical data to back up debates and critical articles in assignments.

In one of my first-year classes Professor Bethwell Ogot, a historian gave us an exercise that simply read "Africa has no history. There is only the history of Europeans in Africa. Prof Hugh Trevor Roper". Discuss. We spent several weeks searching the library to find out that Africa's history was mostly oral and that Trevor Roper did not recognize oral history. This among other class discussion prepared me well for analysis issues in my future career.

Later in 1981 I studied health planning and economic development at the university of Michigan, Ann Arbor, USA. This gave me an opportunity to understand international

issues and to socialize with a multicultural student population that was useful in informing my work in global health.

Q: Tell me about your childhood memories

MASBAYI: As a child I was curious. I had certain desires/dreams about what I wanted to do. Sometimes they became realities and sometimes not. I dreamt I would achieve the university level (reality), preferably a lawyer (not).

I grew up in a family that was polygamous. My grandfather was polygamous. I was his first grandson. Therefore, everyone had expectations for me to lead by example. They always said to me “you should be a good example to your younger sisters, brothers and cousins”. I grew up very conscious that I had a role to play leading this family team.

This influenced me: I started making decisions very early about what was wrong, what was right, how my younger siblings should live.

I also had uncles and aunties who were very progressive and I looked up to them, especially my maternal uncle who had successfully graduated from Forte Hare University, a South African University for black Africans that offered a western style education. I wanted to be like him. He was my hero. He was a successful economist. He crossed the cultural barriers and married a Swiss woman. They were stopped by the Kenya police many times to explain their relationship. He became a very successful businessman and politician in his later life.

The Catholic faith shaped my life significantly. My mother came from a staunch catholic family and got us going to church regularly. Boarding schools further reinforced my catholic faith which I still practice to date.

Q: What values have guided your life?

MASBAYI: My parents were examples and are still so.

My mother, in particular, was very concerned about honesty and drilled it into us. I feel extremely guilty when I tell a lie.

My father used to write letters when I was in boarding school, saying “Son, aim high and maintain high”.

My grandmother influenced me in terms of obedience. She expected when she sent you out to do something you go running. You do the job wholeheartedly and come back

My grandfathers were both leaders, each in his own way. One was an Assistant Chief in the colonial government and the other was a lay reader for the Catholic church and a merchant trading in timber, fish and public transportation.

Q: How did your upbringing impact on the remainder of your life?

MASBAYI: The values I was exposed to during my childhood influenced my life in many ways. I came to value that hard work results in success, a belief that has been seriously damaged by rampant corruption in my country where hard work does not necessarily lead to results any more.

Being the eldest grandchild in a large family exposed me to responsibilities very early in life to take care of others. My interest in development and assisting communities grow may very well have come from this upbringing.

My curiosity and desire to do well has served me throughout my life as has the importance of leadership which was instilled in me from a young age, being the eldest boy child. My family members who served as role models influenced me as did my upbringing as a Catholic where I learned the values of humility and caring for others.

My childhood experiences in taking responsibility seem to have helped build my leadership qualities as I grew in my career. Taking responsibility and the lead seem to come naturally to me. If I was doing anything in life, I put my whole effort into it.

Jobs before joining USAID 1978-1981

Q: Let's move to your work career by starting with a description of your first job

MASBAYI: After graduating from the university in 1976 I took a position in marketing research with Unilever for two years where I designed questionnaires to study the habits and attitudes of consumers of Unilever's products such as cooking fat, washing powder etc.

This job introduced me to my professional career world and taught me the importance and value of communicating clear and accurate information. Wrong data or the use of a single wrong word would bring a company's product to its knees. I learned what it means to be meticulous.

Fortunately, my values of commitment to work came into play. I thought about my contribution to the organization but I also thought about the organization's contribution to me. I was keen to contribute positively to the organization but also to learn from its skills that I would use in future career.

The skills I learned in questionnaire design and in qualitative interviews were helpful in my next job when I went out into the field to see projects in operation. I could quickly and easily identify key information that became useful in the design of new proposals to donor agencies.

Q: What was your next job?

MASBAYI: From Unilever I became employed by the African Medical and Research Foundation (today known simply as AMREF Health Africa) where I stayed for nearly 9

years, between 1978 and 1987. My role was as a project officer. I monitored project progress, edited activity reports, assuring they were in the format donors wanted and participated in the development of new project proposals.

This job introduced me to the reality of the poor health of populations in Eastern Africa. I was particularly perturbed by the high mortality rates of children under five years of age and the high maternal mortality in these countries. Although I was vaguely aware of the statistics, my commitment to support the cause to improve child and maternal mortality was triggered by the scenes of sick children in overcrowded hospitals beds, the poor conditions of maternity services and poor antenatal clinics that had little communication and discussion with pregnant mothers. This greatly influenced my interest in maternal and child health which I have pursued throughout my career.

I played a significant role in the AMREF projects that opened up health services in countries that had under gone strife. These countries included Somalia under President Siad Barre, Uganda after the fall of President Idi Amin and Southern Sudan soon after it became an independent nation.

I contributed to proposals that funded these programs and I made field visits and participated in meetings with senior Ministry of Health officials. In Somalia, the Project Steering Committee of the Government of Somalia in debriefing us on our proposal wanted to know if back at the Nairobi Headquarters we had any Somali staff on our team.

My Director who was chairing the meeting had no clue and looked at me. I immediately said “yes we do”. At the end of the meeting he called me aside and asked “Victor, are sure we have a Somali person on our staff”. I confirmed that we had a very good secretary on our team. When we returned from Somalia, he moved her to the Directors front desk. She was a Kenyan Somali.

Between 1980 and 1981 AMREF sponsored me for a Master’s in Public Health at the University of Michigan at Ann Arbor. My boss was focused on developing local talent. I thought about the organizations that provided health services and the potential to improve their capacities to deliver such services and decided I was making a good choice to join the public health world. I also considered my potential path for growth and felt that a concentration in public health was the thing to do.

When I returned, I enjoyed the work I did in assisting poor communities. We used to go out with the mobile clinics and I would witness communities coming in for treatment. There were all sorts of problems, sick children with conjunctivitis, men and women with trachoma etc. I was sitting there all the time watching community nurses and physicians at work.

MPH at the University of Michigan 1981

Q. Tell me about your experience getting an MPH in the US

MASBAYI: I arrived in Ann Arbor in the fall of 1981. I got a good briefing from students that had been given the task by the department faculty to brief me. They assisted me to get housing and how to navigate my way to class. My class was multicultural with students from all over the world. I enjoyed most classes but always worried about biostatistics and epidemiology. I still passed well in these two subjects.

One Friday our professor announced that we would go for a “happy hour” at a local pub. I expected to find something tangible that Americans referred to as a happy hour only to learn that it was the fun of being together for an hour buying drinks at half price that constituted a happy hour.

But more was to come. I learned that there would be a gay parade on campus one Saturday. I stood by the window of my room to see these gay people but I couldn’t see what they were gay about. They seemed pretty serious to me. I came to learn that it wasn’t “gay” in the sense of happiness but sexual orientation.

One day, in class on Health systems in Developing countries, the professor asked American students if any of them had been to a third world country. I was totally shocked when one responded that he had been to the UK a few years back. For a graduate student not to understand what “third world country” meant was a total shock to me.

Joins USAID/Kenya

Q. It was in 1987 that you took a job with USAID/Kenya?

MASBAYI: Yes. In 1987 I came into USAID/Kenya to manage the Peace Corps Small Projects Assistance program. I wanted to get into international work, but had no direct entry into population and health. I thought this might be a good entry point.

PVO Co-Finance Project: 1988 - 1995

Q. Did this provide a good entry point?

MASBAYI: Yes and no. After a year, in 1988, an opening came to move to the Office of Human Resources to work on the PVO Co-financing project. Eventually, in 1995, there was an opening in USAID/Kenya’s Office of Health and Population which I took.

In the meantime, working on the PVO Co-financing Project gave me some useful opportunities to learn about how USAID operates and the challenges I was to face once I became involved in Health and Population. It also gave me an opportunity to assume a leadership role as Project Manager of the PVO Co-Financing Project. There were just a few foreign services national that served as project managers.

Q. Tell me more about the PVO Co-Finance project

MASBAYI: When I moved to the PVO Co-Finance project, USAID Kenya had recently taken it over to manage directly given that the contractor responsible for managing the project did a poor job.

PVO Co-Finance gave grants to indigenous and US organizations for health programs, water/well building, agriculture, wildlife conservation, and small business. A key objective was institution building. The idea was that each indigenous PVO would be paired with a US NGO so that the US NGOs would help develop the capacity of indigenous organizations.

Where we gave a direct grant to a US organization to work with an indigenous organization the program produced better results. However, the capacity of the local organization didn't improve. Once the US organization left, the indigenous PVOs were unable to continue the work they had started with the assistance of the US NGO.

If we gave money to an indigenous organization, the idea was they were to pair with an American organization. However, there was always friction. The indigenous organizations had set ways of doing business and when the US NGO partners would introduce new approaches which didn't mesh with theirs it created frictions.

The biggest challenge was that the indigenous organizations weren't able to absorb the grant funding they received. Often, they ended up giving back funds they couldn't use by end of the project funding cycle.

It was a catch 22 situation- USAID could not make large grants to these organization to have a wider and more effective reach. And when they got large grants, they often lacked the technical capacity to effectively carry out the job. They had to obtain these technical capacities quickly and deploy it only to lose it when their grant came to an end.

I continued with PVO Co-Finance until 1995 when I moved to USAID/Kenya's Office of Population and Health

Q: Was this worth doing?

MASBAYI: PVO Co-Finance created a stimulus for developing the capacity of local institutions which USAID has continued to date. At that time, other USAID offices also funded US NGOs to do work in Kenya. However, their objectives were not institution building but to achieve results that could be counted. To the best of my knowledge PVO-co financing was the first project designed to specifically address the capacity of indigenous NGOs in Kenya.

Q: What did you learn from this experience that you took forward when you moved to other positions at USAID?

MASBAYI: I learned that indigenous NGOs dependence on a single source donor is very bad for sustainability, as they often have nowhere to get funding when the donor leaves.

Many NGOs had difficulties diversifying their portfolio because all that they did was funded by big donors like USAID and DFID that would come and offer one big grant that would take them through a 5-year period. These projects were very demanding in terms of project targets and reporting. This left little time to look for funds from other sources.

Q: How did this affect what you did when you worked on institution building in USAID/Kenya's Office of Health and Population?

MASBAYI: This was a very difficult problem to resolve. I could not find a good solution when I worked with USAID/Kenya because part of my job was to protect the USAID funds. I was literally telling partners you can't use USAID funded staff to do work funded by other organizations.

USAID/Kenya: Office of Population & Health: 1995-2000

Q: When did you move to USAID/Kenya's Office of Health and Population and how long were you there?

MASBAYI: I moved in 1995 and stayed until 2000.

My patience at USAID paid off when I finally got back into public health by joining the Office of Population and Health. My experience and skills in managing the PVO Co-Financing project trained me well in communicating and working with Kenyan institutional leaders and this was to come in handy in my new job.

My position was that of Child Survival Management Specialist. The USAID/Kenya Health and Population had 4 US Direct Hire and 6 or 7 FSNs. Both the office chief, Dana Vogel, and my direct supervisor, Neen Alritz, were there for the five years I worked in the Health and Population Office. While there were changes at high levels of the Ministry of Population there was little change at the district level which is where we did most of our work.

Q: What projects did you work on?

MASBAYI: While in the Population & Health Office I worked on three projects: (1) the Bungoma District Malaria Initiative, a USAID/W program that aimed to improve the treatment and prevention of malaria in children under five years of age and in pregnant women; (2) an immunization support program; and (3) an HIV/AIDs prevention program for orphans and vulnerable children.

The Bungoma District Malaria Initiative was in a way the equivalent of present-day consortia grants. We had three organizations -- AED, CDC, AMREF -- and the Bungoma District Health Management Team working on this program. It was my job to coordinate their inputs and to ensure they worked in sync. I had good technical support from the Project Director in USAID/Washington and from USAID Kenya. This project took about 60% of time for the 5 years I spent in USAID/Kenya's Office of Health & Population.

One of the great achievements was when the local community of women with children under five learned the correct dosage of the first line drug for the treatment of malaria. They didn't have to rely on the drug sellers advise which was often wrong and biased towards drugs that gave them the greatest profit margin. We also found an increase in the uptake and use of treated bed nets by pregnant women and children under 5. In the beginning it was the men who slept under the net.

When the project ended it was taken over by another USAID-funded program as part of an integrated program.

Q: Can you describe to me how the Bungoma program worked?

MASBAYI: CDC was doing the clinical work, looking at the impact of the malaria drugs. They monitored drug efficacy, in case of drug resistance. They would go to clinics and see how children and women were being diagnosed and to make sure the drugs were administered correctly. CDC also recommended the correct chemicals for treating mosquito nets.

AED was looking at the prevention side. They organized community programs to improve communication and capacity of communities to prevent malaria. They also trained people in the community on the importance of mosquito nets and how to use them. In addition, they trained community workers on how to improve knowledge of correct dosages and communications to women on use/knowledge. They also trained shopkeepers in this first line drug so that they would hand out correct dosages.

AMREF was the technical manager. They were on the ground providing day-to-day management and reporting to USAID.

Initially we had some trouble managing relationship with the District Health management team. They were told they would be getting \$5 million or \$1 million a year. More funds went to CDC and AED than AMREF. This created a problem because the District Health Management Team asked where is the \$1 million a year going to the community when in fact a good portion was going to activities of CDC and AED teams and they didn't know the costs.

At the beginning the communication between teams was difficult. Each organization wanted to come in at a different time, do its own thing and leave. As the person responsible for managing the project in Kenya, I told them they needed to have a joint work schedule to coordinate work more effectively. Before starting the project, Denis Carroll, the Project Manager in USAID/W came to Kenya and we held a team workshop with the district health management team. Denis was very supportive.

Q: What was your involvement with the Bungoma program?

MASBAYI: The Project was funded directly by USAID/W and had independence from USAID/Kenya. I was involved in the original design in which USAID/W put the package together.

The Project began in Kenya with the arrival of the three contractors who I accompanied to Bungoma for a two-week workshop so that they could get local buy in and work with the District Health Manager and his team to develop a 5-year work plan.

One of the biggest challenges when we started the workshop was that most of the people on the District Management Team, along with the community health workers who also attended, couldn't understand the Americans. I suggested that we get District Management Team health members to be the facilitators, and that we step back and steer the discussion. When this happened, the workshop went well.

At the end of two weeks we selected 6 people from the District Health Management Team to spend another week to develop a 5-year work plan. By the end of 3 weeks a good bond developed between three parties. And it worked well.

Q: Tell me about your work on the immunization support program

MASBAYI: We collaborated with UNICEF to get the government of Kenya to increase its contribution to the budget for vaccines and to introduce new vaccines. At that time Kenya was contributing 15% of the budget, by the time I left it was 34%.

When funding agencies work collaboratively, they can get a government to invest in key activities which they otherwise do not prioritize. Partners worked through UNICEF to set up a revolving vaccine fund in which they would put money only if the Government of Kenya put in a certain percentage. The increase in the budget also led to an introduction of new vaccines such as the pentavalent vaccine.

It is important to get community elders to participate in vaccination campaigns. When they don't buy in they can discourage communities from taking their children for vaccinations. A good example is the belief in some parts of Kenya that some vaccines are tainted with chemicals to prevent future generation from having children. This can be devastating to an immunization program.

Q: What about your involvement with an HIV AIDs prevention program for orphans and vulnerable children (OVC)?

MASBAYI: We set up the first urban based OVC program, called Lea Toto. There was an American priest in Nairobi who ran an orphanage for children that were HIV positive or had AIDS. He wanted a grant. USAID said the best approach is to look after children within families. Finally, he agreed. Health workers went out into the slums of Nairobi. When they found a child with HIV, they recruited the household. Several households formed part of this program. Health workers came and looked after them. When they

found a child, whose parents had died and the child was automatically placed with someone else that household would be recruited.

Since my time at USAID much has been learned in regard to home based care and integration of children within the community. It is now generally agreed that institutional care is not the best way to handle children affected or infected with HIH/AIDS.

Q: Were you involved in any other projects while with the USAID/Kenya Population and Health Office?

MASBAYI: I supported colleagues in a social marketing program run by Population Services International. The program was initially used to promote family planning. Later it included insecticide-treated bed nets for prevention of malaria. This program targeted children under five years of age and pregnant women with a clear message that sleeping under a treated mosquito net reduced the risks of malaria infection.

The challenge with social marketing is that it had to cater for different market segments and therefore the quality of treated insecticide nets would differ due to price. Access was still limited to the very poor who could not afford to buy nets and had to get free nets from Government.

USAID's Regional Program for East Africa (REDSO: 2000-2010)

Q: In 2000 you moved to USAID's regional program located in Nairobi (REDSO) to work on their population and health programs. Please tell us about your experience

MASBAYI: I went in as a Maternal and Child Health specialist. The Office had a team of 9 people: three focused on HIV/AIDs, one on TB and infectious diseases, one health care financing, and one on reproductive health. We also provided technical support to USAID missions at their request. Of the nine: three were US Direct Hires, three were Foreign Service Nationals and three were on contract to USAID.

My work with REDSO (later renamed USAID East Africa) gave me the opportunity to share my skills and learn from across East and Southern Africa countries.

The primary mission of REDSO was to provide technical assistance to other USAID missions in the region; also, to manage regional programs in health. We had three regional programs. Each program had an individual person backstopping it. I was responsible for backstopping Regional Center for Quality of Health care Program (RCQHC)

I was proud of the success of RCQHC in improving learning materials for childhood nutrition, pediatric aids, the management of tuberculosis and prevention, and malaria treatment for pregnant women. I spent 60% of my time on this program.

I worked also with the East, Central and Southern Africa Health Community (ECSA-HC) to promote key health policies in countries of East and Southern Africa. We successfully lobbied for the use of misoprostol at the community level in prevention of post-partum hemorrhage which has been adopted by a number of countries. We also successfully lobbied for the fortification of sugar, maize meal, cooking oil with vitamin C. I spent 10% of my time on ECSA-HC.

Q. Tell me more about your involvement in with the Regional Center for East and Southern Africa program (RCQHC)

MASBAYI: The RCQHC was an initiative that came out of a regional network on improving the quality of health care initiated by REDSO before my time. This network set up RCQHC to be managed under Makerere University Kampala with USAID funding. Makerere University, with USAID participation, appointed the RCQHC Director who then ran a program that took promising practices in health, developed learning materials and trained Health managers of Ministries of Health in East and Southern Africa. Key areas of involvement were maternal and child health, TB, reproductive health and HIV/AIDS.

My responsibilities included oversight of USAID resources into the program, assisting with identification of technical assistance and coordinating such assistance from USAID/REDSO USAID/W; and linking them to other regional institutions that would help strengthen the message on improving the quality of health care.

Seventeen countries in east and southern Africa received training and health learning materials from RCQHC. The assessments carried out by RCQHC and results of the training were developed into advocacy papers and shared with the East, central and Southern Africa Health community (ECSA) which we funded to promote improved health policies for adoption by Ministries of health.

The lesson I learned was that Ministries of Health will adopt and change policies if they are persuaded with empirical evidence that the policies work.

Q: Can you describe your experiences providing technical assistance to USAID missions?

MASBAYI:

Democratic Republic of Congo: I was a team member charged with writing the MCH component of the evaluation of the USAID/DRC health program to realign activities to address changing realities on the ground and emerging USG strategic priorities in fragile states (2007).

Republic of Djibouti: I was also a team member charged with writing the MCH component of the evaluation of the Djibouti maternal and child health program (2008);

Kenya: I interviewed on the services delivery component of the review of the USAID/Kenya health program (APHIA II)- 2009

South Sudan: I was a team member responsible for the MCH component of the assessment of Sudan Health Transformation project in March 2008. These assessments set the pace of follow up USAID country operational plans.

USAID/Malawi: I also assisted USAID Malawi to review proposals for funding a major maternal and child health program

I found the USAID missions respectful, supportive and appreciative of the work I did. The challenge was that most USAID missions could receive TA from USAID/W. they preferred this support partly because the USAID/W team was close to the “purse” so to speak and might have advantage in lobbying for resources.

Q: I understand that at some point during your 10-year stay with USAID East Africa you moved up to become the Deputy Office Director. Tell me about how this came about and what it was like to be in this role.

MASBAYI: The position of office Chief became vacant and it took several months for the next office chief to arrive. The Office had two direct hire and two off shore hire Americans, two British off shore hire staff and five FSNs. Most staff were so busy they did not want the job of acting Office Chief.

Andy Sisson, the REDSO Mission Director at the time appointed me Acting Office Chief until the next Office Chief Vathani Amirthanayagam came along nearly four months later. She and Andy Sisson then gave me the official title of Deputy Office Chief. This position wasn't in the official USAID personnel job classification and didn't come with additional pay but it had oversight responsibilities. I held the job for several years.

The opportunity enhanced my supervisory and my negotiation skills. I led the REDSO Health and HIV/AIDS team and had to negotiate with key leaders of ministries of health and regional institutions. Initially FSNs were not keen on taking on a role such as mine but eventually some began to accept such positions offered by their offices. I can say therefore that I pioneered the way for my fellow FSNs.

Q: Anything else you would like to share about your 10 years with USAID East Africa?

MASBAYI: My experience at USAID East Africa opened my eyes to the unusually poor socio-economic conditions in which many us grow up. The odds against an African child surviving beyond the age of five years are pretty high and access to social amenities is negligible in comparison to children growing up in the western world. I have since then come to respect the resilience of African people.

Each time I meet an African professional who has made it in the world I remember the words of Peter Tosh “*Everyone's trying to reach the top. Tell me how far is it from the bottom*”. Africans come from the very bottom of the trench and make it.

Following retirement from USAID: 2010 – 2016

Q: So, you retired from USAID in 2010. Tell me about what you did next

MASBAYI: At the time of my retirement from USAID I was getting close to the official retirement age and didn't want to wait to be let go. However, I felt my career had just reached its maturity. I concluded that my experience in African development work would be useful in the United States where most professionals might have the theoretical knowledge of development but they may be lacking in field experience. I was also cognizant of the fact that American society had more opportunities and tolerance for senior citizens than Kenya which has an extremely high population of young people.

Q. In 2011 you took a position with the Academy for Educational Development (AED). How long were you there and what did you do?

MASBAYI: At AED I worked on the Africa' Health in 2010 project which aimed to provide strategic, analytical, communication and advocacy, and monitoring and evaluation support to African institutions and networks to improve the health status of Africans. The project supported issues identification analysis, sharing of promising practices, and monitoring and evaluation across the areas of maternal and newborn health; child survival; infectious diseases; reproductive health; multisectoral support to improving health outcomes including HIV/AIDS; nutrition; and gender-based violence.

In the short period I was there I worked virtually with RCQHC to complete an assessment a report on the “the Status of Oral Rehydration Therapy for Childhood Diarrhea Case-Management in Selected African Countries” and set the stage for dissemination of improvements in management of diarrheal disease in collaboration with WHO and UNICEF Country offices in Benin, Ethiopia, Mali, Senegal and Zambia. I initiated discussions with Makerere University, Uganda 's RCQHC program on the start of an East Africa regional newborn health network. I did not stay long enough at AED to follow up on how these activities performed.

Working as a contractor was quite different from my previous work as a USAID employee. I had to respond to all sorts of questions and suggestions from USAID technical staff. I realized that USAID technical staff sometimes propose far too many ideas some of which are not easily implementable and that it is important as a contractor to have the knowledge to push back on some of these ideas to keep your project within manageable limits.

Q: In 2011 you went to Tanzania with the University Research Company (URC) where you spent 5 years. Tell me about the experience. I can imagine that being a Country

Director managing several staff and dealing with the local authorities must have had its challenging moments.

MASBAYI: I spent five years in Tanzania working for the University Research Company as Chief of Party on a USAID funded program to improve the diagnosis and treatment of severe febrile illness in children under five years of age in the Lake Zone of Tanzania.

Professionally this was an exciting time for me. For the first time I independently managed a program. My supervisors worked with me remotely from the United States.

My management skills were seriously tested on this program. To begin with I had to coordinate staff from three different organizations. Compared to the Kenyans I was used to this team was slower and staff lacked the “killer” instinct that I was used to among my Kenyan workmates. To motivate the team, I encouraged short-term three-month activity plans for each technical staff member and held one-hour briefing meetings each Monday. This greatly improved performance.

Initially my biggest challenge was following discussions at workshops which were conducted mostly in Swahili. Although I speak and understand Swahili, the Tanzanian brand of the language was much more sophisticated and it took time for me to get used to it.

Working with Tanzanian counterparts at the regional and county level was not difficult as long as you kept them well informed of the work that was going on. They were very supportive overall.

The big challenge was making contact and communicating effectively with Ministry of Health head office which was in Dar es Salaam, a one and half hour flight from Mwanza where I was based. I made quarterly visits with some of my team members to debrief the Ministry of Health Headquarters and USAID staff. However, the distance put me at a disadvantage because I could not easily forge close working relationship with staff at the ministry of health headquarters.

In this malaria endemic area with limited access to resources malaria diagnosis was often based on clinical signs which was unreliable. Parasitological confirmation of malaria parasites became necessary and this was usually done via a rapid diagnostic test promoted by the project. This was preferred to microscopy confirmation because microscopy was prone to many obstacles that ranged from poor maintenance of the equipment to poor lighting etc. While the rapid malaria diagnostic test had its own challenges such as improper handling of blood slides, the positive predictive value was well over 90%.

I found Tanzanians to be friendly and trusting people. They will not pass you by without a greeting and they expect you to respond. I spent much of my free time learning to play golf at the Anglo- Ashanti mining company’s golf course about 40 minutes away from Mwanza. My game hasn’t improved much though.

Concluding reflections/observations

Q: What do you value as your most significant contributions over your career?

MASBAYI: I value my contribution to improving the health of children under 5 years. Especially children with preventable malaria and immunizable ailments – those have been very important to me. I have seen the difference we have made in under 5 child mortality

Seeing communities change in terms of putting health as one of the topics they discuss, especially improving women's health, maternal health and getting men to appreciate that they have a role to play in discussing the issues that affect children and women. That was something that did not happen much in Eastern Africa at the beginning of my career, but it has been happening progressively. In Tanzania I saw men bring children to clinic which is unusual.

I have been an influence and mentor to many young men and women who are contributing to society today.

I value my contribution to building the capacity of regional health management and training institutions in East Africa that have contributed significantly to improving and changing health policies in the region

I am proud of a generation of younger people from my community who meet me and say I was their role model

Q: Who are some of the people you worked with, especially those who made a difference in your career?

MASBAYI: My supervisors at the African Medical Research Foundation (AMREF), Douglas Lackey and later Katja Janovsky, believed strongly in developing a strong cadre of young Kenyans who would contribute to development. That included ten of us. We were in different fields: health, education, clinical services, program management. We were all given an opportunity to come to the US or the UK and get Masters degrees. We all went back and made a contribution to AMREF. Because there were so many of us as a cohort, we couldn't go up in the organization. So, we began to leave with AMREF's blessings. Both were very open about feedback and were straight forward in the appraisals they gave me.

Many people I worked with at USAID Kenya and REDSO had a very strong influence on me. At one time I was having a real hard time from some American staff at a meeting. After the meeting, one of my supervisors Tom Ray told me to take it easy. He said to me "in this organization you will always get some quacks and some good people. They come and go". I took this to heart as I navigated my way through the years.

The supervisors that had the greatest impact on me were Vathani Amirthanayagam and Marcia Bernbaum. Marcia described me as a “natural leader”. This set me thinking about why she said so. I began to look at myself more closely and got motivated as a manager.

Vathani appreciated this quality in me and often referred to me as her “secret weapon”. She delegated responsibilities to me and let me make key speeches as the USAID representative at openings of regional workshops which improved my confidence greatly.

There were many office colleagues that were supportive and helped urge me along such as Emma Mwamburi, Jerusha Karuthiru, Esther Ndiangui, Tim Takoma, the late Moses Mukuna, Zack Ratemo and Nancy Gitau to name but a few. Good leadership can only come to shine when you work with a good and strong team.

I appreciated these colleagues greatly. They challenged me to become a better performer. They were very good at their respective jobs and to work with them and to supervise some of them I had to raise my own bar so to speak.

I had some very good American supervisors; but they never lasted. Their frequent changes were a disruption in the development process.

My longest serving supervisors were Dana Vogel and Neen Alrutz of the Kenya office of Health and population. Their long stay meant we had a progressive program. We achieved very good results in increasing contraceptive prevalence, getting the Ministry of health to improve policies in maternal and child health, which resulted in increased immunization rates and increased uptake of treated mosquito nets for the prevention of malaria in under five children and pregnant women and improved access to HIV/AIDS prevention and treatment services.

Q: Can you describe the opportunities and challenges you encountered working as an FSN with USAID?

MASBAYI: Working as an FSN at USAID was a rewarding experience because of the relatively objective and fair recruitment, training and performance review systems. Most FSN staff held positions that they deserved and the results of their work was evident.

The second advantage was exposure to a multicultural working environment. We learned to work with and understand professionals from different cultures. The American staff came from a wide background of cultures so did the Kenyans.

Even though all our contracts were on an annual basis one felt confident that if one’s annual review was good one would stay on the job. Most people felt secure in their jobs

Q: What do you see as USAID’s greatest successes in health/population in East Africa?

MASBAYI: USAID was a leader in reproductive health and family planning, HIV/AIDS treatment and prevention, and maternal and child health.

On the basis of its technical programs USAID achieved much success in assisting the ministries of health to change and improve their health policies based on evidence. The use of family planning contraceptive methods became acceptable, the HIV/AIDS stigma was significantly addressed and new malaria policies significantly improved the management of malaria in children under five-years-old and in pregnant women.

Together with other agencies such as the UNICEF, WHO, DFID etc. USAID led the lobbying for the Government of Kenya to increase its health budget. I recall a significant increase in the budget for vaccines that happened about the year 2000 or there about.

Q: What were USAID's greatest challenges in health/population in East Africa?

MASBAYI: One of USAID greatest challenge was its failure to effectively participate in “basket funding”. While other bilateral agencies put their funding into basket funding and forged closer working relationships with key staff of the Ministry of Health, USAID looked like an outsider even though they were accepted by the Ministry on the basis of its strong and diverse portfolio of support.

The Kenyan Ministry of Health (MOH) has always been of the impression that USAID wants to call all the shots on the projects they fund. Frustrated MOH staff could often be heard saying “Pesa in zao. Tufanyeje” (It is their money. What can we do about it)?

The second challenge was the frequency with which programs were “re-engineered”. It seemed like every new office chief felt they knew better than their predecessor and wanted to “fix” the program even when it wasn’t broken. This would lead to disruption and delays in implementation.

Sometimes this was compounded by the tendency of some incoming American staff to assume the FSNs on board didn’t know much and needed “mentoring”. This was not necessary in most cases because most FSNs had vast experience. Some are much more experienced than their supervisors.

Q: What advice you would give to incoming FSNs and USDH's in general and interested in working with USAID in health/population?

MASBAYI: Take time to make field visits and be observant about what you see and hear. Take time to talk to staff implementing projects at the grass roots level and ask strategic questions. This gives one a very good understanding of the public health challenges.

It is important for the field team to meet when they return from the field and briefly discuss their observations. Find like-minded organizations addressing similar issues and do workshops focused on potential solutions to problems identified. Get away from the attitude that “we can do it better than other partners”. This is where true collaboration lies.

Fair treatment for FSNs is paramount to the performance of USAID missions. When they get demoralized the organization performance slips. I was working for USAID Kenya when the embassy and USAID moved into their current Gigiri premises. FSNs were designated parking spaces a mile away from the building and were to be ferried onto the embassy compound by bus. After a few weeks it was noted that there were plenty of empty parking slots on the embassy compound. When FSNs asked to use these spots, the administrative office responded that they were reserved for spouses of American staff. Now spouses don't work for USAID and don't need all day parking space. Fortunately, this policy was changed.

Be aware and be sensitive to cultural differences and to the significant differences in income between FSNs and Americans. For example, when you celebrate birthdays at the office the American staff carry the burden of bringing the birthday cake. For the average FSN a birthday cake is not a priority and is an expensive proposition in their kitchen budget so they are unlikely to bring a cake to the office. In any case it might not survive a "matatu" ride to work.

Q: If you could share 2 – 4 recommendations to USAID on how to increase its effectiveness in general, and specifically in health/population, what would they be?

MASBAYI: USAID needs new approaches to develop the capacity of local institutions and to work through them. The current approach to institutional capacity buildings seems fret with issues of sustainability. It often happens that at the end of the project key staff find another donor funded project and move away with the skills developed thus far. Due to the fact that most Ministries of Health don't a keep a good record of technical staff trainings, ministry staff often apply and participate in many trainings including those they have trained in already- the key motivation being per diems. This leads to much wastage and overtraining. Because staff are away from work so often, they don't have enough time to manage programs effectively.

I believe that donors can work with Ministries of Health to develop some key basic training in program implementation so that development partners don't have to run separate training programs. Training often targets the same managers of the Ministry of Health. Take for example a District Health Management team. The team might receive training in say "quality of care" from three or more USAID funded programs. Each partner claims their training is different.

Many countries in Africa are buying into a decentralized system of government in order to move services and decision-making closer to the populations served. USAID needs to watch the pace and move along with the changes. There is a risk of USAID remaining engaged with national management at the Ministry of Health Headquarter and leaving the regional communication to junior staff. I think this would weaken the USAID impact at the regional level.

Thank you very much for the interview. I hope it will be of value to others both at USAID and in the development sector in general.

Q: Thank you, Victor, for participating in the oral history program. It is wonderful to have your story added to the ADST collection.

End of interview