

## RE-THINKING HIV AIDS FUNDING FOR SUSTAINABLE DEVELOPMENT IN KENYA

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### Abstract

*The changing face of donor driven HIV funding in Kenya poses one of the main economic threat to people living with HIV (PLHIV) in the country. Most countries transitioning from low income economies to middle income countries should/are required to demonstrate progressive ownership in financing their own health care systems. Kenya recently achieved a middle income economic status yet financing of HIV Programmes and other healthcare programs remains lowly funded. The high HIV burden in Kenya limits the attainment of the healthcare financing for those living with HIV AIDS in Kenya. The potential upshots includes, and not limited to, rise in medical expenses among the PLHIV. As a result, this reverses the economic milestones achieved in the past years. Other consequences include increase in impoverished populations due to increased disease burdens, increase in the number of Orphans and Vulnerable Children among other downsides that are implied by such reversals. Indications to ascertain these are deduced from key findings of the empirical literature review. First, Kenya allocates approximately 4% of the GDP in all of healthcare sectors and has remained so since 2002. Secondly, 80% of HIV AIDS financing is by donors, that the progress towards increasing domestic financing has remained relatively same since FY 2013/14 to FY 16/17 fluctuating between 24% in FY 13/14, 30% in FY 14/15, and 29% in the FY 15/16. Some of the proposed solutions for to mitigate such eventualities are outlined in this paper. Empirical literature review and secondary data use inform on the potential strategies adopted and potential consequences of non response. Notably, the study establishes that about 80% of HIV AIDS is donor funded. This over reliance on donor funding is catastrophic in the face of donor withdrawal from middle income countries with Vietnam being an example. Some of the solutions and recommendations proposed to prevent the uncertainties that may prevail in such circumstances include enhancement of healthcare insurance policies for the PLHIV and the citizenry, enhanced and strategic tax collection mechanisms, and encouraging scientific based planning of insurance policies.*

**Key Words:** Disease Burdens, Domestic Financing, Economic Development, Endemic, HIV, People Living With HIV (PLHIV), Sustainability

## INTRODUCTION

The healthcare sector is most essential among other sectors of the economy in all countries. The need to strengthen healthcare services have in the recent past received major boosts given the integration of healthcare policies into the global spectrum and that they are effected at the global level. These policies, defined at the global level, are aimed at enhancing sustainability of healthcare programming (Pibulsonggram et al, 2007). The burden of diseases in Africa is considerably high and HIV & AIDS remains as one of the primary disease burdens alongside Malaria and TB. These diseases together are key among the global health challenges (Murray et al., 2014). In light of these challenges gaining traction in international politics, Millennium Development Goals (MDGs) which formed the later Sustainable Development Goals advocated for the control of these three diseases (Sachs & McArthur, 2005). In order to ensure sustainability of healthcare in developing and underdeveloped countries, it was agreed Abuja Declaration that most member countries needed to allocate 15% of their respective GDP into healthcare programming (Kanya *et al.*, 2015). In the second half in the implementation of Sustainable Development Goals in 2015, most African countries were found to lag behind in allocation targets for healthcare financing ("Public Financing for Health in Africa: from Abuja to the SDGs", 2015). The need to measure up to healthcare as an indicator for economic development needs to be institutionalized and supported from within the respective institutions leading such programmes in respective countries.

In terms of the HIV burden, Kenya is ranked fourth globally alongside Mozambique and Uganda (UNAIDS Data, 2017). As at the year 2016, about 1.6 Million Kenyans were estimated to be living with HIV (UNAIDS Data, 2017). The adult HIV prevalence was estimated to be about 5.4% with about 62, 000 new HIV infections and 36,000 HIV related deaths recorded in the same period. In light of these facts, the National AIDS Control Council (NACC) is persistent in its mandate of coordinating multi-sectoral response for HIV as well as developing policies and strategic frameworks to help achieve this goal. Key among the developed strategies spearheaded by NACC is the Kenya AIDS Strategic Framework (KASF) that was developed to outline strategies that would help the institution to achieve its mandate.

Increasing domestic financing of HIV programmes is outlined under Strategic Direction 7 in the Kenya AIDS Strategic Framework along with policies to ensure that the directive is achieved (National AIDS Control Council, 2014). Despite the government's increased efforts in the HIV AIDS response, the roadmap towards domestic financing is still obscure. The financial allocation of resources by the government was recorded to have increased from KSh. 20.4 billion to about KSh. 26.4 billion shillings in between FY 2013/14 to FY 2015/16 ("KENYA NATIONAL AIDS SPENDING ASSESSMENT REPORT FOR THE FINANCIAL YEARS 2009/10-2011/12", 2015). This represented an increase of about 29% from the preceding year. It is however noted that the amount spent on HIV AIDS has risen significantly over time. The 2015 Kenya National AIDS Spending Assessment (KNASA) report showed that the amount spent in HIV AIDS in FY 2013/14 was estimated at about KSh. 69 billion compared to FY 2015/16 where the spending was estimated at about KSh. 85 billion representing about 24% increase in spending ("KENYA NATIONAL AIDS SPENDING ASSESSMENT REPORT FOR THE FINANCIAL YEARS 2009/10-2011/12", 2015). Based on the FY 2016/17, the proportion of government contribution to the total is about 30% while its contribution in FY 2013/14 is about 29%. The proportion in terms of spending between the two periods does not imply any significant shift in terms of ownership of the response towards HIV AIDS in Kenya. It is undoubted that the economic potential of Kenya is bound to increase over time (KNASA, 2015) and so should the need to have increased ownership of different healthcare initiatives.

Like many developing countries, Kenya is heavily reliant on foreign aid in the execution of the HIV response. According to 2018 HIV Implementing Partners Online Reporting System report ("Report on The HIV Implementing Partners Online Reporting System (HIPORS), for the Financial Year 2015/2016", 2018), 80% of the Kenya HIV response is facilitated by the development and implementing partners. This implies that Kenya contributes only 20% in HIV response financing. This proportion is dismal considering the fact that Kenya has transitioned into a middle-income country in the recent past and must gear towards improving healthcare financing. Thus, its commitment in channeling finances towards healthcare should be higher given that the higher economic potential it posits as a middle income earner.

It was estimated that 6% of the Gross Domestic Product (GDP) was allocated to health financing in 2010 (Munge & Briggs, 2013) and reduced to about 4% in the FY 2014/15 (Health Policy Project, 2016) which is lower compared to other regional counterparts like Uganda which allocated much higher (8%). The lack of sufficient government funding

makes it hard for the Kenyans to access healthcare services. These shortfalls were noted to push over 1.5 million (83%) Kenyans to poverty every year (Okungu, Chuma, & McIntyre, 2017). Most of them are forced to exhaust most of their income and even assets to cover for their medical expenses. Geng *et al.*, (2017) also noted that health insurance coverage in the country is relatively low which also increases the vulnerability of Kenyans to become impoverished.

## Problem Statement

In spite of the fact that the HIV response in Kenya has taken significant strides, the need for the country to shoulder its financing remains a matter of importance to its economic sustainability in future. Kenya's progression into the middle-income economic status is imperative of its ability to finance major sectors of the economy with health being one of them. Being a mandate of Kenya's Ministry of Health (MOH), HIV response is heavily donor dependent. Recent decades have seen some middle-income countries including Malawi, Gambia, Lesotho among others (Fox, 2015) rendered ineligible for foreign aid and have since struggled to ensure sustainability of HIV response. Given the high prevalence rates in the country and the high disease burden, it is necessary that the country increases domestic financing of HIV activities (UNAIDS Data, 2017). Kenyan is by far performing dismally given the fact that its financial contribution towards this is estimated by the 2016 HIPORS report at only 20%. Given that donors tend to withdraw financial support and redirect to countries which require more financial support in growing their structures. The resulting economic implications necessitates that such countries institute measures to ensure stability and growth in different sectors of the economy. It is therefore important that Kenya seeks to channel more resources towards this course. However, the country is yet to define actionable strategies to complement increased domestic financing.

The overriding goal of this paper is to identify opportunities that can be used in bridging the gap of financing HIV AIDS in Kenya. An elaborate assessment of the financing strategies employed in Kenya and the situation that it brings to development and economic sustainability. Additionally, policies to accelerate HIV and AIDS interventions in the country shall be assessed to maximize on the opportunities that can be derived from them. Costs of healthcare financing being one of the core determinant the nation's wellbeing and thus economic development. Focus on countries that have been in the same position as Kenya primarily inform on the opportunities that Kenya can explore and how well the country can adapt to it.

## Empirical Literature Review

The study relied on literature and secondary data review in order to create the significance of the research. The basis for this decision was pegged on the idea that adoption of experimental models would be inadequate due to the administrative constraints. Naga (2014) further interrogated the fact that expansive literature would be assessed systematically in order to establish a definitive flow of certain procedures or event flows. Because of the sensitivity and expanse of health policies, it was deemed important that the study undertook a review of available documentation that speak into government expenditure and policies that govern allocation of such expenditures to the healthcare domain and more specifically HIV financing. The review however sought to draw statistics from various countries in order to contextualize how Kenya is progressing so far in the funding of their HIV AIDs activities.

There exist several policy declarations that exist to spur economic development in developing countries. They include the Millennium Development Goals (MDGs) and Sustainable Development goals (SDGs). MDGs were conventionalized at the dawn of the 2<sup>nd</sup> Millennium. The MDGs were settled upon with the sole aim of enhancing partnership in global development among the United Nations (UN) member states so as to accelerate the economic growth of low income nations. The key declarations adopted for MDGs were poverty reduction, disease eradication, and increased access to education, improved climate management, and promotion of gender equality ("United Nations. Department of Public Information", 2009).

The expiration of MDGs in 2015 ushered in the institution of Sustainable Development Goals which were deduced from MDGs. This was in part, informed by the fact that most African countries has lagged behind in the implementation of MDGs (Easterly, 2009) because some of the goals were not tenable. However, "Sustainability" was a deliberate term that was pegged on practical applications of different programs that spoke into the overriding objectives of the developed goals. In order to effect this, precise and deliberate expansion of the development goals was done in the later compared to the former. As a matter of fact, SDGs are broader when compared to the MDGs with 17 strategic goals

developed to spearhead the development agenda; MDGs had 8 goals. Being a member of the United Nations and a country in Africa, the Kenyan government has with time adopted the SDGs and was part of those that subscribed to the millennium development agenda.

Healthcare provision is one of the key deliverables of the Sustainable Development goals captured as sustainable development goal 3 (Taneja *et al.*, 2017). As a matter of fact, the same goal was also prioritized for MDGs which highlighted Malaria, TB and HIV AIDS to be the yardstick to attainment (Travis *et al.*, 2004). The government of Kenya acknowledges therefore, that upward development mobility is fueled by healthcare assurance of its citizens. It is on this note that in outlining the big four transformative agenda, the government of Kenya reiterated on the importance of Universal Health Care (UHC) (KIPPRA, 2018).

In their paper, Travis and counterparts (2004) acknowledged that improved healthcare increased the wellness of the people. This in turn increased the production ability of its citizens which increases their economic potential as well as that of their countries. In high burden countries, people bear a high financial burden on health expenses. Teneja *et al.* (2017) took note of the fact that reproductive, maternal, newborn and child health (RMNCH) services for developing countries needed higher investment rates for them to be covered compared to developed nations. Buse, Jay, & Odetoynbo (2016) found that AIDS remained as one of the leading causes of deaths among women of reproductive age. The trio further acknowledged that since the burden was considerably damaging, they suggested that the best way to attain the aims of SDG 3 would be through UHC. This ensures governments are able to mobilize resources that can help people obtain quality and affordable care and thus develop a healthy community.

Beefing on the renown cliché that purports that a “healthy nation is a wealthy nation”, complements that some of the empirical results are luminous to the impacts of HIV on personal economic development as well as the development of nations. A significant portion of the developing countries witnessed a significant loss of its human resource capital to HIV and AIDS (Poku, 2017). In the United State of America for example, the number of deaths that were lost due to HIV in were estimated to be about 1.2 million (Dutta, Wirtz, & Stanciole, 2012). These deaths were recorded in an eighteen-year span starting from 1980. The escalation was mainly attributed to inability of the affected persons to access treatment coupled with lack of appropriate medical interventions (Dutta, Wirtz, & Stanciole, 2012). Sickly individual's economic potential was thwarted and so was their contribution towards production. Instead, they were subjected in an endless pursuit of treatment and care services which were very expensive given that they did not have medical insurance covers. The insurance companies feared investing in PLHIV since the economic gains were not determinate. The insurance scheme for PLHIV in Kenya is relatively low. As Koseki, Chumo, and Musau (2015) pointed, only 20% of Kenyan's were insured under the NHIF. This was a serious challenge considering the fact that NHIF is considered a good insurance scheme for the PLHIV because it receives government support and can sustain long term care initiatives.

With failure to settle on insurance schemes for the PLHIV the doubt of sustainability looms and potential reversal of several human development indicators are likely to occur (Isaksen *et al.*, 2002). There also exists a greater risks in HIV response given that the successes made by Kenya are donor driven. Given Kenya's middle-income status, sustainability of HIV and AIDS is in doubts since donors are restructuring their priorities. Changes have been witnessed in countries like Vietnam, Macedonia, Montenegro, and Montenegro "Lost in Transition: Three Case Studies of Global Fund Withdrawal in South Eastern Europe", 2017). Three Case Studies of Global Fund Withdrawal in South Eastern Europe" report of 2017 indicates that a lot of struggles have been endured to sustain service delivery for HIV interventions because of financial constraints. This comes in the wake of economic expansion in different countries and that for sure donors withdraw their support if the country they are based in is deemed to have an economy that can self-sustain or is approaching a state described as such.

“Assessment of the Socio-economic Impact of HIV and AIDS on Key Sector in Kenya” report documented by NACC (2006) highlighted several economic implications of HIV on the people. Affected households were deduced to have a lower income distribution compared to those that were not affected because of increased dependency and costs incurred in treatment and upkeep. Secondly, HIV deaths led increase in the number of orphaned children with little ability to vend for themselves. This subjected the children to poverty with no access to basic necessities like education, food, clothing, and shelter. While some may rely on their relatives and well-wishers, the financial implication of their custody lowers the financial positions of their sympathizers. Given the rise in Kenya's rising economic status, foreign aid is bound to decline over time. Recurrence of previous challenges cannot be over-implied if measures are not put in place to

mitigate them. To explicate how adapting has been done in the past policy makers in the USA adopted the Punctuated Equilibrium Theory (PET) to provide an insight into the global health finances.

### **Punctuated Equilibrium Theory (PET): An insight into Global Health Financing**

The PET provides an insight into the foreign and fiscal policies and their implications in resource mobilization for different disease interventions. The administrative constrains of disease funding are some of the greatest inhibitors to the global health financing. According to Baumgartner et al. (2014), the Punctuated Equilibrium Theory PET seeks to interrogate how political processes are characterized by stability and incrementalism. However, they noted that there are tendencies that such observations are more likely to cause major changes from the past undertakings. The theory in application has a lot of use in the American politics in shaping the policies around foreign aid. According to Martin & Streams (2015), the American system focused more on HIV funding that did in other diseases. The need to re-diversify was called for by the administration of president Obama who reconstructed the fiscal system of the American government and foreign AID policies of global health financing (Kaiser Family Foundation, 2014). The context of application of the theory is not pegged on the American policy formulation system but the opportunity that is presented in this respect.

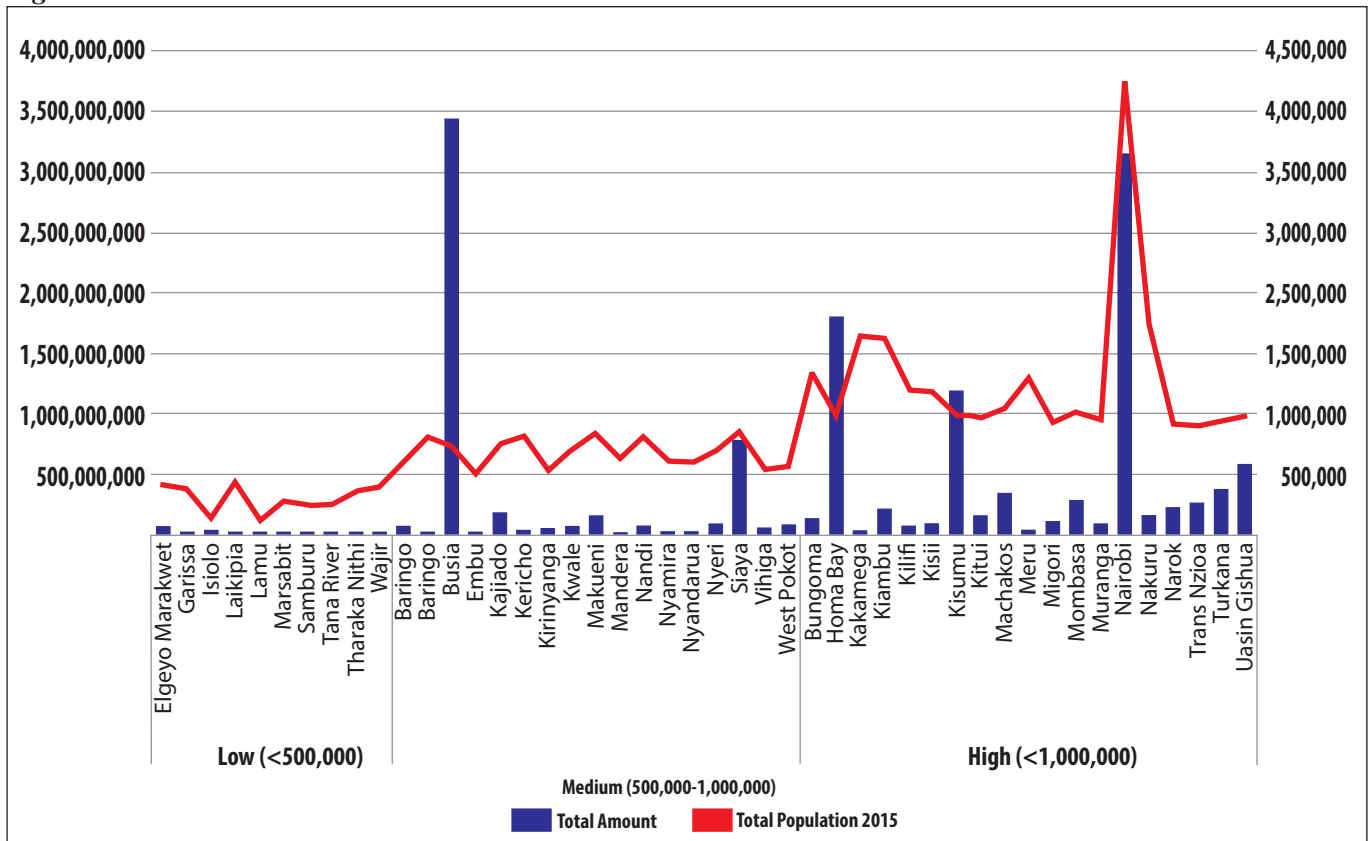
One of the main concepts that the theory portends is punctuation. The need to adapt to different needs in the society is primary in the global health financing. Drawing reference to the initial assertion of donor withdrawal, it is necessary to understand that is an instance and consequently a punctuation that must be acted on. The main idea of the theory being instances in time where needs need to be addressed is one of the clarion calls that government must be able to act on. In order to increase sustainability and therefore create an economic safe house, a call to reinstitute different sectors of health must be considered at different punctuations. Such options include budgetary allocations, tax systems, policy changes, are some of the suggested by PET. In order to remain abreast therefore, there is need to invoke on its application.

The contextualized literature in this paper, implies that there are several limitations that hinder domestic financing of HIV AIDS activities in Kenya. One of the challenges deduced includes improper policy formulation by the government. As a result there has been a poor tendency to integrate global health policies into the national context ("UNESCO HIV Health Clearing House", 2006). Nyikuri (2016) noted that this has resulted in failure for different countries including Kenya to utilize foreign funding well. The study also underpinned the fact that there is a very low allocation of finances in the health sector by the government. This has to a large extent been contributed to by the fact that Kenya has a high overreliance on foreign aid (Saleh et al., 2018). The implication of such economic growth is in many ways definitive of how donor funds are distributed. Most countries that have attained the same level as Kenya have experienced significant cuts in HIV funding and even other sectors of the economy. The case could not be exclusive for those nations because Kenya is moving in the same economic stature and must recognize the need to shoulder such responsibilities.

The average cost of treatment in Kenya for the affected individuals is relatively high. According to Kariuki (2012), the average monthly cost of treatment was estimated at roughly KSh. 200,000 per month. He expressed concerns over how tenable the cost of treatment was given that at the time the Clinton HIV/Aids Initiative had stopped its support for pediatric antiretroviral drugs. In reaction to this the government decided to enact a bill to establish a trust fund to help the affected individuals. However, there are no concrete efforts that have been witnessed in the past relating to the trust fund. According to IT News Africa publication on March 16, 2019, PEPFAR reduced AIDS funding by \$100 Million dollars in 2018 and disbursed USD 102 Million which is expected to drop to 43 Million by 2020. "Public Financing for Health in Africa: from Abuja to the SDGs" (2015) noted that the unpredictable aid flow are also an impediment to enhancing domestic financing of healthcare.

HIPORS provides a benchmark for monitoring of services offered by implementing partners from county to county. This will help in coordinating and redistribution of donor related activities where they have been covered to reduce duplication of services. This can be achieved by redistribution of minimum resources and redirecting donor funding where the burden is huge. Figure 1 shows that while some of the counties were reportedly over funded; there were others which did not have sufficient resources. By identifying such gaps, the government could renegotiate on behalf of counties with unmet need with the donors. Hopefully, such measures shall redirect resources to needy counties and hopefully reduce the financial burden when the government takes responsibility.

Figure 1:



Source: 2018 HIV Implementing Partners Online Reporting System Report

Table 1:

	County	Resource Needs <10 Billion
1	Vihiga	771,000,000.00
2	Kericho	1,161,000,000.00
3	Turkana	1,453,000,000.00
4	Nandi	1,531,000,000.00
5	Trans Nzoia	1,627,000,000.00
6	Nyamira	1,669,000,000.00
7	Bomet	1,673,000,000.00
8	Busia	2,886,000,000.00
9	Kakamega	3,464,000,000.00
10	Wajir	3,731,000,000.00
11	Kisii	4,151,000,000.00
12	Migori	5,827,000,000.00
13	Mandera	7,500,000,000.00
14	Tana River	7,888,000,000.00
15	Siaya	8,476,000,000.00

Table 1 provides a list of counties whose County AIDS Strategic Planning Resource needs were below 10 Billion Kenyan Shillings in the financial year 2015/16. These budgets are relatively low and the Kenyan government could begin planning for such counties on a domestic level. The practical application given that progressive assumption such low costs is tenable.

Constitutional reforms in the advent of the Kenya 2010 constitution provides a platform to improved healthcare. Devolution, which is entrenched in the constitution, encourages service delivery to the people and provides a platform for accountability in resource management. County governments in Kenya are self-governing units with authorized revenue collection bodies. Whereas this is also the case, the National government also facilitates the fiscal budgets for the counties from one financial year to another. A suggestion is therefore floated to encourage the county governments to partake in the HIV response by allocating some of their budgets to HIV financing. Mairura & Mwai (2018) noted that the devolution of health by the Kenyan government has been instrumental raising budgets for HIV response. A progressive approach to financing began in the FY 2016/17 with 12 counties committing \$2 Million and increased in 2017/18 with 26 counties contributing \$4 million. The contribution is low (Wilson, Masaki, Langenbrunner & Taaffe, 2014) but the overall contribution is minimal compared to the burden of disease and potential challenges that the country is faced with. Increasing the collection of funds through counties is a possibility that should be explored to improve the trust fund suggested by the cabinet in 2012 (Saleh, Bitran & Couttolenc, 2018). Saleh, Bitran & Couttolenc (2018) noted that by 2013, the government of Kenya had already placed levies on certain commodities to contribute to the AIDS trust fund. This was encouraged by the successful implementation of such strategy from other countries like Nigeria, Tanzania, and Cote D'Ivoire.

It is notable that the flattening donor aid does not match the increase of domestic finances towards the epidemic as outlined Wilson, Masaki, Langenbrunner & Taaffe (2014). Policy formulation to accelerate increased allocation are therefore necessary. The government must therefore seek to evaluate its fiscal policies and further redefine the taxation structures in the country. According to "Public Financing for Health in Africa: from Abuja to the SDGs" (2015) the tax to GDP ratio for the country is considerably low meaning that there are high cases of tax evasion or non-compliance. Nargis et al. (2015) took note of the need to increase taxes on luxury products such as tobacco to increase the tax to GDP ratio. Nargis and counterparts established that the overall prevalence of tobacco smokers in Kenya was estimated at about 7.8% with about 1.95 million people being smokers in Kenya in the year 2014. However, the 2016 NACADA report showed that the overall prevalence may have increased to about 8.6% ("NACADA | Tobacco", 2018). The reports further suggest that there were more smoking related deaths that were reported for smoking compared to those related to AIDS and accidents combined.

Finally, more resources should be built around prevention care incentives to save up on future costs of treatment. A case scenario presented in the United States showed that the success of prevention through treatment provided the country with a chance to lower the incidences (Centers for Disease control, 2011). Creese et al. (2002) however noted that there is no clear roadmap for Sub Saharan African countries in determining the cost efficiency of preventive interventions because of the high number of infected people. Bautista-Arredondo et al. (2018) however attempted to determine the costs of antiretroviral drugs in Nigeria but did not document the costs of living in entirety for the infected and affected people. However, they established that prevention was the best way to reduce HIV infections and consequently taming the economic implications of such. Counties could be tasked with providing prevention services using the proposed budget allocation as the national government focuses on treatment.

## CONCLUSIONS AND RECOMMENDATIONS

### Conclusion

Kenya is widely a donor dependent nation in its HIV and AIDS response. With over 80% of the response being funded by the international organizations and partners, the need for Kenya to step up in the domestic financing of HIV AIDS is apparent. There have been countries whose eligibility to donor funds has failed to be renewed in the past. Some had strategic measures that helped them through the adjustment periods. Other examples that were noted are Macedonia and Vietnam. As such, the trend is in part determined by the economic status of countries. Most middle-income countries at some point in time assume responsibility in the HIV response. As such, Kenya's position in terms of donor eligibility remains uncertain. It is therefore important that Kenya braces up and prepare for any eventuality by devising and proper strategies crafted to ensure that these HIV services transition effectively without any major economic implications. Some of the strategies identified include increasing the tax to GDP ratio, reinstatement of fiscal policies, and leveraging on the donors available currently.

It is established also that the potential ramifications of withdrawal of donors from countries catastrophic. In the face of uncertainty in terms of aid flows, the budget plans cannot be determinate. This affects the allocations made domestically as overreliance and faith based budget planning by the countries is challenging especially when these obligations are not fulfilled in the long run. Noting on, it is established that the healthcare costs in Kenya pushes more than 1.5 Million people to poverty every year. This, in part, is contributed to by the fact that most Kenyan households are impoverished and unable to access basic services including healthcare. Even though donor withdrawal may not be an imminent challenge, it does not imply that such an occurrence is unlikely. Importantly, it is established that lack of proper insurance schemes for PLHIV attracts several risks and challenges that disparage the gains that have been made in the epidemic control.

## Recommendations

The need for economic development is dependent on human resource development. Whereas this is the case, there is need to understand that the reduction of HIV AIDS cases does not imply that the chances of spread have been minimized. It is therefore the recommendation of the study that future deliberations to ensure HIV response on a domestic level be centered on the following:

Geng *et al.* (2017) noted that the insurance coverage for most people in the country is low. Adoption of good insurance policies for the populace is therefore necessary and more so to those affected by HIV and AIDS. This can be achieved through expansion of the national insurance which increases the amount of money available for funding healthcare incentives in the country.

Kariuki *et al.* (2012) noted that one of the main challenges that the PLHIV may face in the face of donors withholding their support for different intervention could increase the financial liability on those affected and infected with AIDS. It is therefore necessary that initial cost subsidies for HIV drugs and services to enhance a collaborative engagement to minimize the financial burdens among the patients.

Nargis *et al.* (2015) alluded to the fact that most luxury products can help fund essential programmes if taxed a considerable levels. As such, the study suggests that there is need to have improved tax collection mechanism imposed on certain luxury products with the likes of tobacco among others. Finally, further studies should be centered on the how to revitalize the macro-economic enablers for developing countries especially gearing towards improving healthcare.

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