ROLE OF DONOR FUNDING AND MULTI-NATIONAL CORPORATIONS IN HEALTHCARE FINANCING IN AFRICA: CASE STUDY OF KENYA (2000-2015)

BY

RUTH DAMA MASHA

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DECLARATION

I, **Ruth Dama Masha** hereby declare that this project is my original work and has not been presented for a degree in any other University.

Signed……. Date……

Ruth Dama Masha

R50/81179/2012

This project has been submitted for examination with my approval as University Supervisor;

Signed…… Date……

Gerrishon K. Ikiara

Senior Lecturer

DEDICATION

I dedicate this research project to my late ‘babu’ Dr. James Maneno, my Dad Eng. Alfred Masha, Mama Joyce Masha, Husband Katana Mwagawe and to our sons John and Alfred for the love and support you have shown me all throughout the writing of this research work.

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God bless you all.

ABSTRACT

Healthcare financing in Africa is a major challenge due to the many problems ranging from poverty, corruption, misplaced priorities just to name but a few. Most of the African Countries are under developed but still try to improve health outcomes by steering towards achieving Universal Health Coverage in an effort to meet the sustainable health development goals. Donor funds and Multi-national corporations consist of international entities beyond national jurisdictions in terms of economic resources and decision-making responsibility in the Kenyan health sector. Despite their involvement the Kenyan health sector still suffers.

This study generally evaluates the role of various donors and Multi-national Corporations financing the health sector in developing countries Kenya being one of them. Specifically the study aimed; to examine the contributions made by Multi-national Corporations in financing healthcare services in Kenya, the influence of Multinational Corporation financing healthcare services and to recommend ways of improving donor funding and it's contribution to healthcare services. This study was underpinned by the Theory of Change and made use of descriptive research design. Both primary and secondary data was used in this study, with representation of the three Target groups; Users being healthcare personnel both in public and private sectors, MNCs and NGO's.

This study sampled top management in various MNCS, NGO's, Government officials from the Ministry of Health and other donors within Kenya using stratified random sampling technique. Panel data was used to estimate a demand model for health care in the country. The data covers a 15 year period which is later analyzed in a five year phase. Phase one being 2000 when there was so much hype about the millennial bug, 2010 when Kenya welcomed its new constitution and the last phase analyzes the challenges that came with the new constitution. The massive involvement of for-profit hospital chains in the delivery of health services has created a considerable growth of the for profit sector.

The benefits of health care financing by donor funds and MNCs and donors are in three different segments based on their expectations of health care financing: first being holistic, that is considering health care financing from aspects of financial success, company's ethical behaviour and its societal impact as well as interaction with local communities. The second aspect is relational, which focuses primarily on financial success and impact on people and society as a whole. The third is financial where low interests in societal and ethical issues are in main emphasis on financial performance. In this case the stakeholder segments should be taken into consideration while evaluating health care financing influence on the stakeholder's behaviour. The study recommends that MNCs and donor funding in health care must focus on the unique, basic needs of developing countries in a particular region or country, financing of health care must seek to adapt solutions from other markets and other applications to local needs. Financing of health care must examine local practices to identify useful principles and potential applications that will strike a balance between ensuring improved healthcare andthe Donors making their profit. MNCs also need to form new alliances, through public -private partnerships since no firm can create the commercial infrastructure that will sustain health care financing to the targeted vision alone. Finally, there's need to strengthen our national insurance scheme as this will ensure that there's a mechanism that allows every Kenyan to access healthcare services.

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LIST OF ABBREVIATION AND ACRONYMS

AFRO: Africa Regional Office

AIDS: Acquired Immune Deficiency Syndrome

DRGs: Diagnostic related groups

GDP: Gross Domestic Product

GoK: Government of Kenya

HIV: Human Immunodeficiency Virus

KES: Kenya Shilling

KNBS: Kenya National Bureau of Statistics

LMICs: Low and Middle Income Countries

SDG's: Sustainable Development Goals

MNCs: Multinational Corporations

NGO: Non-governmental Organization

NHIF: National Hospital Insurance Fund

NSAs: National Strategy Applications

OOP Out of Pocket Payment

OECD: Organisation for Economic Co-operation and Development

UHC: Universal Health Coverage

UNAIDS: United Nations Programme on HIV and AIDS

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund Somalia

US: United States

WHO: World Health Organization

CHAPTER ONE
INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Background

Globally, health care financing continues to stir debates as countries continue sourcing for funds to sustain the sector.[1]Globalization of health care is on the rise due to the steep rise of health care in developing countries compounded by the ageing populations and increase in the non-communicable illnesses with cancer taking the lead, diabetes, hypertension, obesity, depression, alcohol and substance abuse among others.

Health systems finances are faced differently by most of the developing countries.[2] This is due to the under-funding of their chronic health systems. Most of the health systems in these countries are run by the intervention of multi-national corporations who help in the funding. These are companies that operate globally away from the initial home country.

Multinational Corporations in healthcare are firms that own a significant equity and are instrumental in promoting Global health in various capacities. They are important actors and areknown as businesses that have invested directly abroad and in many nations.[3] These firms play a crucial complementary role to governments in the provision of health care in both developed and developing countries. However, their role still remains insignificant in terms of their financial contribution vis-à-vis government contributions and their profit margins.In Kenya, multinationals including pharmaceutical companies, since the 1990s have helped in the development of health systems and the saving of lives by involving themselves in the improvement of the systems.[4]

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[1]WHO. (2014). The world health report: health systems financing: the path to universal health coverage. Geneva, Switzerland: World Health Organization.

[2] Fabian, C., Johnson, J. & Kavanagh, S. (2011). *Anatomy of a Priority-Driven Budget Process.* The Government Finance Officers Association.

[3]Hyun S., Nishizawa T. & Yoshino N. (2015).*Exploring the Use of Revenue Bond for Infrastructure Financing in Asia.*JBICI Discussion Paper No.15. Japan Bank for International Cooperation: Tokyo

[4]OAU.(2015) *Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases,* Addis Ababa, Organization of African Unity.

In the year 2001/2002, Out of pocket payment was at 51.1% of the total amount spent on health, the Government's contribution was only 29.6% that meant that most Kenyans dug deeper in their pockets to fund for their health needs. In 2005/2006, Out of pocket payment was at 35.6% of the total health expenditure. There was a notable trend, donor funding had started rising. In the year 1994, donor funding had been estimated to be at 8% but in 2001/2002, it rose upto31%and in 2005/2006 further rose to 40%respectively, this clearly shows that when the public and private health sectors work together, outcomes tend to improve .In many countries, FBO (Faith based organizations) are more trusted because they are dominantly non-profit providers and also because their social aims plus their commitment to the public is good.

Globally, most of the MNCs and donors tend to protect their economic, political and cultural interests as they belong to rich and developed countries. Markets are created by MNCs and donors through collaborations with already existing ventures and other firms. Competitiveness is improved by these MNCs and donors due to the collaboration they create with other countries. Example to note include Aga Khan University which is a multinational health facility that has created its own niche in the health sector by offering healthcare technology in various departments like Setting up a state of the art Cancer Centre with an upto date infrastructure, offering grants to Medical students in the region like Tanzania, Uganda and Kenya and also has an elaborate Research laboratory.[5]

Besides the stated benefits, MNCs and donors have been accused of undermininghealth measures within the society where they extract resources and gain profits.[6] The other major concern is when MNCs and donors pressure developing countries to get cheaper drugs since they are the ones producing them. Most of them are commercial organizations and their interest is to gain maximum return on their invested capital. This study therefore aims to examine and highlight the benefits and shortcomings of MNCs and donors in developing a country's health sector and subsequently make policy propositions in global healthcare governance so as to enhance their contribution.

[5]Patcharanarumol, W. & Tangcharoensathien, V. (2014).*Can Earmarking mobilize and sustain resources to the health sector? Bulletin of the World Health Organization*, 86:898-901

[6]WHO. (2015). *Macroeconomics and health: Investing in health for economic development*, Geneva, World Health Organization.

1.2 Statement of the Research Problem

Healthcare financing in Africa is a major challenge due to the many political problems ranging from poverty, corruption, misplaced priorities just to name but a few.[7] Most of the African Countries are under developed or slowly developing but still try to improve health outcomes by steering towards meeting health sustainable development goals. The Kenyan Constitution Article 43(1) guarantees the right to the highest attainable standards of health yet this can never be achieved without a proper health work force.[8] A proper health workforce is one that the health workers are competent and well compensated. Ideally quality healthcare should and is a fundamental need for all and the government should be able to provide this service to all its citizens regardless of their cadre, gender and socio-economic background. Currently, all countries are aiming at achieving Universal Health Coverage by 2022 through ensuring that everyone is able to access promotive, preventive, curative, rehabilitative and palliative health services, this can be made possible by partnering with various stakeholders in the industry.

The vulnerable are mainly the less fortunate in the society who are victims due to their universal economic policies and poor status. Thus, they suffer mentally, emotionally, and physically. Facility Improvement Fund-Supervision survey show that Multinational Corporations in the health sector have more shortcomings that prevent them from making significant contributions in developing countries as they do in developed states.[9] As a result there are challenges related to health financing in Kenya. Key among them is the lack of adequate quality assurance mechanisms to guarantee that scarce funding which is used to provide sufficient quality care.

The country has less of stern policies in terms of offering equitable, affordable and accessible health to all its Citizens. There has been a never ending debate when it comes to our country's health insurance Scheme.[10] The Devolution of health is another major crisis that has affected Kenyans due to the poor disbursement of funds from the Central government, additional economic resources and the responsibility of decision making is determined by international entities of the MNCs and donors. As a result there has been very minor improvements in

[7]WHR. (2014). *Health system financing: the path to universal coverage.* World Health Statistics.
[8]Ministry of Health (2013), Kenya Household Health Expenditure and Utilization Survey. Nairobi: Ministry of Health; 2013.
[9]Government of Kenya (2014).*Facility Improvement Fund-Supervision Manual,* Nairobi: Government Printer.
[10]GoK, (2015), Kenya Health Bill 2015, Government Printers, Nairobi

accountability of this conundrum for the last thirty years.[11]Take for example the US Government and GAVI suspended funding to the MOH in May 2017 after Kenya was classified among 24 other countries as a high risk environment for donor funds. The Country now has to comply to highly stringent conditions on accessing and spending donor funds.

A number of studies have been done on multi-national corporations and health care financing. Kumaraswamy's study focused on developing countries and was based in United Kingdom.[12]Maitra and Mukhopadhyay's study was a comparative one done in Asia to compare MNCs and Donor health financing in Japan and China.[13] Further a study by Barrow done in Great Britain where the findings were similar to Maitra and Mukhopadhyay's study. [14] Locally Maina conducted a study on multinationals and scholarships which focused more on the education sector.[15]Mwabu, Ainsworth and Nyamete's study evaluate the influence of Coca-Cola Company on healthcare financing. However, Maina and Mwabu's did not include all the multinationals and the study only focusedon the North Rift counties.[16] The above review shows that there is need therefore to emulate the role of multi-national corporations and health care financing in developing countries precisely in Kenya.

[11]GoK/Health Systems 2020 Project (2015), Kenya National Health Accounts 2005/2006. Bethesda, MD:
[12]Kumaraswamy, S. (2012). Service Quality in Health Care Centers: An Empirical Study. *International Journal of Business and Social Science, 3*(16).
[13]Maitra, B. &Mukhopadhyay, C. (2012). Public spending on education, healthcare and economic growth selected countries of Asia and Pacific. *Asia-Pacific Development Journal, 19*(2), 19-48.
[14]Barro, R. (2015). *Three models of health and economic growth*. Unpublished Manuscript. Cambridge, MA: Harvard University.
[15]Maina, M. (2014).*Strengthening the Foundations of Health in Kenya*. Vol. II: 1997–2000. New Delhi, India: World Health Organization.
[18]Mwabu G., Ainsworth M., Nyamete A. (1993), "Quality of Medical Care and Choice of Medical Treatment in Kenya. An Empirical Analysis". *Journal of Human Resources* 28(4): 283-291.

1.3.1 General Objective

The general objective was to evaluate the role of Donors and multi-national corporations in health care financing in developing countries with aspecific reference to Kenya.

1.3.2 Specific Objectives

Specifically the study aimed:-

i. To examine the contributions made by donors and Multi-national Corporation's in financing of healthcare in Kenya.
ii. To assess the influence of donor funding Multi-national Corporation's financing healthcare services in Kenya.
iii. To recommend ways of improving donor funding and Multi-national Corporation's contribution in healthcare service in developing countries.

1.4 Literature Review

This section deals with a critical examination of the available literature on matters of healthcare financing in developed and developing countries. It also attempts to highlight the role of Multi-national corporations in Developing countries and the general overview of healthcare financing.

1.4.1 Contributions Made by Multi-national Corporations in Health Financing

According to Grepin and Dionne Multi-national Corporations through corporate social responsibility contribute in the goals of global health development programs known as 'corporate philanthropy' in simpler terms.[17]In the public subsidy, the involvement of taxes means that the expenditure is permanent in private foundations. Contribution of global health programs can be made by private foundations and private companies by use of their own programs. Private foundations and companies use their own income but sometimes it is derived from tax exemptions from public subsidies.[18]

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[17]Grepin, A. & Dionne, Y. (2013). Democratization and Universal Health Coverage: A Case Comparison of Ghana, Kenya, and Senegal. *Global Health Governance, 6*(2): 23-101.
[18]Kumaraswamy, S. (2012). Service Quality in Health Care Centers: An Empirical Study. *International Journal of Business and Social Science, 3*(16).

Meessen, Kouanda and Musango asserts that the Multi-national Corporations are the greatest spenders in the finances of global health, although they make the greatest contributions especially in drug donations, these are said to spend the profits on themselves.[19] Private companies view spending as the direct purchasing of medicines and other vital commodities. New research and development in purchase of products is done by lots of funding which is channeled through the private sector.[20]

As indicated by Mwabu, Ainsworth and Nyamete Multi-national Corporations financially support the purchase of products and services with respect to health care, which is also called supply side financing, which incorporates the various courses of action utilized by buyers of health care services to pay providers of medical care.[21]Some multi-nationals benefit public employees by providing services in public facilities. Others buy services from private and public providers. Some incorporate both approaches. Allocation of resources and procedures of purchasing have essential ramifications for cost, access, quality, and satisfaction of the consumer. Proficiency increases (both allocative and technical) from procedures of purchasing give better value to the cash and in this manner provide an opportunity of acquiring more finances in the health system.[22]

An investigation by Bardhan and Mookherjee demonstrates that market development for five Multinational Companies dealing in health care was seen in two different ways, and both were subject to identifying ways for consumers/patients to pay for services of health care. In the private sector, marketing of health care and medical coverage was a key essential component for expansion of private health care except if subsidized by private direct payers.[23]Findings by Chris and William study demonstrates that Multi-nationals perceive the public health care segment as a

[19]Meessen, B., Kouanda, S. & Musango, L. (2015). Communities of practice: the missing link for knowledge management on implementation issues in low-income countries? *Tropical Medicine & International Health*, 23 (16): 1007–14.
[20]Montalto, N. & Spiegler, E. (2013).*Functional health literacy in adults in a rural community health center*; 97(2):111–114.
[21]Mwabu, G., Ainsworth, M. & Nyamete. A, (1993). "Quality of Medical Care and Choice of Medical Treatment: An Empirical Analysis." *Journal of Human Resources* 28(4): 838–62.
[22]Filmer, D., Hammer, S. & Pritchet, H. (2013). Weak Links in the Chain: A Diagnosis of Health Policy in Poor Countries.*The World Bank Research Observer*, *15*(2).199–224.
[23]Bardhan, P. & Mookherjee, D. (2013).*Decentralization and Local Governance in Developing Countries*: A Comparative Perspective. Cambridge, MA: MIT Press.

growing market.[24]The outsourcing of services by multi-nationals, including clinical administrative services, has expanded and in this way leading to an increase in the health outcomes. Contracting of clinical administrators and use of highly innovative diagnostic testing tools has expanded because of health policies and legislations that lead to an increase in private health care providers giving patients more hope.

As indicated by the WHO Report, health care aid increased from US$2.5 billion in 2005 to nearly US$14 billion in 2015.[25]An examination by Wamai additionally indicates that Multi-nationals financing increased from US$8.5 billion in 2010 to US$13.5 billion in 2016.[26]The expansion in financing of health care was related with Multi-national Corporation's contribution where there has been an expansion in private subsidizing for worldwide health care, which presently represents about a fourth of all health development aid. The objectives of health financing by MNCs and donors incorporate promoting equality, keeping people from falling into destitution because of disastrous medical costs, securing and enhancing the health status of people by guaranteeing money is accessible to private and public health care facilities.

Stenberg's study shows that Multi-national Corporations have ensured that in the benefit package, allocative efficiency is a vital element which helps in decision making.[27]The ill-heath causes of the beneficiary population should be well known to the ministry of health, County health office or the insurance scheme. This leads to the advantage and improvement of the health issues of the general population.

A study by Ogola and Kizito assert that the benefit package by Multi-national Corporations is beneficial only when accredited user providers are used; that's the only time reimbursement of

[24]Chris, J. & William, D. (2014).*Risk pooling and redistribution in health care: an empirical analysis of attitudes toward solidarity.*
[25]World Health Organisation. (May, 2016) Country Health Profile. Retrieved fromhttp://www.who.int/countries/ken/en/
[26]Wamai R. (2016) Recent International Trends in NGO Health System Development, Organization, and Collaborations with Government in Transforming Health Care Systems: The Case of Finland and Kenya. Department of Social Policy/Institute of Development Studies. Finland: University of Helsinki; 2016 Jun.
[27] Stenberg, K. (2015). *Responding to the challenge of resource mobilization – mechanisms for raising additional domestic resources for health*. World health report, background paper, no. 13.

beneficiaries will be stipulated due to the cost of health care.[28]When value for money is provided, a willingness to change the rate and the appropriate range of services is provided, then that is termed as accreditation. There is also provision of accreditation if there exists a stable contract between the purchaser and the provider and a clear understanding between the two. This contract involves the types of services offered or to be offered, the money to be received for the services, the methods used to pay the provider and the service provided requirements that involve performance.[29]

An investigation by Harrison demonstrates that Multi-national Corporations have discovered that the absence of transparency of cost of public health made is becoming more conspicuous.[30]In 2005, the establishment of the diagnostic or health resource group pricing system, by the public segment, was viewed as a positive advancement by the five health care organizations. Diagnostic related groups (DRGs) sorted patients independently based on their diagnosis, procedures/treatments, age and duration of stay. Multi-national Corporations then presented DRGs as a method of endeavoring to control the spending plan. These new national frameworks of health/diagnostic related groups have been all the more generally embraced in the course of recent years by Multi-national Corporations in connection to allocation of resources and planning.[31]

Barzelay observes that MNCs and donors face various difficulties in the quest for enhanced healthcare in developing nations.[32]The study reveals that the improvement of new knowledge and ideas that solve some of the issues confronting public healthcare is additionally important and can be utilized as a method of understanding the market. The commitment of MNCs and Donors, assist the public in improving the productivity of an ageing community.

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[28]Ogola, P. &Kizito, M. (2015).*Decentralizing Kenya's Health Management System: An Evaluation*. Kenya Working Papers No. 1. Calverton, MD: Macro International Inc.

[29] Stenberg, K. (2015) *Responding to the challenge of resource mobilization – mechanisms for raising additional domestic resources for health*. World health report, background paper, no. 13.

[30] Harrison, S. (2011). Policy analysis. In: Fulop et al., eds. *Studying the Organization and Delivery of Health Services: Research Methods.* London: Routledge.

[31]Gianos, J. (2013). A brief introduction to Ansoffian theory and the optimal strategic performance- positioning matrix on small business (OSPP).*Journal of Management Research, 5*(2), 107-118.

[32]Barzelay, M. (2015).*New Public Management: Improving Research and Policy Dialogue* .Berkeley: University of California Press.

In most of OECD nations, governments have chosen to freely fund or to require private financing for the main part of healthcare services by welcoming MNCs and donors. By the given both low wage levels and points of confinement on residential asset preparation conceivable outcomes in low-wage nations and some middle wage nations, these nations confront extreme difficulties in freely financing basic personal and public healthcare services. They are additionally regularly faced with troublesome tradeoffs in relation to financing these fundamental services and providing insurance coverage against costs of illnesses.[33]

Lombardi states that minimizing inequality is a key objective in health care financing by MNCs and donors, but lack of political will by the governments is one of the major setbacks.[34]

1.4.2Donors and MNCs in Improving Healthcare in Developing Countries

One aspect of commercialization of healthcare is the developing function of organizations in the healthcare sector. Nonetheless, the World Bank and International financial organizations additionally assume an imperative function in empowering the production of medical services. MNCs and donors utilize this impact to force governments to be "more aggressive" by executing national policies helpful for advancingit's citizens' healthcare.[35]

Social health and multinational corporations operations have a close relationship that exists between them.[36]Contradictory capabilities arise from the powerful and influential positions of the MNCs and donors in the international community. The promotion and the undermining of social health is determined by this position that either enhances or inhibits the international community development founded by a stable local community.[37]Donors have obligations to control individuals and group activities through diplomacy to promote socio-economic developments and also outline their donor obligations as emerging subjects of international human rights law.

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[33]Smith, R. & Hanson, K. (2011).*What is a Health System? In: Smith R, Hanson K, Eds. Health Systems in Low and Middle-Income Countries: An Economic and Policy Perspective*. Oxford: Oxford University Press.

[34] Lombardi, E. (2014): *Health literacy in low-income Latino men and women receiving antiretroviral therapy in community-based treatment centres*; 17(6):283–298.

[35] Lucy, G. (2016). MNCshealth financing in Rwanda. *Health Policy and Planning 26; (2): 16-29.*

[36]Kramon, N. & Posner, J. (2011). "Kenya's New Constitution." *Journal of Democracy* 22(2): 89–2013.

[37]Degenholtz, B. & Gazmararian, A. (2011): Identifying elderly at greater risk of inadequate health literacy: A predictive model for population-health decision makers. Res SocAdm Pharm. 2007; 3:70–85

A number of incentive based payment systems depend on capitation and supervised care, case-based installments to medical facilities, and related instruments to guarantee a more impartial sharing of budgetary hazard between the buyer and the provider. This issue has gone up against expanded significance since benefactors need to be guaranteed that their services in low-salary nations are being utilized effectively. Nobody wants to empty cash into wasteful healthcare frameworks.[38] In addition, the effectiveness of a system has vital budgetary ramifications for governments to locate the "fiscal space" in very obliged spending settings for expansive increments out in the public spending. Health financing approaches (gathering, pooling, and buying) must be created with regards to the available fiscal space of a government.

In 2006 external resources represented 14.8% of all health spending in Kenya[39]. The United States was the biggest reciprocal giver, diverting assets through PEPFAR, the President's Malaria Initiative, and USAID. In 2009 the United States used $529.1M through PEPFAR programs alone.[40]The United Kingdom additionally dedicated critical bilateral assets to the health sector, followed by Denmark, Germany, Japan and the Netherlands. The European Union likewise dedicated assets to health programming in Kenya, and Kenya gets bolster from the World Bank and organizations inside the United Nations framework, including WHO, UNAIDS, UNICEF and UNFPA.[41]The Clinton Foundation is active in Kenya's health sector, as well as religious associations, for example, Catholic Relief Services, Lutheran World Relief, the Aga Khan Foundation the Mater Misericordiae and Coptic Hospitals.[42]

[38]Suberu, S. (2010).Budgeting strategies in selected federal polytechnic libraries in Nigeria. *Samaru Journal of Information Studies,* 10 (3): 77-91.

[40]Government of Kenya (2015). Accessible and Affordable Quality Healthcare services in Kenya, Financing Options for Universal Coverage, Nairobi: Government Printer

[41]Ministry of Medical Services and Ministry of Public Health and Sanitation, Kenya (2015).*Kenya Household Health Expenditure and Utilization Survey Report*.

[42] Noor, A. (2014). Modelling Distances Travelled to Government Health Services in Kenya. *Tropical Medicine & International Health* 11(2): 188–196.

1.5 Gaps in Literature Review

According to the reviewed literature, donors and MNCsin health financing systems ensure effective health service delivery. However, studies by Grepin and Dionne[53]; Meessen, Kouanda[54]and Musango and Bardhan and Mookherjee[55] observed that there is often a mismatch between health financing systems and health service delivery thus creating a gap. They noted several reasons for this mismatch including poor leadership, inadequate resources, unclear accountability structures, corruption and shortage of workforce. Different health institutions as well as different countries face unique challenges at different times and so there is no one best remedy or solution to these challenges. From the review empirical studies on MNCs and Donorsin health care financing benefits in other countries have produced mixed results.

In 2010 August, Kenya promulgated a new Constitution, which devolved the National government and the health system into 47 counties, this had a direct impact on health care, because the disbursements of funds would be channelled from the National to the County government and this came with many corruption woes. Whereas this was the overall national picture, very few studies have been conducted with specific interest to tease out the unique circumstances brought in by MNCs and donors in financing the counties or even the Ministry of Health. There was therefore a need to fill this gap by evaluating the role of multi-national corporations and health care financing in developing countries precisely in Kenya.

1.6 Justification of the Study

The present study could be beneficial to the following stakeholders;

To Kenya policy-makers in putting in place necessary policies in health financing in Kenya by creating an environment that will aid the system to be successful in strategy execution. The research is helpful in highlighting areas of policy gap that would require improvement within the industry, this would result into cost effective policy decision making processes regarding the influence of government's regulations in the industry. This may spur an enabling environment for the health business to grow.

The study in addition to the above, may be useful to financiers, and investors in formulating and planning areas of intervention aimed at improving healthcare in developing countries. This may enable Multinational Corporation and local companies to be encouraged in taking part in improving healthcare.

The health practitioners may benefit from this study as it may enlighten then on health financing system on delivery of health services. It is further hoped that health workers may use the findings of this study for their planning purposes. Some of the findings and recommendations to be drawn from this study may in future be applicable to other sectors of the economy as well. The present study is of theoretical significance as it sought to add to the body of knowledge regarding the role of Multi-national Corporations and health care financing in developing countries. Interested future scholars may benefit from this study as it forms a basis of discussion.

1.7 Theoretical Framework

This investigation was supported by the Theory of Change. This hypothesis rose in the 1990's at an Aspen foundation roundtable on network change development as a way to assess extensive network activities.[43]Methodologists like Huey Chen, Peter Rossi, Michael Quinn Patton, HeléneClark, and Carol Weiss are defenders of this model.[44]This hypothesis is a particular sort of procedure for financing, arranging and investment that is utilized in philanthropic activities and for governments to advance change and reclassify long haul program objectives. It maps in reverse to distinguish important preconditions that clarify the procedure of progress by sketching out causal linkages. According to this investigation, change is expected in the delivery of healthcare services by theincreasing contributions from the MNCs funding the healthcare systems. This theory characterizes the building squares required to achieve a given change and shows to what extent long term objectives will be reached and what will be utilized to gauge advancement. This theory hypothesizes that members in intercessions should be clear in recognizing quantifiable markers and in detailing of activity designs.

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[43]Bernard, F. (2013). "*Decentralisation and Governance in the Ghana Health Sector*", The International Bank for Reconstruction, The World Bank, Washington

[44]Nishizawa T. & Yoshino N. (2008).*Exploring the Use of Revenue Bond for Infrastructure Financing in Asia.* JBICI Discussion Paper No.15. Japan Bank for International Cooperation: Tokyo.

The theory of change grounds this examination since it decides change process related with conduct change and health providers.[45]This theory brings out appropriate differences among wanted and real results in mediations and expects partners to show wanted results prior to settling on types of intercessions to accomplish those results. The theory of change is basic as it centers around creating a good learning environment as well as focusing on accomplishing attractive change results in the health segment.

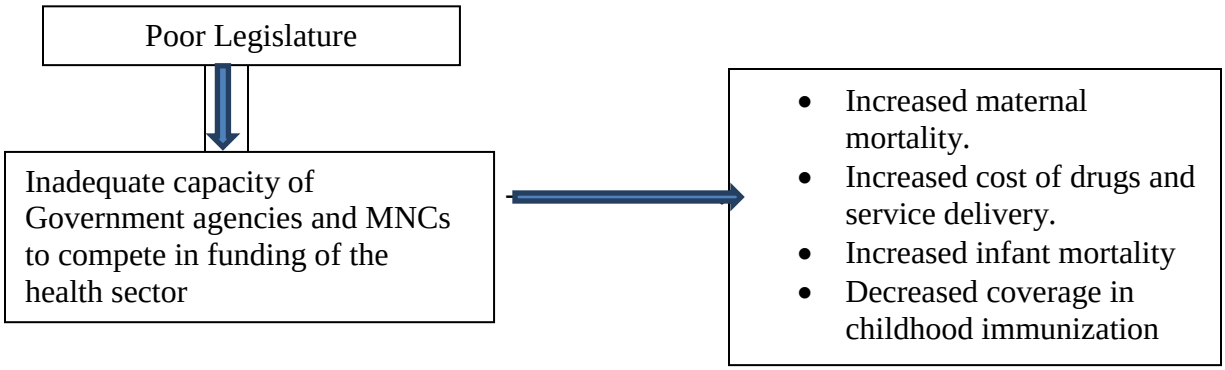
1.7.1 Hypotheses

H_1 Donors and MNCs significantly finance healthcare services in Kenya

H_0 Donors and MNCs financing significantly influences healthcare services.

H_2 Donors and MNCs contribution in healthcare services influences change.

Figure 1: Schematic analysis of the Theory of change



This study will use the change approach to analyse the need for MNCs and donors in complimenting healthcare financing. The independent variable being the MNCs and donor funding while the dependent variable is health care financing. The null hypothesis is to establish the relationship between the two variables and what changes these two variables bring.

[45]Xu, K. (2010). *Financial risk protection of national health insurance in the Republic of Korea: 1995–2007.* World health report 2010 background paper, no. 23.

In this theory we note that increased donor funding in the health sector will lead to a positive step and change in achieving UHC by 2022 in that healthcare will be more accessible, the cost of healthcare will be affordable to all, through research and trainings the burden of disease especially the NCD's will be reduced significantly.

The change theory emphasize a form of authority or management based on their functions and their needs.[46] The current trend of globalization has made the change theory successful especially in other states where sovereignty has been heavily eroded by the forces of globalization.[47]

Change theory looks at areas like the legislature tasked with changing the health care sector. They are supposed to source for stakeholder's who can partner with the Ministry in innovation, stocking of medicines as well as healthcare machines in order to change the health sector. The current state is that the government agencies have inadequate capacity to change the health system. The cost of drugs and health related service delivery are high and the public outcry is loud on needed intervention so that they can afford health services. There is therefore need for collaboration between the government agencies tasked with health issues to collaborate with MNCs and donors who havean interest in improving healthcare.

1.8 Research Methodology

The study used a descriptive research design. The choice of this design was motivated by the fact that it is a process of collecting data in order to answer questions concerning the current status of the subject under study. The descriptive aspect was used to portray an accurate profile of the persons, and situations in the study.[48]

As indicated by Mugenda and Mugenda it is important to test over 10% of the populace given that the subsequent sample isn't under 30 and not in excess of 1000 units.[49]They prescribed

[46]Brosio, G. (2014). Decentralization in Africa. In Ahmad, E. and Tanzi, V. Managing Fiscal Decentralization.
[47]Bal, D. (2010). Reducing tobacco consumption in California. Development of a statewide anti-tobacco use campaign. *Journal of the American Medical Association*. 264:1570-1574.
[48] Kothari, C. (2004). Pretesting in questionnaire design: The impact of respondent characteristics on error detection. *Journal of the Market Research Society*, *36*(October), 295–314.
[49]Mugenda, O. & Mugenda, A. (2003). Research Methods: Quantitative & Qualitative Approaches. Nairobi: Acts Press.

sufficient sample sizes in connection to particular populaces. Where a populace of 1,000 is considered for the examination, they prescribed a sample of 100. For a populace of 5,000 they prescribed a sample of between 100-500 while for a populace more noteworthy than 10,000 a sample of between 200-1,000 is viewed as satisfactory. The gathered information from the interview schedules was analyzed utilizing SPSS. Information gathered was arranged, characterized and coded then classified for simplicity of analysis. The information was condensed and ordered by regular subjects and presented by means of discussion and explanation of the study findings. Here all the data findings from the participants were combined in the final stages of presentation and from which conclusions were made.

1.8.1: Sampling

The study statistically enumerated all the members of the population, to arrive at the required respondents, stratified sampling technique was used by categorizing 6 categories of the respondents; Healthcare personnel, procurement officers, financial representatives, NGO's, MNC representatives, and others(Medical representatives from pharmaceutical firms).

From the list of the stratified categories, the study picked all the odd numbers and these were included in the sample size. The study depended on primary information which was gathered utilizing a Interview guide (attached in appendix I) and upheld up by secondary information sourced from major data institutes in Kenya that is KNBS, NHIF, MOH and Economic survey.

The content validity of the instrument was determined by seeking opinion on the content. First, the researcher discussed the items in the instrument with the supervisors, colleagues and other lecturers in the department. The advice given helped the researcher to determine the validity of the research instruments. The advice given during the consultation with the other partners in the research included suggestions, clarifications and other inputs. These suggestions were used in making necessary changes to the collection instrument before taking it out to the field. We utilized a sample size of 40 respondents distributed;

Table 1: Sample Size Distribution

Respondent	Frequency	Percentage
Health care personnel/user	18	45
procurement officer	2	5
Financial officer/Insurance representative	4	10
NGO/MNCs Representative	11	27.5
Others	5	12.5
Total	40	100

Source: Survey Interviews conducted and Questionnaires presented

All the respondents were fully aware of the research study, Selection of the health care personnel involved utilization of simple random sampling technique whereas the rest of the respondents were selected based on stratified random sampling technique.

There was 100 response since the questionnaires were guided, out of these most were healthcare personnel at 45%,NGO's/MNCs and representatives were 27.5% and the least were procurement at 5%.The differences in percentage were as a result of stratification and purposive sampling. The healthcare personnel were available and open to the study while others like the procurement officers were less responsive due to the recent government activities that targeted them. The bias that could have resulted due to these disparities was mitigated by engaging MNC representatives at 27.5% and others at 12.5%, this means that the marginal error was reduced significantly to less than 0.03%.

1.9 Chapter Outline

Chapter one, introduces the topic of our research study, by putting across the broad perspective upon which our study is based on, it outlines the statement of the research problem, broad and specific objectives of the study, hypothesis, literature review, significance of the study, theoretical and conceptual framework of our study as well as the research methodology which was used to collect and analyze the study.

Chapter Two, provides the background of the role of multi-national corporations and health care financing in developing countries from a global, regional level and in Kenya.

Chapter Three, looks at the benefits of MNCs and Donors in financing health care. Here the environmental conflicts will be identified and discussed as per the reviewed literature.

Chapter Four, presents content analysis of both the benefits and challenges of MNCs and Donors health financing. The chapter utilizes the collected data to develop answers to the research hypotheses tests by determining their statistical significance. Other emerging issues not addressed in the study but have a close link with the objectives will be presented.

Chapter Five provides conclusions to the findings of the study, giving recommendations of enhancing Multi-National Corporations and health care financing in Kenya. Further suggestions on other areas for further studies are highlighted.

CHAPTER TWO

OVERVIEW OF CONTRIBUTIONS MADE BY DONORS AND MULTI-NATIONAL CORPORATIONS IN FINANCING OF HEALTHCARE

2.1 Introduction

This section discusses the contributions made by Donors and Multi-national Corporation in financing of healthcare by commencing with an overview of health care reviewing the African continent in this case, Kenya and its pattern of Spending. Involvement of MNCs and Donors in health financing as well as their role in developing countries is presented.

2.2 Health Care - Overview

In Africa, the analysis of economic and institutional transformations is used to conduct the assessment of health care demands which mostly deal with the marketing of health care, provision of medical supplies and other promotive health care needs.[50]Since independence, African countries have not been funding the services that they provided before. Thompson, Miller and Witterpointsthose health disparities in the developing countries arise from the population's limited access to public resources and if these resources were available to the community, then thishealth disparities would have been dealt with.[51]

Ghana, one of the developing African states championed the UHC legislation by adopting a policy that broadly benefits a large proportion, rather than targeted approaches to health financing reforms. It started by working towards ensuring that there was 100% coverage by the national health insurance scheme, as of now, Ghana is at 61% of the scheme's membership.

Rwanda, closer home follows a UHC model which has ensured that 90% of the population is financed by tax revenue. It's one of the African countries that has been able to achieve National health insurance coverage by 91% by 2010 and succeeded in allocating 16.5% of its public budget to health thus surpassing the 15% minimum of the public budget as per the Abuja Declaration. Healthcare has been made more accessible by the country having 4 National

[50]World Health Organization (2016), Report on Study on Effect of Health Stakeholders Analysis in Kenya, WHO and Ministry of Health Nairobi, Kenya.

[51]Thompson, R. Miller, N. and Witter, S. (2016), Health Seeking Behavior and the Rural/Urban Variations in Kazakhstan. *Health Economics*. 12: 553-564.

Hospitals which are distributed evenly across the country. Rwanda has also signed anMoU with American Universities to train their Doctors for specialties.

2.2.1 Kenyan Picture

Kenya is a low income country located on the East coast of East Africa with an estimated population of 46 million. The under 5 mortality rate has declined greatly from 68.74 per 1,000 live births in 2000 to 37.1 per 1,000 live births in 2017 and the maternal mortality ratio is currently at 362 per 100,000 in 2018 this has reduced tremendously from 488 per 100,000 in 2008[52].This has largely been contributed by the various programs funded by the MNCs or international institutions like UNICEF, WHO just to mention but a few.

The health care system in Kenya is organized in a pyramidal pattern.[53] The health centers and dispensaries are at the bottom of the pyramid of the system, while the sub-County, county hospitals and referral hospitals make up the middle part of the health systems, with referral hospitals comprising the apex. The health centers are mainly involved in the provision of preventive and curative services whereas dispensaries provide first line contact services with a patient and provide preventive health measures which in the Kenyan health policy is one of the main goal. The National hospitals which are the Kenyatta National Hospital in Nairobi and Moi Teaching and Referral Hospital in Eldoret provide sophisticated diagnostic, therapeutic and rehabilitative services and the county hospitals provide highly specialized care to support sub-county hospitals.[54]

Since independence, the most encouraging achievements in the health sector were between 1964 and 1994 when the ‘Sessional paper no.10 on African Socialism and its Application was used for planning. This policy provided for free health care for all. There was a drop in the maternal mortality rate from 126 to 52 per 1000 live births while there was also a drop in from 211 to 75

[52]KNBS, Economic Survey 2018.
[53]Segall, M. Tipping G. (2016), Health Care Seeking by the Poor in Transitional Economies: The Case of Kenya, Institute of Development Studies, University of Sussex., Brighton.
[54]Kahenya, G. & Lake, S. (2016), User Fees and Their Impact on Utilization of Key Health Services, UNICEF, Kenya.

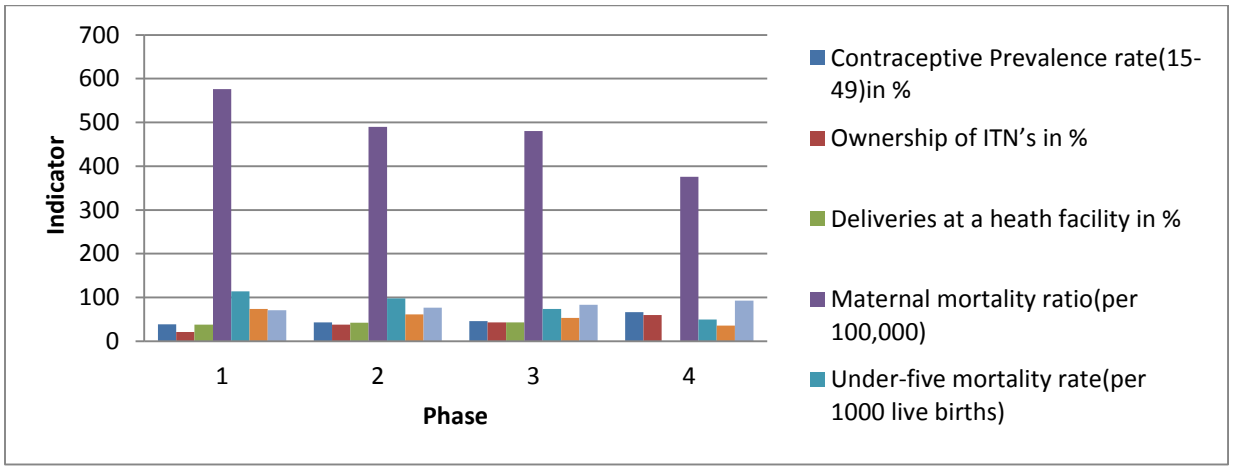
per 1000 live births in the under-five mortality rate. [55] The life expectancy rate rose from 40 to 60 years. The death rate also dropped from 20 to 12 per 1000 in 1994 and the birth rate from 50 to 46 per 1000 in that same year. Despite the improvement, there has been noticeable changes from the 1990s in both morbidity and mortality.[56]

Table 2: Selected Demographic and Health indicators for Kenya from the year 2000-2015

Indicator	Contraceptive Prevalence rate(15-49)in %	Ownership of ITN's in %	Deliveries at a heath facility in %	Maternal mortality ratio(per 100,000)	Under-five mortality rate(per 1000 live births)	Infant mortality rate(per 1000 live births)	Childhood immunization coverage
2000	39	21.2	38	576	114	74	71
2005	43	38	42	490	98	61	77
2010	46	43	43	480	74	53.5	83
2015	66.3	60		376	50	35.6	93

Source: KNBS, Economic survey2011,2015

Graph 1: Demographics and key Health indicators for Kenya



Source: ***KNBS, Economic survey2011,2015***

[55]Oloo, D (2013). Human capital development and economic growth in Kenya (2008-2011) (https://www.researchgate.net/publication/257555850)

[56]Gemmell, N. (2016).Evaluating the impacts of human capital stock and accumulation on economic growth: Some new evidence. *Oxford Bulletin of Economic Statistics, 58*(1): 211-929

The selected demographic distribution and health indicators were paneled in phases, with each phase covering a 5 year gap. This means that the first phase being analyzed was in the year 2000 followed by 2005, 2010 and 2015 respectively. Take for instance the maternal mortality ratios per 1000 live births were noted to have reduced over the years under study. With the first phase havinga mortality ratio of 74, the ratio reduces phase by phase and the year 2015 hada mortality ratio of 35.6. The Contraceptive prevalence rate as a percentage follows in extent of change, with comparison of the phases under the studywhere the first phase had the lowest rate at 39%, followed closely by phase 2, at 43%, phase 3 at 46% and the highest being the last phase at 66.3%.

Under five mortality rates per 1000 live births was such that the first phase had the highest mortalities with a decrease in each phase, the last phase had the lowest mortality rates compared to the first three phases at a rate of 50 per 1000 live births. Infant mortalities followed an equivalent distribution as the under-five mortality Indicator with the rates being high at phase one and a decrease to phase four exhibiting low rates. Deliveries at health clinics have risen over the phases with phase being represented by 38% to phase 3 represented by 43%.

Funding the health sector.

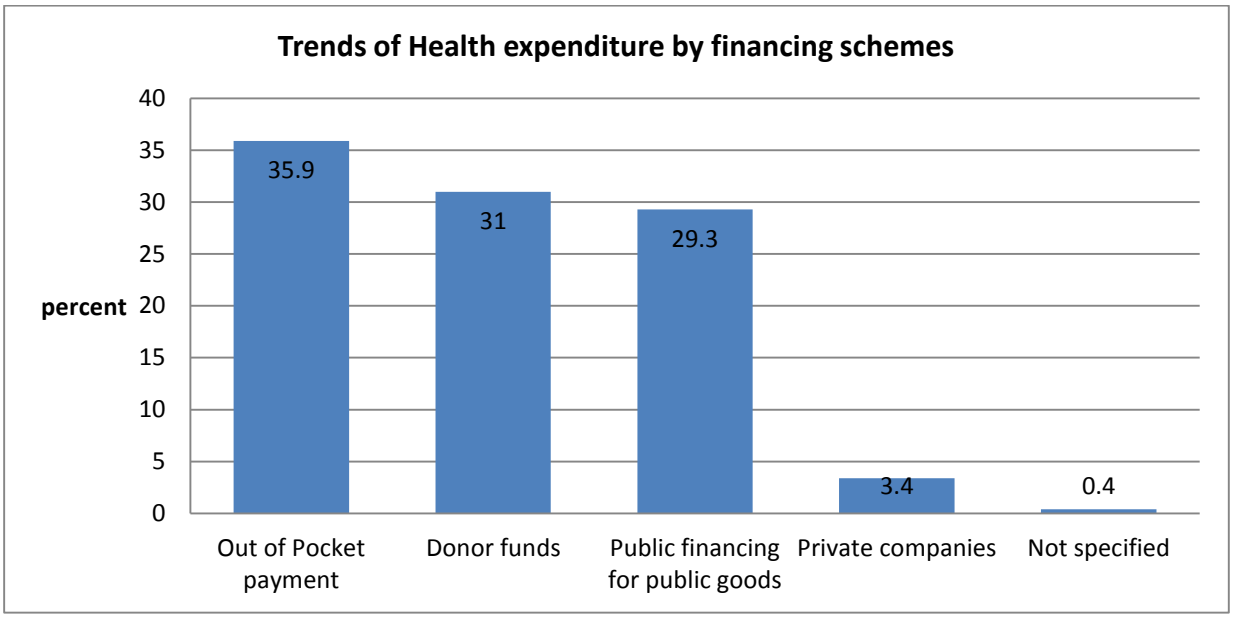
Kenya obtains varying levels of funding from the traditional sources: public (government), private firms, households and Donors. According to the 2005/06 National Health Accounts (NHA), households remain the largest contributors of health funds, at 35.9%, followed by the government, and then donors, who contribute approximately 30%.

Table 3: Breakdown of Total Health Expenditure by Financing Source

Source	**Frequency**	**%**
Out of Pocket payment	14	35.9
Donor funds	13	31
Public health financing (NHIF)	10	29.3
Private health insurance	2	3.4
Community based financing	1	0.4

Source KNBS, Economic survey 2010

Graph 2: Health Expenditure



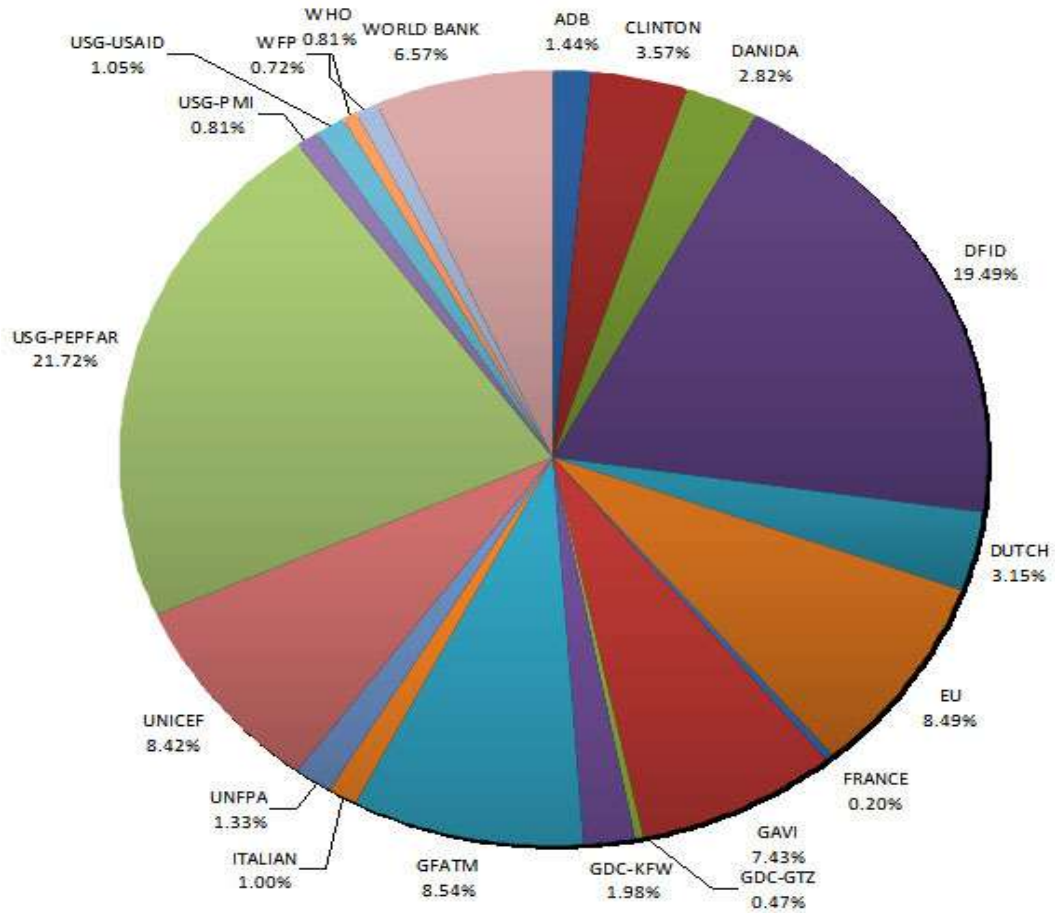
Source KHF 2016

From Graph 2, it is evident that a greater percentage of health expenditure is out of pocket and therefore a big barrier from Kenyans accessing healthcare. Donor aid from development agencies and NGO's follows next with 31 %.Kenya has 29% coverage of NHIF contributors and we still have a long way to go, Rwanda is leading in the region at 91% coverage on the national health scheme, Ghana follows at 61%.The rest of the health expenditure is community based.

A good health financing system raises adequate funds for health, in ways that ensures its people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services. In 2009 the United States is spent $529.1M through PEPFAR programs alone. The United Kingdom also committed significant bilateral funds to the health sector, followed by Denmark, Germany, Japan and the Netherlands. The European Union committed funds to health programs, World Bank had agencies within the United Nations system, including WHO, UNAIDS, UNICEF and UNFPA. The Clinton Foundation is active in Kenya's health

sector, as are faith-based organizations such as Catholic Relief Services, Lutheran World Relief, and the Aga Khan Foundation.

Figure 2: MNCs and Donor funding in Kenya in USD



Source. Centre for Strategic and International studies, 2014

Figure 2 shows that there are two main donor contributors, PEPFAR at 21.72% and DFID at 19.49%. This adds up to 41.19% of the total donor funds. The other Donors contribute less than 10% each. Italy, France and Netherlands low funding is largely explained by language barrier.

National Health insurance Fund

To finance health care and offer services to its citizens, the Kenyan government introduced National Hospital Insurance Fund (NHIF) which was established on 12th July 1966 vide the National Hospital Act, Cap 255, laws of Kenya.[57] This was in line with the government development strategy to overcome poverty and ensure productivity and welfare. The Fund was to enable Kenyans to get access to hospital in-patient insurance cover services as a compulsory scheme for employed persons. Thus, the Act establishing the Fund provided for enrolment of all Kenyan residents between the age of 18 and 65 years. It further mandates employers to deduct premiums from wages and salaries of the employees at a graduated scale.[58]

To understand its order, the Fund is guided by core capacities as expressed in NHIF Act No.9 of 1998, Laws of Kenya.[59]That is: to enroll and receive all contributions and different payments required by the Act from its individuals as accommodated in section 15 and 16 of the act, that is standard regulations of contributions, set criteria for the hospital declaration and certify them, make payments out of the fund to the hospitals declared, manage payable contributions to the fund, the advantages and different payments made from the fund, secure the interests of supporters of the fund and offer advice to the government on the policies of the nation to be pursued with respect to national medical coverage and to execute all policies relating thereto.[60]

The Fund has stayed on course in fulfilling its mandate and core functions partly by developing capacity building as reflected through various policy documents, namely: customer service policy, customer service charter, corporate social responsibility policy, corporate branding policy, brand network policy, investment policy, debt and credit management policy, property management policy, training policy, and information and communication technology policy.[61]The membership to the fund has increased from a mere 40,000 members in 1966 to about 4,450,393 members in 2015, expanding geometrically to the current membership level of

[57] Appleton, S. (2015) Education and Health at the Household Level in Sub-Saharan African CID Working Paper No 33 Center for International Development Harvard University.
[58]Davis, K. (2016), Inequality and Access to Health Care. *The Milbank Quarterly*, 69(2): 253-273.
[59]Mushkin, S. J. (2016). Health as an investment. *Journal of Political Economy 70:* 129-57
[60]Nyamwange, M. (2012). Economic Growth and Public Healthcare Expenditure in Kenya (1982-2012).
[61]Behrman, J. & Taubman, P. (2016). The integrational correlation between children's adult earnings and their parent's incomes: Results from the Michigan panel survey of income dynamics. *Review of Income and Wealth, 36*: 115–127

about 2.1 million people (about 1.8 million from the formal sector and about 0.3 million from the informal sector).[62]The Fund is one of the viable parastatals in Kenya that offers both out and in-patient benefits

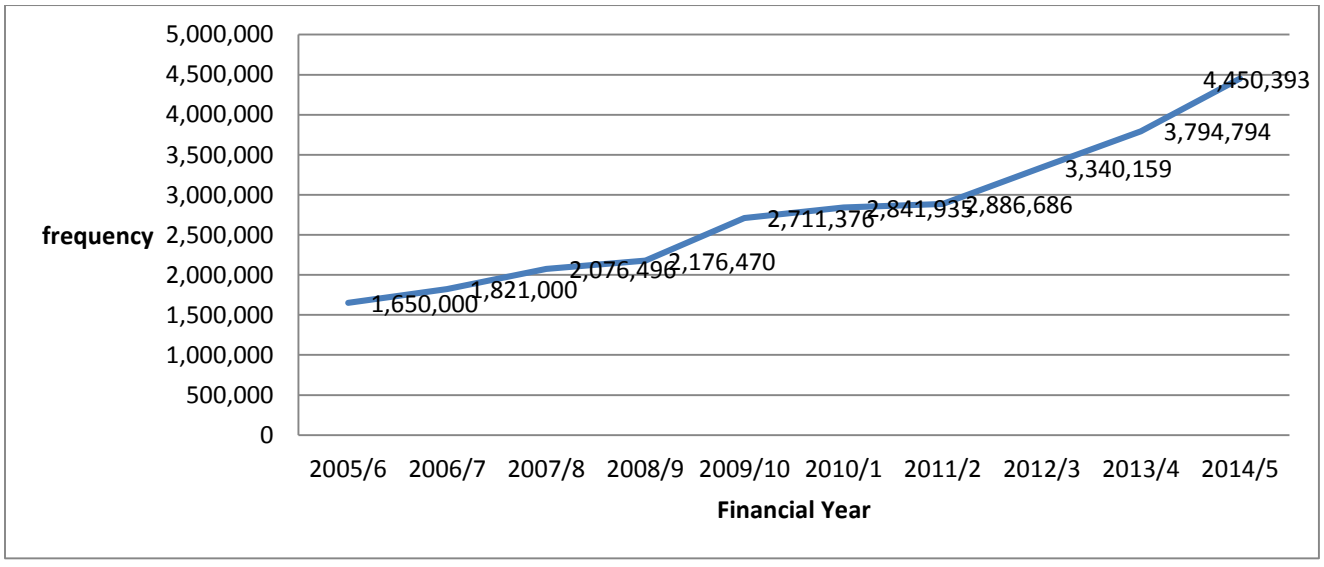
Table 4:Registered NHIF members

	2005/6	**2006/7**	**2007/8**	**2008/9**	**2009/10**	**2010/1**	**2011/2**	**2012/3**	**2013/4**	**2014/5**
Formal sector	1,540,000	1,620,000	1,775,390	1,800,000	2,192,723	2,286,205	2,197,940	2,441,795	2,679,370	2,952,362
Informal sector	11,0000	201,098	301,106	376,470	518,656	555,730	688,746	898,364	1,115,424	1,498,031
Total	**1,650,000**	**1,821,000**	**2,076,496**	**2,176,470**	**2,711,376**	**2,841,935**	**2,886,686**	**3,340,159**	**3,794,794**	**4,450,393**

Source: KNBS 2011/2015

Table 4 shows how the membership recruitment has been increasing over the years. As of 2014/2015 the scheme has funded 17.2 %of the total population in the country. This is way below par as the organization is aiming at having a 46%coverage of the total population.The increase has been steady among the formal sector members as compared to those in the informal sector.

Graph 3: NHIF Registered members



Source: KNBS 2015

Graph 3 reflects an upward trend between 2005 to 2015 of the NHIF registered members.

[62]Kurt, S. (2015). Government health expenditures and economic growth: A Feder–Ram Approach for the case of Turkey. *International Journal of Economics and Financial Issues*, *5*(2), 441-447.

The fund is meant to operate as a public social insurance scheme aimed at offering cost effective health-care packages and premiums as well as to meet the satisfaction of its clientele.[63] This is in line with the Fund's performance contract with the government of Kenya and its service charter that commits it to improve on service delivery and satisfaction levels to external clients who include the accredited hospitals, corporate employers and individual members.[64]

The financing of health sector by NHIF has been boosted by the number of registered members, where based on financial years, the members registered have exponentially increased from 2005 to 2015.The biggest challenge facing the organization at the moment is how to increase coverage by 46%.

Table 5: NHIF Resources (million Kshs)

Financial year	**2005/6**	**2006/7**	**2007/8**	**2008/9**	**2009/10**	**2010/1**	**2011/2**	**2012/3**	**2013/4**
Receipts	3458	3954	4546	5079	5742	6765	9595	12054	13629
Benefits	1105	1414	2054	2813	3110	3677	5999	8236	9401
Contribution Net of benefits	2352	2540	2492	2266	2632	3088	3595	3818	4227

Source: KNBS2011/2015

The NHIF is a compulsory health insurance contribution fund for all employees which assists by paying a fraction of the cost of healthcare, it usually takes care of in-patient bills and has some out-patient benefits as well. Table 5 above shows how benefits accrued from 1,105 million Kshs in 2005/2006 to 9,401 million Kshs in 2013/2014.

According to Todaro and Smith cost sharing resulted in a drop in the use of public health facilities in Kenya when fees were imposed in the public health system in 1989.[65]Lustig noted that public health facilities take a high priority among the other alternative facilities as sources of

[63]Chang, C., & Ying, Y. (2016). Economic growth, human capital investment, and health expenditure: A study of OECD countries. *Hitotsubashi Journal of Economics, 47*(1), 1-16.
[64]Odusola, A. (2015). Rekindling investment and economic development in Kenya. NES Selected PA World Health Organization. June 2015. WHO on Health and Economic Productivity. Population and Development Review 25.2: 396-401.
[65]Todaro, M., & Smith, S. (2016).*Economic development*.(9th ed.), Pearson Addison-Wesley Printing Press.

care when serious illnesses occur.[66] Patients who shift across free government facilities are always in a continuous search for health services that yield medical benefits equivalent to those obtained from fee-charging clinics. Despite the introduction of the fund not much has been achieved in proving health care in Kenya. In 2001, African governments signed the Abuja declaration, agreeing to devote 15% of their domestic budget to the health sector as a move towards universal health care. This commitment is restricted to domestic public sources of funding and excludes external funding.

In pursuit to address the above noted challenges the Kenyan government through the Ministry of Health collaborated with private sectors to improve the health care services and MNCs and Donors were as well accommodated. Since then the per capita health care expenditure in Kenya followed an upward trend. It grew form KES 3,000 to KES 7,800 between 2006 and 2014.[67] In the Financial year 2016/7, 4.5 billion was allocated to lease medical equipment; 14.6 billion was allocated for National hospitals, 1.7 billion for Research, 6.5 billion for training and 4 billion to miscellaneous activities such as AIDS control and portable clinics.[68]

Since then the Kenyan health sector has been pluralistic with the Ministry of Health playing a major role while parastatals, the private sectors, NGOs and FBOs all play different roles.[69]In every county the running of health activities play a major role in the financing of all health faculties. Health facilities in Kenya are 11,324 in number as per the economic Survey 2018. While the public sector caters for 48% of all the facilities, 38% is run by private sectors/commercial and 14% are run by the faith based organizations and are community based.[70]. 24 health facilities serve 100,000 people, 63% of Kenyans have access to government health facilities within an hour. 86% of the health facilities have basic medical equipment and 66% of these cannot respond promptly to emergencies.

[66]Lustig, N. (2016). Investing in health for economic development: The case of Kenya. *UNU World Institute for Development Economics Research (UNU-WIDER), 5*(2), 1-16.
[67]World Health Organization (2015).*World health development indicators.* Washington, DC.
[68]Barro, R. (2013). "Growth, Annals *of Economics and Finance, Society for AEF, 14*(1), 121-144.
[69]Bloom, D. & Sachs, J. (2016).Geography, demography, and economic growth in Africa. *Brookings Papers on Economic Activity, 2*, 207-73.
[70]Temitope, A. & Bola, S. (2014).Effect of health investment on economic growth in Kenya. *IOSR Journal of Economics and Finance, 1*(2), 39-47.

Pattern of Spending

The total private spending on health increased from US$ 17.5 per captain 2001/02 to US$ 21 in 2011/12. The contribution by donors, on- and off-budget, also increased from US$ 5.3 per capita to about US$ 15 during this period. OOP payments are inequitable thus leading to a major barrier to access, and contribute towards household poverty and impoverishment.

The government has taken measures to increase the share of expenditure in primary health care by introducing the Health Sector Services Fund (HSSF) to increase the share of funding for primary health care and to ensure timely flow of resources to the facilities. However, Level 4 and 5 hospitals remain key drivers of curative expenditure in the sector, which amounts to about a third of total public the current pattern of spending presents three main challenges which undermine efficiency in the sector.

(i) High level of OOP payments increase the burden of care by households; are inequitable, inefficient and a barrier to accessing health care by the poor;

(ii) The high share of off-budget donor funding undermines strategic prioritization, it is disease focused, does not support health system strengthening and has potential contingent liabilities on the government when donor funds decline. Under the current devolved system of Government, donor funding is likely to be more fragmented unless there is stewardship from county and National governments to ensure that donor support is aligned to local priorities

(iii) Heavy reliance on OOP payments and donor funding undermines financial risk and income cross-subsidization, which is critical for the country's progress towards universal health coverage.

Table 6: Kenya allocation of health fund between 2013-2018

Financial Year	Health Ministry Budget (in billions of KSh)	Total Budget (in billions of KSh)	Health Allocation as a % of Total Budget
2013/14	41.70	1136.20	3.7
2014/15	54.10	1433.10	3.8
2015/16	61.70	1493.30	4.1
2016/17	73.60	1805.70	4.1
2017/18	61.64	1578.34	3.9

Source; KNBS, Economic survey 2015,2017

Table 6 illustrates that in the fiscal year2013/14, the budget allocation to the health sector between 2013 and 2017 increased by 0.2%. However, in 2018, there was a decrease in the allocation by 0.2%.This means that the gains that had been made would easily be lost through this budgetary decrease.

2.3 Involvement of MNCs and Donors in Health Financing

MNCs and Donors have a way of offering corporate social responsibility globally.[71]The financing offered in health services is supplemented to privately owned hospitals and FBO's and cover a range of various programs like curative, preventive, family planning, nutrition and emergency aid assigned for health.

In Kenya Donors and MNCs have been accommodated by the government in collaboration with the ministry of health and the National Health Sector Strategy Plan which implements all laws governing health sectors.[72] The development and expansion of health care services and facilities

[71]Glick, P., Razafindravanona, D. & Randretsa. I. (2015). Education and Health Services in Kenya: Utilization and Demand Determinants. Cornell Food and Nutrition Policy Program Working Paper No.107.Cornell University, Ithaca New York.

[72]Ngugi, R. (2016), Health Seeking Behaviour in the Reform Process for Rural Households: Kirinyaga District, Kenya. AERC Research Paper 95.

include, training of personnel and tertiary health care delivery via bilateral, multilateral sources and Public, Private Partnership.[73]

2.4 Role of Donor and MNCs in Developing Countries

MNCs which put resources into programs of immunization were keen on the impact that immunization had on monetary development. These effects originated from the way that immunization protected or rather prevented people against getting an ailment. Measles, for instance, could cause damage to the brain or disable learning capacities, with extreme effects.[74]Kenya is currently standing at 83% of all the childhood immunizations of children less than 1 year old. This is a good thing because this has led to a reduction in the child mortality rates as well as the infant mortality rates. Sanofi and GSk are some of the Pharmaceutical MNC's that have spearheading innovations that deal with vaccine consumer healthcare. The key players in the pharmaceutical business in Kenya which are MNCs include; Pfizer, GSK, Boots Pharmaceuticals, Bayer, Sanofi, Novartis, Astra Zeneca, Eli Lilly and Roche contending with neighborhood foundations like Dawa Pharmaceutical Ltd and Cosmos Pharmaceuticals among others.

Abbasa and Foreman asserted that there were several channels through which MNCs can improve health and wealth.[75] The first was through its impact on education. Healthier children have better school attendance which increases their ability to learn while in class. Deworming programs, iron supplementation and other such health interventions lead to a significant reduction in school absenteeism. Treating whipworm infection, meanwhile, lead to improved test scores.

The second channel through which MNCs and Donors have improved lives in developing countries is through health's impact on productivity. Healthier workers are generally more energetic and mentally robust, while having fewer absent days. Moreover, workers in healthy

[73] McFadden, D. (2015). *Structural Analysis of Discrete Data with Econometric Applications*: Cambridge, MA, MIT Press.
[74]Dor, A. (2015), Non-Price Rationing and the Choice of Medical Care in Rural Kenya, *Journal of Health Economics.* 6: 291-304.
[75]Abbasa, Q., &Foreman-Peck, J. (2017).Human capital and economic growth: Kenya, 1960- 2016.*Cardiff Economics Working Paper E2007/22*. Cardiff, UK: Cardiff University.

communities do not need to take as much time off to take care of sick relatives. Workers that do not suffer poor health in their childhood have better immunity which has an impact on long term productivity.[76]

Grossman asserted that MNCs that fund healthcare boost economies via a demographic dividend.[77] The provision of better health care and dietary improvements through MNCs and health financing has led to a rapid transition in many developing countries from high to low mortality rates, reduced the burden of disease and improved quality of life.

MNCs and Donor firms have however been criticized for specific behaviours such as setting prohibitively high prices and sluggishness in responding to demands to provide access to life saving drugs for poor populations.[78]MNCs and Donors firms have been critiqued for using health financing to repair compromised reputations or to reverse public beliefs about their commercial endeavours being unethical.

[76]World Bank Group (2016). Health Expenditure per Capita (Us Dollar) in Kenya. Retrieved from: http://data.worldbank.org/indicator/SH.XPD.PCAP

[77]Grossman, M. (2015).On the concept of health capital and the demand for health. *Journal of Political Economy 80:* 223-55.

[78]Maitra, B. & Mukhopadhyay, C. (2012). Public spending on education, healthcare and economic growth selected countries of Asia and Pacific. *Asia-Pacific Development Journal, 19*(2), 19-48.

CHAPTER THREE
FACTORS INFLUENCING MULTI-NATIONAL CORPORATION IN FINANCING HEALTHCARE SERVICES

3.1 Introduction

This section presents both primary data and secondary data. Primary data was through interview schedule while secondary data was from published documents and the internet in relation to financing healthcare by Multi-national Corporation.

3.2 Multi-national Corporations in Kenya

MNCs dealing with pharmaceuticals represent around 4% of the aggregate health segment financing.

The following multinational pharmaceutical companies participated in this study Maylan, Intas, Sun Pharmaceuticals, BD, Novartis Johnson and Johnson, Janssen, GlaxoSmithKline, Pfizer, Sanofi, Mercury Healthcare, Global Holistic Health Centre, Sumitomo chemical, WHO country representative, AgaKhan Foundation ,The Mater Hospital, AMREF, AAR, and Astra Zeneca.

The analysis herein depicts the levels of contribution made by the MNCs and donors towards healthcare sector.

MNC Pharmaceutical representatives which made up 27.5%of the respondents in response to what motivated their company to finance healthcare services in Kenya listed the following as their responses: *'the need to create sustainable partnership programs regionally and globally'. 'Kenya being a hub of various health businesses in the region was more easier to work with because of the country's policies on investments in health.*

One of the MNC that manufactures non-pharmaceutical medical commodities like Sumitomo chemical which mainly dealt with insecticide treated nets and indoor residual sprays contributed significantly to the supply of vector control products by collaborating with NGO's and governments during mass anti-malarial campaigns. They do so by supplying nets to the various governments in Malaria prone areas while targeting mothers in the ante-natal clinics.

Sumitomo chemical's Olyset net revolutionized the global fight against Malaria by supplying approximately one million netsannually .In the year 2015 there was a notable decline in the malaria prevalence rate to 27% from 38%in 2013 in the lake region The current overall malaria prevalence rate in Kenya is currently at 8%.As of 2014, 58.7% of households in Kenya had at least one insecticide treated net. This implies that Sumitomo chemical in partnership with other stakeholders have played a significant role inpreventive healthcare by reducing the morbidity and mortality rates due to Malaria in Kenya therefore reducing the childhood deaths in both under 5 and children less than one year.

45%of the respondents interviewed (healthcare personnel) indicated that the contributions made by Multi-national Corporation's in financing of healthcare in Kenya included;
''*research and training, innovation of new drugs, setting of health services infrastructure and consultancy within the health care system. One of the firms indicated that their role specifically is to generate generic drugs which are chapter and service the same purpose with the original and are much preferred by the Kenya Ministry of Health''.*

BD,(Becton Dickinson) East Africa an MNC with offices in more than 50 countries mainly focuses on medical technological industry by selling a variety of laboratory equipment and has been in the country for more than 40 years agreed strongly that the organization focused more on medical commodities in order to help all people live healthy lives .They supply insulin syringes to hospitals and sometimes partner with CDC and NASCOP .By supplying the syringes to NASCOP, the injecting drug users are able to minimize HIV infections because they do not have to share the needles with other drug users.

Sun Pharmaceuticals another Pharmaceutical MNC that has been in the country for less than 20 years , strongly agreed that their organization focused more on curative and faced a challenge on the counterfeit/fake production of medicine and therefore recommended the government to have stringent measures to curb these vices.
10% of the interviewees which made up the procurement authorities indicated that health care was greatly influenced by MNCs and Donors funding to a great extent as there was much improvement since they engaged in supporting the health sector.

Table 7: Distribution in (%) of Visits to providers by regions

Province or area	Public facilities	Private facilities	FBO facilities	Chemists and pharmacies	Others, e.g., shops	Total
Nairobi	34.6	34.6	8.3	18.6	3.9	100
Central	69.1	18.0	10.5	2.3	0.0	100
Coast	56.3	27.0	2.6	12.5	1.6	100
Eastern	66.4	18.4	10.2	4.6	0.4	100
North Eastern	79.8	17.1	0.0	2.5	0.6	100
Nyanza	60.1	12.4	2.9	20.9	3.7	100
Rift Valley	55.4	20.4	8.7	12.3	3.2	100
Western	47.5	15.5	3.4	30.5	2.9	100
Urban	45.5	29.0	4.8	18.7	2.0	100
Rural	59.5	16.8	6.8	14.3	2.7	100

Source: Mwabu[79]

The study findings show that the outpatient's total visits from the rural population represented 59.5% in the government facilities while the urban population had 45.5% visiting the public facilities. On the other hand 29% of those living in the urban settlements went to the private facilities as compared to the 16% from the rural settlements. This implies that more people living in the urban areas went to private facilities .The pharmacies and chemists were frequented more by those living in the urban than those in the rural settlements.

[79]Mwabu, G., Ainsworth, M. &Nyamete. A, (1993). "Quality of Medical Care and Choice of Medical Treatment: An empirical Analysis." *Journal of Human Resources* 28(4): 838–62.

Table 8: Inpatient Visits by Income Quintile

Facility types	Percent of Visits by income quintiles				
Health facility type	Poorest	Second	Middle	Fourth	Richest
Government hospitals	55.1	64.4	70.9	54.7	46.6
Private hospitals	7.2	4.3	7.5	21.3	29.1
FBO	14.7	16.9	12.0	14.2	13.0
Government health centres	13.2	9.2	4.0	3.7	0.6
Private health centres	2.8	1.8	0.7	0.6	0.2
Mission health centre	4.6	1.8	2.2	1.6	1.8
Nursing/maternity homes	1.7	0.0	0.9	2.7	7.8
All others	0.7	1.6	1.8	1.2	0.9
Total	100	100	100	100	100

Source; survey data, 2018

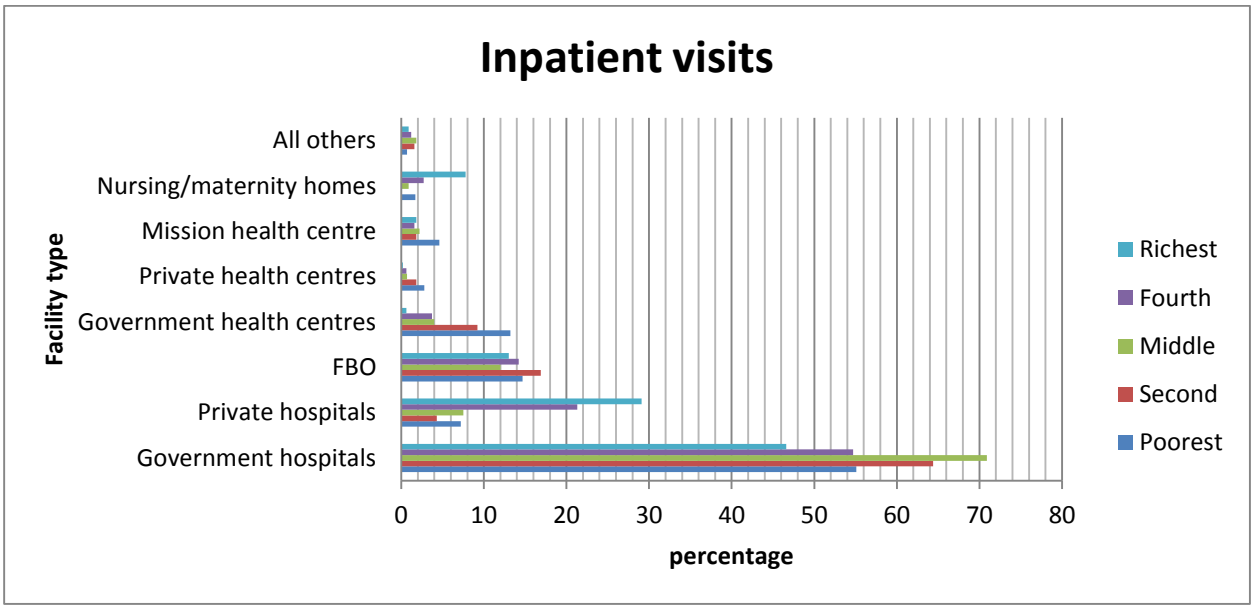
Table 8 shows that the larger part of inpatient visits were to public hospitals at 55.1%. Indeed, even the rich family units (46.6%) of inpatient care visited public hospitals, as compared to 29.1% of the same who visited private hospitals. Strikingly, family units at the main three quintiles of wealth use medical facilities services more than the lower quintiles of the wealthy. Nursing homes are likewise moderately prevalent among families at the most extravagant quintile.

Hospital services utilization can be influenced by these three explanations, the hospital's physical location; Most of the hospitals are located in urban areas and therefore makes it easier for urban populations to access the services easily compared to the rural populations.[80]Secondly, is the cost of acquiring health service where the people have a greater chance to access health services.Thirdly is the access to the use of health insurance. This simply means that people with insurance schemes can access health care services more conveniently than others. This mostly advantages those with salaries as it compulsory for all employees in the formal sector to contribute to insurance covers [81]. Another advantage is the fact that some insurances coversalso

[80]Republic of Kenya (2016), Kenya National Health Accounts, 2015/16 FY. Ministry of Health, Division of Planning, Nairobi, March 2016, Nairobi: Government Printers.
[81]Republic of Kenya (2015).*Statistical Abstract*, 2015, Nairobi: Government printers

contain some medical benefits, for example Jubilee car insurance premiums also contain medical benefits, such that in the event of accident, the insurance will not only tow your vehicle but will also provide an ambulance service.

Graph4: Inpatient Visits by Income Quintile



Source: Survey data, 2018

3.3 Kenya Health Expenditure

KNBS Economic Survey report shows that economic growth results in increased healthcare expenditure leading to better health care and innovations in medical technology, leading to an increase in life expectancy and a decrease in infant mortality rate, which are key indicators of the health situation in a country.[82] Kenya has been following an upward trend over the years. It grew form KES 3,000 to KES 7,800 between 2006 and 2014.

In the Financial year 2016/7, through MNCs and Donors financing 4.5 billion was allocated to lease medical equipment; 14.6 billion was allocated for National hospitals, 1.7 billion for Research, 6.5 billion for training and 4 billion to miscellaneous activities such as AIDS control and portable clinics.[83]Amid the medium-term period of planning, the MNCs and Donors

[82]Republic of Kenya (2016).*Economic Survey, (2016*), *Nairobi:* Government Printer.
[83]Republic of Kenya.(2017), Kenya AIDS Indicator Survey. Preliminary Report. Government Printers

accentuation was on strengthening of health systems by concentrating on priority venture zones. To quicken this procedure, the MNCs focused more on the quality of drugs and medical supplies across the nation, infrastructure on health, protection of social health, dynamic change of health financing structures and human asset for health.[84]

3.4 Challenges Faced by Donors and MNCs in Financing Health Care Services

Pharmaceutical corporations doing businesses in the development arena are faced with many challenges and this optimism on projections could be derailed by unforeseen factors.[85]Some of the unexpected challenges include diversity of culture by some MNCs, management problems and financial hurdles. These challenges are enumerated below as also supported by the MNCs and Donors that participated in this study.

Table 9 Challenges Faced by Donors and MNCs in Financing Health Care Services

MNC	Challenge	Recommendation
Pharmaceutical (BD,Intas,Sun,Sanofi,Novartis ,Astra,Mylan,Jansenn,Gsk, Sumitomo,Mercury	*procurement *poor governance *lack of accountability	Transparency Policy guidelines
WHO country representative	Inadequate allocation of funds Lack of prioritization Lack of accountability	Policy Address the poor governance
AMREF	Funding(late disbursement of funds)	Proper working policies
GHCC(NGO)	Lack of sustainability in the funding	Policy

Source: Survey data

[84]Republic of Kenya (2017).*Kenya Integrated Household Budget Survey*, 2017, Nairobi: Government Printers.
[85]Yoder, R (2015), Are People Willing and Able to Pay for Health Services?" *Social Science and Medicine*, 29:35-42.

3.4.1 Political-Legal Factors

Political factors generally involve the legal and regulatory factors that MNCs and Donors operate within to ensure there are efficient health care services. Fair trade decisions, anti-trust laws, tax programs, minimum wage legislation, pollution, and pricing policies normally define the political barriers.[86] Importing of duty, importing of licenses, exporting of licenses, importing of quotas, tariffs, and subsidies, non-tariff barriers, voluntary export restraints, local content requirements and embargoes are other factors that are associated with the rules and regulations that political factors contribute to enhancement of health care services. The protection of employees, consumers, and the general public is ensured in their place of work by these actions.[87]

Mr. Jotham Katana one of regional managers at Sumitomo chemical stated that *'recent trends have shown that donor funding in Malaria programs is dwindling probably due to donor fatigue.Therefore it is imperative that African governments including Kenya take up the challenge and allocate their own resources to this noble cause of reducing morbidity and mortality due to Malaria .Entomological surveillance, pharmaco-vigilance and monitoring and evaluation is required in order to reduce the malaria prevalence'.*

According to Hensen many companies operating in most Sub Sahara African countries are faced with challenges that are political-legal in nature.[88] Many of these countries have unstable government structures and are riddled with corruption. It becomes difficult for a corporation to set up a health facility and operate as their values may not be embraced by those of the host country. This makes the companies face challenges involving piracy, counterfeiting and challenges that cause black markets and illegal markets of their health products within.

[86] Chandra, H. (2016), A Self Instructing Course in Mode Choice Modeling: Multinomial and Nested Logit Models. US Department of Transportation Federal Transits Administration, Washington D.C.
[87] Chung, J. (2015), Estimates of the Demand for Medical Care under Different Functional Forms: *Journal of Applied Econometrics*, 9, (2): 201-218.
[88]Hensen, D. (2015). Sequential and Full Information Maximum Likelihood Estimation of Nested Logit Model, *The Review of Economics and Statistics*, 68 (4), 657-667.

3.4.2 Technological and Product Innovation Factors

To ensure a long term business growth.Itis important to ensure that technology in this modern day and age is a driver of change. This could range from having electronic patient data through the patient's health card, bar coding of all drugs to avoid counterfeits as this could avert some of the challenges faced by Pharmaceutical MNCs.[89] The scanning and manufacturing of techniques generally involve the technological analysis which deals with the production of goods and services. It is therefore important for all firms to understand the technological advances that affect their products and services. There is need for human resource that has expertise as most of the MNCs and Donors operate by use of high technology.

Established pharmaceutical companies such as GlaxoSmithKline that have been in the country for long, in most instances end up becoming the leaders in technological transfer in the pharma industry.[90] In third world countries, technological inhibitions deter pharmaceutical company's growth as huge investments are needed upfront. Though this gives a potential disadvantage on the part of the local firm, the MNCs and Donors are unable to operate to full potential.

3.4.3 Infrastructure

Infrastructure influences both the efficiency and adequacy of health products and services offered by MNCs and Donors. In this study only 25 % of the respondent supported infrastructure in healthcare funding Medical Infrastructure here entails medical commodities, health units or structures, laboratory equipments, functional and well serviced theatres, ICUs, radiological equipment among others. Major emphasis was put on monitoring of projects which stood at 33%Studies likewise point to infrastructural barriers having a bearing on the advancement of the economy of third world nations due to the lack of technological skills amongst others.

Aga Khan University Hospital established in 1958 is a tertiary teaching and referral health facility in Sub-Saharan Africa. It is a Multi-national for it has a network in Mumbai, Dar essalaam and its headquarters are based in Pakistan. In Kenya it has three major hospitals in

[89]Dow W. (2015), Unconditional Demand for Curative Health Inputs: Does Selection on Health Status Matter in The Long Run. *Labor and Population Program Working Paper Series* 95-22 DRU-1234-RC., Corporation, C.A.
[90]Cisse A. (2016), Analysis of Health Care Utilization in Kenya, Final Report No AERC, Nairobi

Nairobi, Kisumu and Mombasa with about 49 out-patient medical centres within Kenya. This shows that AKUH has played a major role in health care accessibility in the region. On 26th October 2018, the hospital launched the state of the art PET CT services that will improve in the diagnosis and treatment of Cancer, heart disease and other diseases. NCD's take into account for nearly three in ten deaths in Kenya. This will in turn reduce the travel costs to India by the Cancer patients.

3.5 Summary

This section demonstrates that Donor and Multi-national Corporations dealing with healthcare financing can contribute to the advancement of local economies, including creating employments, capacity building, and the exchange of innovation by 27.5%. Donors and Multinational companies subsequently have a positive effect in developing nations, particularly through headway of health innovation and generally speaking enhanced services of healthcare.

CHAPTER FOUR
WAYS OF IMPROVING MULTI-NATIONAL CORPORATION'S CONTRIBUTION IN HEALTHCARE SERVICE IN DEVELOPING COUNTRIES

4.1 Introduction

This section will review ways of improving Multi-national Corporation's contribution in healthcare service in developing countries. Other emerging issues relating to the topic will be presented including presentation of the results from utilization of the collected data.

4.2 Multinationals Interest in Healthcare Financing

There has been an increase in multinational activities in the recent past in developing countries.[91]MNCs and Donors conducting their businesses across nations always want to maintain the company's best practices therefore would be socially mindful of their undertakings in the host country.

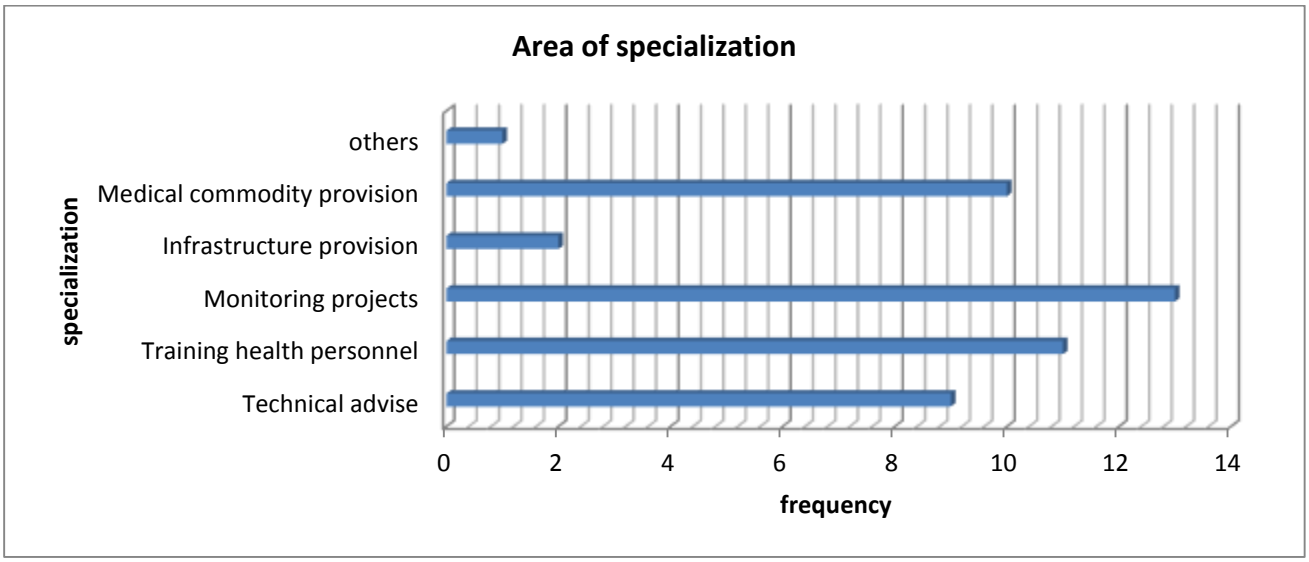
There is a dire need of enhancing affordable health care systems in developing countries without compromising the quality of primary healthcare in order to achieve UHC. This is achievable by collaborating with other stakeholders. The Common financing practices by MNCs and Donors are mostly centred on research and trainings, healthcare, poverty alleviation, cultural enrichment, youth development, charity activities and women empowerment. These undertakings are formulated to be the partners of development.[92]

Result based Financing initiative which promotes greater autonomy and better management has contributed to better health outcomes. This ensures that the funding allocated to the various health sectors by the MNCs can be easily accounted for. NHIF recruitment needs to be encouraged, this is one of the ways of making health care more accessible.

[91]Fosu B. (2015), Access to Health Care in Urban Areas of Developing Societies. *Journal of Health and Sociological Behavior*, 30 (4): 98-411

[92]Chang, C., & Ying, Y. (2016). Economic growth, human capital investment, and health expenditure: A study of OECD countries. *Hitotsubashi Journal of Economics, 47*(1), 1-16.

Graph 5:MNCs and their area of specialization



Source; survey data

MNCs largely fund for monitoring projects, training of health personnel, provision of medical commodities and technical advice. Provision of infrastructure and other services attracts the least funding. This implies that although there could be better trained personnel, medical commodities and frameworks for monitoring and evaluation, healthcare services are therefore undermined by lack of infrastructure.

Table 10:Distribution of projects by MNCs and Donors

No of Projects	Frequency of MNCs and Donors
0	4
1	1
2	6
3	1
4	5
5	11
Above 6	4

Source: survey data 2018

MNCs and donors have been involved in healthcare projects with 11 MNCs and 6 Donors having funded 5and 2 projects respectively.

4.3 Overview of Donor Funding In Kenya

Global business relations require common responsibility in form of partnerships.

The point of universal laws as well as approach, for example, is to guarantee that human health must be protected so that the community where the multinational operates as well has something to pride in as far as their health is concerned. The creation of a better social environment benefits both society and organizations and thus attracting foreign investors.[93] Kenya being a business hub in the region is currently doing well apart from NHIF coverage where Rwanda has taken an early lead at 91% in the region.

However, there is lack of an institution that guides and monitors such activities. One will find that it is mostly (but not exclusively) organizations in the private sector that finance health services. This is because some private sector organizations are largely commercial and sometimes are multinational entities with financial ability to take up societal issues. An organization should evaluate itself and determine whether or not they can integrate health financing into their structure and successfully implement it fully in the form of a series of projects. They should do this keeping in mind that the health projects are to benefit the society.[94]

Table 11: Distribution of the benefits of MNCs and donors in Kenya

Benefit	Frequency	Percent
Research grants and trainings	13	40.625
Provision of medical services	11	34.375
Subsidized pharmaceuticals	8	25

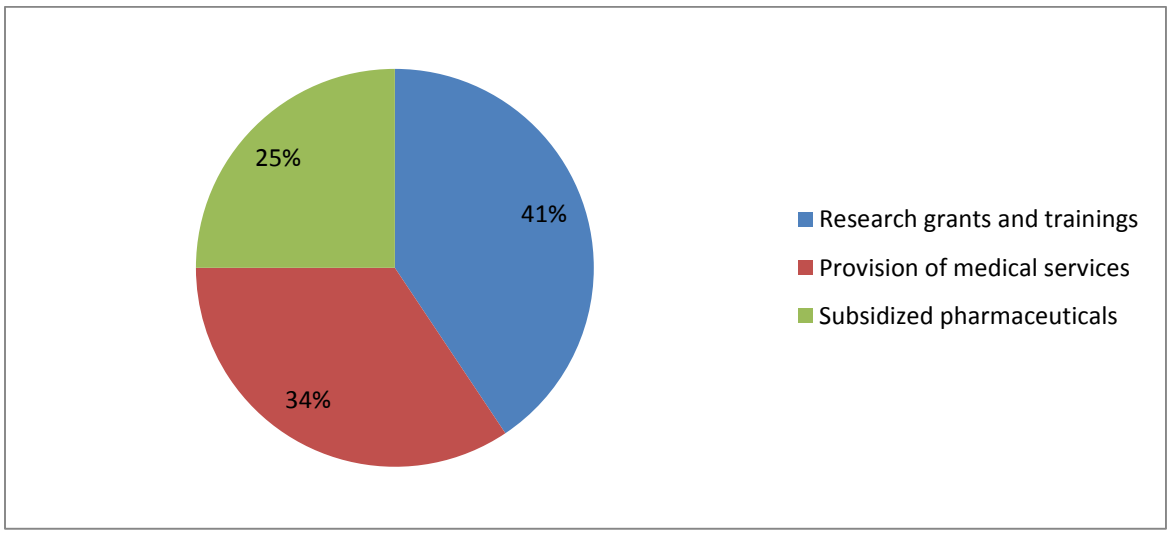
Source: Survey data, 2018

[93]Krishina, H. (2016), Quality Improvement and its Impact on the Use and Equality of Outpatient Health Services in Kenya. *Health Economics*.

[94] Hallman, K., (2016) Child Health Care Demand in Developing Country: Unconditional Estimates from Kenya International Food Policy Research Institute, 70: 34-51.

Table 11 asserts that the major benefit received from the donors as well as multinational corporations is in terms of Research grants and trainings with a representation of 40.6 by 25% of the responses, followed closely by the benefit of provision of medical services at 34. 4% and the least being subsidizing pharmaceuticals at a representation of 25%. This is further displayed in figure 3

Figure 3: Distribution of the benefits of MNCs and donors in Kenya



Source: Survey data, 2018

The frequency distribution table that generates the pie chart depicts that the donor and MNCs funding majorly benefits the sector by presentation of channels for research grants and trainings at 41% representation, followed closely by medical services at 34% representation and last significant benefit is on the subsidizing pharmaceuticals at a representation of 26%.

Nevertheless, this section will provide a description of some of other emerging and recurring reasons that further describe why MNCs and Donors engage in health financing in developing countries.

4.3.1 Direct Economic profits

The business of health financing states that the profits of a social or natural speculation or activity are bigger than the expenses related with it. This view considers organizations to be sane performers with exercises driven exclusively by productivity and benefit.[95]

The complexities of health care in Kenya are being felt by the citizens ranging from high cost of healthcare services, inadequate emergency services, reduced funding in mental health care and lack of basic health services. County governments are now ensuring that even the rural population and low income earners are being registered to NHIF, there have been massive campaigns lately by the County Health officers.

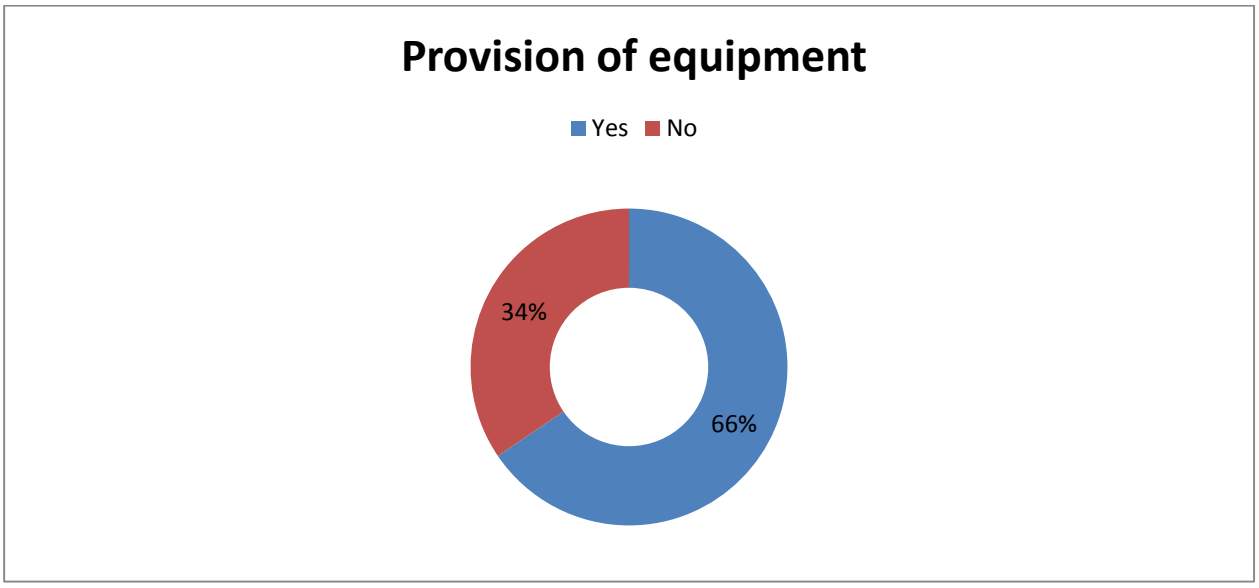
Furthermore, the health financing advocates or the financial drivers of change show that organizations taking part in health financing see the engagements making benefits that surpass the expenses. One could contend that these MNCs would take part in these activities so as to upgrade the health sector of a given group. This might be valid, but the winds of change are yet to blow towards that direction.

4.3.2 Provision of equipment

MNCs and Donors have been of economic importance through various channels, the study identifies that provision of health care sector equipment's have been on the forefront by majority of the MNCs and Donors with majority, 66% having contributed an equipment or two whereas 34% have not provided any. This could be explained by the fact that some of the equipment needs are so costly. Take for instance the PET scan recently purchased at AKUH, cost the organization so much money and running it in the Country also needs expertise amongst other needs. It is therefore cheaper for these MNCs to fund in other less costly ventures.

[95]Odusola, A. (2015). Rekindling investment and economic development in Kenya. NES Selected PA World Health Organization. June 2015. WHO on Health and Economic Productivity. Population and Development Review 25.2: 396-401

Figure 4: Provision of equipment



Source: Survey data, 2018

A Doctor working in a government health facility noted in an interview that' *The Government acquired modern hospital equipment without personnel to run the same equipments, he felt that there should be criteria in which the hospitals purchased this equipment, he recommended that the equipments ought to be purchased on a need basis with well trained healthcare personnel to manage the equipment.* This 'implies that even MNCs don't find it cost effective to fund for medical equipments.

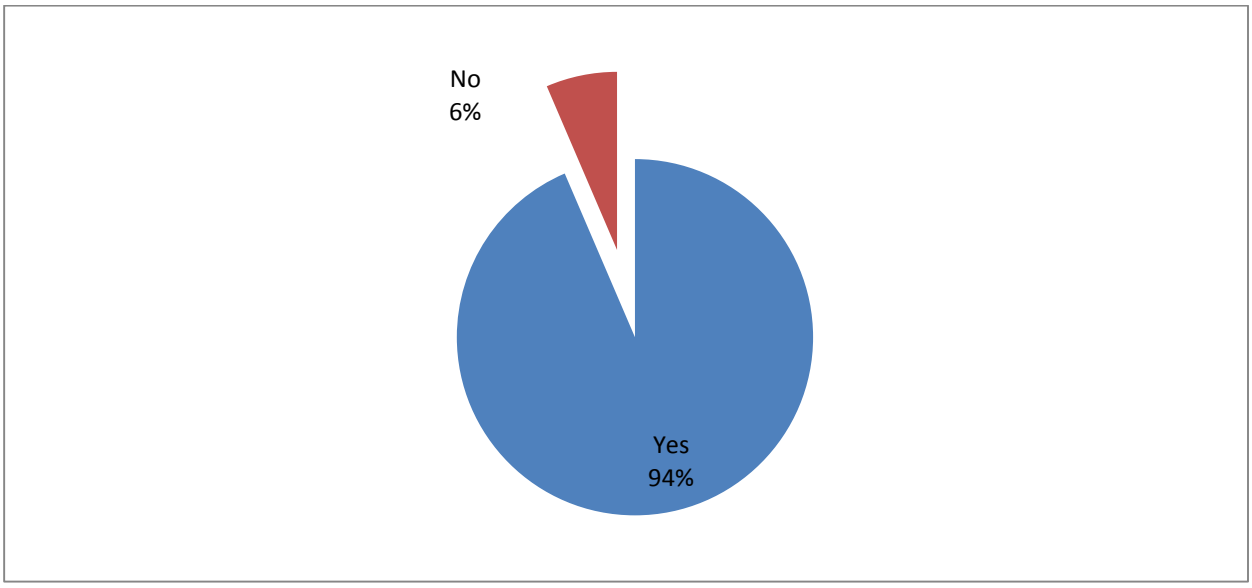
Table 12: MNCs/ Donors and their collaboration with other stakeholders

Collaborated	Frequency	Percentage
Yes	29	93.5
No	2	6.5

Source: Survey data, 2018

Table 12 depicts that 93.5 %o f MNCs collaborated with other stakeholders in an effort to fund for healthcare services

Figure 5: Level of Collaboration



Source: survey data, 2018

94% of the MNCs and Donors had a collaboration with other entities or organization and 6.5% not collaborating as shown from the survey data.

4.3.3Sustainability

The complexity of health financing has called for the inclusion of other stakeholders like county employees, National governments employees, suppliers, customers, local communities and environmental groups which are affected by the actions of the organization through health financing. An all around actualized and powerful health financing plan upgrades the picture of the firm through enhanced productivity and good business environments.

Orione Irungu , a mental health expert working at Great Holistic Health Centre an NGO noted '*that the major challenge the organization faced was the lack of sustainability of the funding received due to the conflict in priorities, this he further mentioned could be avterted by creating strict national policies on NGO's and collaborations with other stakeholders in mental health'.*

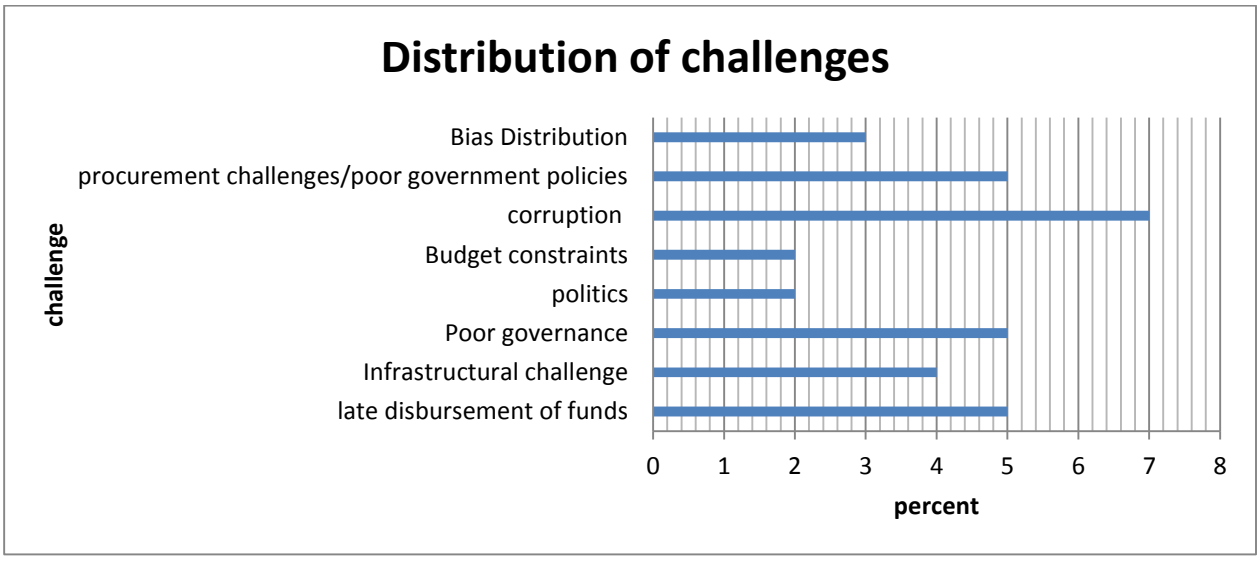
Temitope and Bola noticed that a powerful Corporate Social Responsibility procedure will undoubtedly offer clear business benefits and a firm establishment of sound morals and values.[96] Health services financing depends on the gains for the survival of the MNC conducting the CSR projects.

4.3.4 Research findings

Table 13: Challenges faced by Donors and MNCS

Challenge	Frequency	Percentage
late disbursement of funds	5	15%
Infrastructural challenge	4	12%
Poor governance	5	15%
Politics	2	6%
Budget constraints	2	6%
corruption	7	21%
procurement challenges/poor government policies	5	15%
Bias Distribution	3	9%

Graph 6: Distribution of Challenges



Source: Survey data, 2018

[96]Temitope, A. & Bola, S. (2014).Effect of health investment on economic growth in Kenya. *IOSR Journal of Economics and Finance, 1*(2), 39-47.

The Donor and MNCs funding on health care in Kenya has faced a number of challenges as in the bar chart, with corruption being the major challenge faced, with 21% of the respondents asserting so, followed closely by the challenges of late disbursement of funds, Infrastructural challenge and Procurement challenges or poor government policies at a representation of 15%. Bias distribution of funds with a representation of 9 % and the least challenges faced were political interference and Budget constraints at 6% representation.

4.3.5 Recommendations made by the MNCs and Donors

The last portion of the interview schedule using the question inquired on recommendation from the respondents on articulating for efficient day to day activities and well as success of the MNCs and Donor funding.

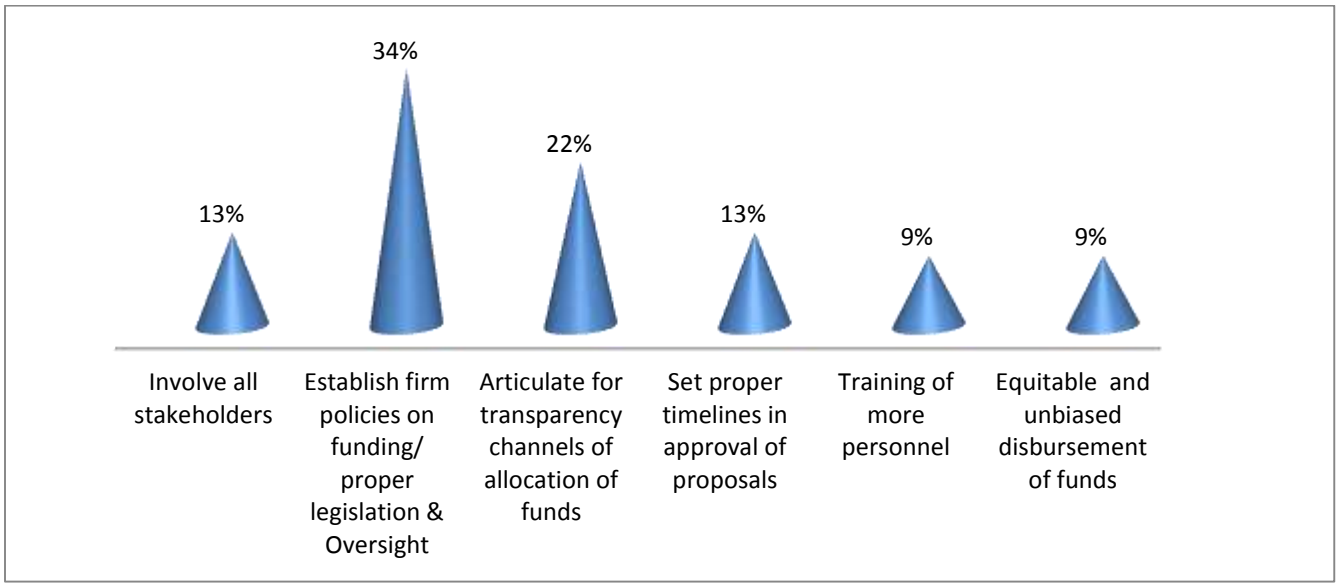
Table 14: Distribution of the Recommendations

Recommendation	Frequency	Percent
Involve all stakeholders	4	12.50%
Establish firm policies on funding/ proper legislation & Oversight	11	34.38%
Articulate for transparency channels of allocation of funds	7	21.88%
Set proper timelines in approval of proposals	4	12.50%
Training of more personnel	3	9.38%
Equitable distribution of funds	3	9.38%

Source: Survey data, 2018

Policies are the major drivers of change in healthcare funding, was agreed upon a majority of the respondents, 34.38%, followed closely by articulation of transparency channels of allocation of funds at 21.88%, Involvement of all stakeholders and setting proper timelines for approval of funds equivalently being represented by 12.50% and the least portion recommend was training of more personnel and equitable distribution of funds at respondent representation of 9.38% each.

Graph 7: Pie chart on MNCs/Donor Recommendations



Source: Survey data, 2018

Graph 7 represents a summary of the recommendations as given by MNCs and donors.

4.4 Chapter Summary

The chapter has reviewed other emerging issues that can improve multinational interest in financing health care services. To note the following areas have emerged to influence MNCs and Donors decisiveness in financing health care in developing countries: - direct economic profits, investors in the market for virtue, employees and consumer's interest and governmental regulation. The creation of firm policies or proper legislation or oversight authorities will enhance health care financing from both Donors and MNCs.

CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

5.1 Key Findings

This chapter presents the key findings in reaching a decision on the route for the hypothesis in the study**.**Fundingis largely given to monitoringof projects, training of health personnel, provision of medical commodities and technical advice while Provision of infrastructure and other services attracted the least funding. This implies that although there could be better trained personnel, medical commodities and frameworks for monitoring and evaluation, healthcare services are however undermined by lack of infrastructure like functional theatres, laboratories, well equipped ICUs, radiologicalequipment this is some of the infrastructure that the Kenyan healthcare system needs. In addition despite MNCs funding health care in Kenya, there are challenges, with corruption leading at 21% according to the respondents, followed closely by the late disbursement of funds. Lack of infrastructure and Procurement challenges or poor government policies are at 15%. This means that healthcare is still provided at a very low success rate. The bias in distribution of funds which was at 9 %and political interference and budget constraints at 6%clearly undermined proper delivery of healthcare services.

5.1.1The contributions made by donors and Multi-national Corporation

Donors and multinational corporations have been significant contributors of health care in Kenya. Results from the secondary data and survey data based on the distribution of data source Centre for Strategic and International Studies, 2014 which showed that 18 Donors and MNCs being players in contribution of health care funding. USG-PEPFAR leads the cohort in contribution with a percentage of 21.72%, followed closely by DFID at 19.49% the contribution is significantly displayed for all the 18 MNCs and Donors as per figure 2. Survey data postulated that the number of projects ventured by the MNCs and donor funding in the health sector were significant with majority having undertaken above 4 projects in the healthcare sector as displayed in table 10 .The benefits that the respondents had received were further described by displaying the contributions of the duo (MNCs and Donor funding) on table 11.Where 41% of the respondents asserted that they had received Research Grants and trainings and the rest postulating that they had received subsidized pharmaceuticals and medical services. With this information, we clearly fail to reject the null hypothesis under the contibution of donors and

MNCs in health care financing and thereby conclude that donors and Multi-national Corporation contribution is significant in financing of healthcare in Kenya

5.1.2 Influence of Donor and Multi-national Corporation in health care financing

MNCs and Donor funding has influenced health care financing through provision of aid including; recurrent expenditure, Training medical personnel, Research collaboration, Provision of medical infrastructure and many more. This has been elicited by the survey data displayed in Figure 4, showing the contribution of the MNCs and Donors by provision of equipments as well as the level of collaboration with charitable organization where 93.5% had collaboration with at least one organization, with only 6.5% having no collaboration, as evident in Figure 5. This two instances highly articulates for acceptance of the null hypothesis with a conclusion that MNCs and Donor funding has a significant influence in health care financing. Amref has been influential by directly partnering with government projects and various stakeholders in ensuring that the health care personnel are trained and offering accessible healthcare for all.

5.1.3 Enhancement of Donor and Multi-national Corporation's contribution in healthcare.

Donor funding has not fully infiltrated into the Kenya's healthcare sector, this had been attributed to the challenges that must have accrued over the whole process of funding by the MNCs and Donors. This has been found in the study to include; Budget constraints, Infrastructural challenge, Corruption, Politics, Poor government policies, Late disbursement of funds and any more, as asserted by Table 10 sourced from the survey data.

Novartis one of the pharmaceutical MNCs expanded its partnership with medicines for Malaria in 2016 to develop the next generation anti-malarial treatment in an aim to reduce the morbidity of childhood deaths due to Malaria. The organization has collaborated with CHAK,ICRC,KRCS with an objective of scaling up of diagnostic tools ,programs and NCD guidelines in Kenya. The hypothesis on Donor and Multi-national Corporation's contribution in healthcare service in developing countries enhancement can hereby be accepted upon addressing these challenges.

5.2 General Conclusion

The data uncovered an assortment of the practices by the various health care financers and donors.A few practices are universally overseen by the Donors and a few of health care services varied over the MNCs and Donors units or were particular to the local tasks. Findings show that MNCs and Donors are diverting their corporate social responsibility programs to the developing countries. The market is so huge and differing that numerous associations globally are attempting to set up their quality in the market with their services and products. Despite the fact that the purchasing intensity of the person in the developing nations consumer is low contrasted with the west, the future capability of the market seems extremely alluring to MNCs and Donors. Accordingly, MNCs and Donors are occupied with investigating this undiscovered potential by financing the healthcare services as a marketing technique.[97]

The research findings as seen in part chapter two, three and four denotethe key issues in the developing the healthcare sector.[98]The enormous contribution of revenue driven chains of hospitals in the conveyance of healthcare has made a significant development of the revenue driven segment. This inclusion has encouraged policies and projects, for example the legislature has demonstrated a few endeavors in financing the health segment, however, have not figured out on how to control the conveyance of health services and gave endowments speaking to a huge extent of in general expenditure on health. These conditions added to the issue of health services in the developing economies. Pharmaceutical based MNCs and Donors have contributed 12.5 % in this study.

Recipients from these contributions have kept on supporting the interests of the industry of healthcare over the interests of the general population.[99] Legislators receiving such campaign funds have casted a ballot to debilitate patients' capacity to consider their managed care associations responsible for their activities and furthermore have advanced the interests of doctors looking for higher charges. As the residential market turned out to be more disagreeable

[97]Odusola, A. (2015). Rekindling investment and economic development in Kenya. NES Selected PA World Health Organization. June 2015. WHO on Health and Economic Productivity. Population and Development Review 25.2: 396-401.

[98]Kurt, S. (2015). Government health expenditures and economic growth: A Feder–Ram Approach for the case of Turkey. *International Journal of Economics and Financial Issues, 5*(2), 441-

[99] Appleton, S. (2015) Education and Health at the Household Level in Sub-Saharan African CID Working Paper No 33 Center for International Development Harvard University.

and less appealing, a progress from national to multinational managed care has risen and MNCs and Donors pharmaceutical organizations, have swung to health financing services as a source of alternative profits.

Healthcare financing envelops the monetary, legislative and moral factors due to the commitments these organizations have steered towards achieving UHC. The older MNCs in the Country have chosen to fund the health sector in various segments and focused on mostly curative, promotive and preventive health care. Rehabilitative healthcare is still under funded as most of the funding for mental health care still comes from the MOH basket and studies haven't been done yet to show the exact allocation of mental health care in the country.

5.2.1 Recommendations

To achieve and sustain UHC, there is need to explore various partnerships in healthcare financing and service provision, UHC is one of the cornerstones of SDG's, without it Kenyans are at risk of losing the opportunity to have fulfilling healthy lives. There was also a gap when it came to mental health financing, as the allocation of funds in the department of mental health was entirely from the MOH and the healthcare personnel working at the Mathari,National Teaching and Referral hospital felt that the institute would benefit more if they were allocated for conditional grants rather than get the pool funding from the Ministry. Since they are on the ground and therefore know exactly what they need. Public Private Partnerships with MNCs and grants would work best for them, they also felt like their infrastructure was poor and needed to be reinforced, more NHIF recruitment of members was recommended so as to make mental healthcare accessible to all.

The study recommends that Donors MNCs and Donors financing health care must pay attention on the unique, basic needs of developing countries in a particular region or country. Second, health care financing must try to embrace solutions from different stakeholders, by linking national and community health insurance schemes so as to make health care more accessible and equitable. The Makueni County Health care model is a good venture for the government to ape from. Launched in 2016, this model involves payment of 5 dollars per household per year where the people of Makueni are able to access healthcare for both in and out-patient services at the

County hospital. Healthcare financing must analyze societal practices to distinguish valuable standards and potential applications that will strike a harmony between enhanced health and MNCs. The donors additionally need to shape new collusions, since no firm can make the foundation that will support healthcare financing alone. By going into partnerships, MNCs and Donors gain understanding into creating a nations' cultural and societal knowledge, and enhance their very own validity.

Finally it is suggested that MNCs and donors ought to revise financing of healthcare cost structures. There's an essential need to re-examine the whole procedure with an emphasis on usefulness and not the huge business opportunity that is in the developing nations. They see the market potential, and the possibility to make profits, despite the unforeseen challenges. Pharmaceutical MNCs in the developing economies have staged up a competitive advantage as the market for the health care service develops. The investigation prescribes that further examination ought to be undertaken to build up the genuine incentivesofthe donors.Societal welfare in different segments like education. Additionally further research ought to be carried out to measure how much or to what degree these healthcare financing programs have affected on the general public and its relating value generation for the MNCs and Donors in developing nations with the end goal to have a comparative study.

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APPENDICES

Appendix I: QUESTIONNAIRE

Introduction

I am a student at The University of Nairobi undertaking a Masters of arts in International studies and Diplomacy and currently undertaking a project on 'The **Role of donor funding and multi-national corporations (MNCs and donors) in health care financing'**, a Kenyan case study. The questions herein are for academic purposes only and your responses will be treated with utmost confidentiality.

Instructions:
For the following set of questions please tick in the box that best describes your feelings about donor funding and multi-national corporations (MNCs and donor's) in health care financing in Kenya.

SECTION A

DEMOGRAPHICS

1. Name/Name of the institution

2. Gender: ☐ Male
☐ Female

3. Age bracket

☐ Below 25
☐ 25-35
☐ 36-45
☐ 46-55
☐ Above 56

4. Level of Education

Diploma ☐
Degree ☐
Masters ☐
PHD ☐

6. Designation

☐ Healthcare personnel/User

☐ Procurement Officer

☐ Financial Officer/ Insurance representative

☐ NGO /MNC Representative

☐ Others(specify) Medical Sales Representative

7. Indicate the nature of the institution

☐ Public

☐ Private

☐ International organization.

☐ Faith Based Organization.

☐ Others (specify)…….

8. When did the organization start its operation?

☐ Less than 10 yrs

☐ 11-20 yrs

☐ 21-30 yrs

☐ 31-40 yrs

☐ Above 41 yrs

9. Indicate the main area of specialization of your organization in the health sector in Kenya.

☐ Technical advise

☐ Training Health personnel

☐ Monitoring Projects.

☐ Infrastructure Provision

Others(specify)

10. Indicate the key area of specialization of your donor/multinational corporation within the health sector

☐ Promotive

☐ Supportive(Infrastructure)

☐ Curative

☐ Preventive

☐ Others(specify)…….

SECTION B

Contribution made by the donor or Multinational Corporation

11 (a) How many projects/products has your organization dealt with in the health sector/industry

1 ☐

2 ☐

3 ☐

4 ☐

5. ☐

(b) For the following set of questions please tick in the box that best describes your feelings about the extent you agree or disagree, your organization has ventured in:-**SD**-Strongly Disagree, **D**-Disagree**, N**-neutral, **A**-Agree, **SA**-Strongly Agree.

ITEM	**SD**	**D**	**N**	**A**	**SA**
Promotive health services					
curative health services					
preventive health services					
medical commodities/ infrastructure/ research/training					

(c)To what extent does your organization assist in infrastructure and research/training of health care personnel?

ITEM	**High**	**Medium**	**low**
Provision of medical infrastructure			
Training medical personnel			
Provision of Research grants			
Provision of pharmaceuticals suppliers.			

(c)What Benefit have you received from donors or Multinational Corporation in the past 15 years?

☐ Research grants/Training of healthcare personnel?

☐ Provision of medical services

☐ Subsidized pharmaceuticals

SECTION C

Assess the Influence of donors and MNCs in Healthcare financing

7 (a) Do you receive aid?

☐ Yes

☐ No

(b)If yes in 7(a) from which source.

☐ Public

☐ Private

☐ NGO

☐ International organization

☐ Others

(c)Indicate the nature form of aid you get

☐ Recurrent expenditure

☐ Training of medical personnel

☐ Research collaboration

☐ Pharmaceuticals and medical supplies

☐ Medical infrastructure

☐ Others (specify)……

(b)Has your organization provided any equipment to any health facility in Kenya in the past 15 years?

☐ Yes

☐ No

If yes, Specify the equipment(s) provided.

……
……
……
……..

(c) Does your organization collaborate with other charitable organization?

☐ Yes

☐ No

If yes, specify.

We have a CSR department that deals with
that……
……
……

SECTION D

Recommend ways of improving MNCS/donor funding in Kenya

8(a) What are some of the challenges faced by donors/MNCS in contribution to the health sector

(i)……
……..

(ii)……
……

(iii)……
……

(b)Based on the challenges above, briefly recommend possible ways of averting these challenges

(i)……
……

(ii)……
……

(iii)……
……

Thank you

Appendix II: introduction letter

UNIVERSITY OF NAIROBI
College of Humanities and Social Sciences
Institute of Diplomacy and International Studies

Tel : (02) 318262
Telefax : 254-2-245566
Fax : 254-2-245566
Website : www.uonbi.ac.ke
Telex : 22095 Varsity Ke Nairobi, Kenya
E-mail : director-idis@uonbi.ac.ke

P.O. Box 30197
Nairobi
Kenya

October 30, 2018

TO WHOM IT MAY CONCERN

RE: RUTH DAMA MASHA – R50/81179/2012

This is to confirm that the above-mentioned person is a bona fide student at the Institute of Diplomacy and International Studies (IDIS), University of Nairobi pursuing a **Master of Arts degree in International Studies.** She is working on a research project titled, **"ROLE OF DONOR FUNDING AND MULTINATIONAL CORPORATIONS IN HEALTHCARE FINANCING: A KENYAN CASE STUDY 2000-2015".**

The research project is a requirement for students undertaking Masters' programmes at the University of Nairobi, whose results will inform policy and learning.

Any assistance given to her to facilitate data collection for her research project will be highly appreciated.

Thank you.

UNIVERSITY OF NAIROBI * APPROVED * DATE: SIGN: INSTITUTE OF DIPLOMACY AND INTERNATIONAL STUDIES

RECEIVED CSOHS 17 JULY 2019 Kenya Medical Sup...

Professor Maria Nzomo,
Director, IDIS
&
Professor of International Relations and Governance

Appendix III: List of MNCs and Donors with Regional Africa Headquarters in Kenya

1. GlaxoSmithKline
2. Johnson and Johnson (Janssen)
3. Novartis
4. Pfizer
5. Roche
6. Sanofi
7. Mercury Healthcare
8. AghaKhan Foundation
9. Kippra
10. WHO
11. ICIPE
12. AMREF
13. Sun Pharma
14. Intas
15. AAR
16. Sumitomo Chemical
17. BD (Becton Dickinson)