An appraisal of the implementation of the UHC Policy in Nyeri County: challenges and policy options

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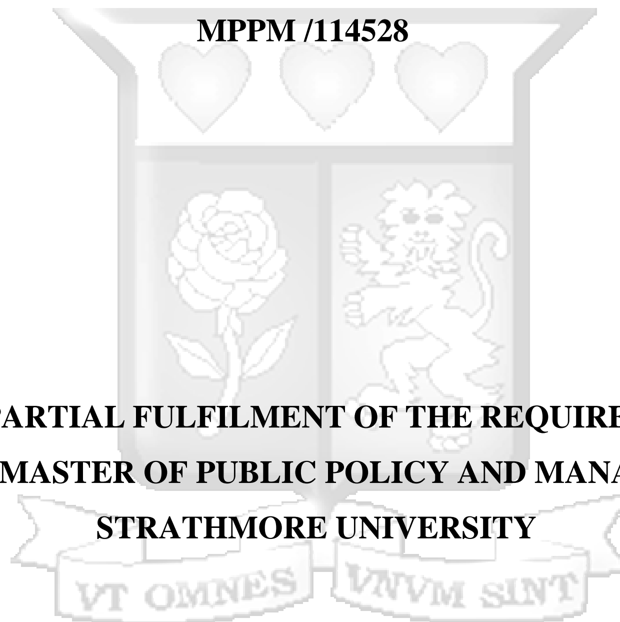

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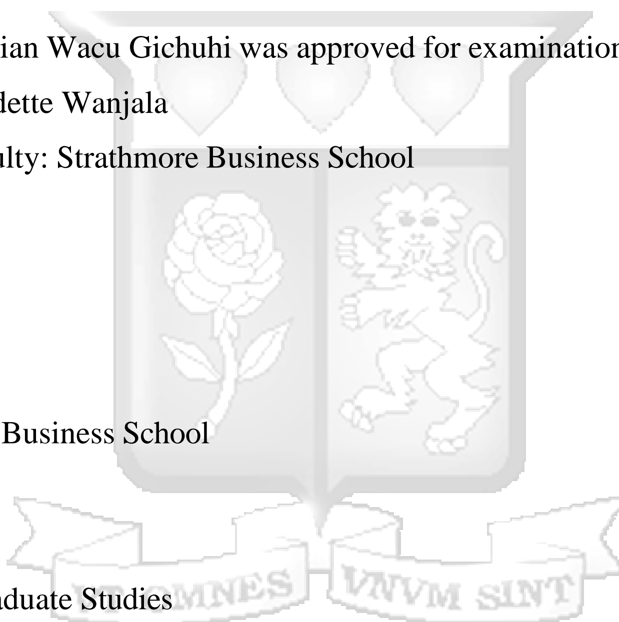

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Abstract

Access to quality health care remains a challenge to many Kenyan citizens. The Government of Kenya has adopted a universal recommendation to implement the UHC program. However, nothing is known if the provision and access is evenly affordable to every Kenyan. Secondly nothing is known about government capacity to fund the program, provide adequate human resource, infrastructure and other health commodities necessary for provision of health care services. Although the program was piloted in four counties, there is no evidence to show that it was successful. The study adopted an exploratory research design where research participants were selected purposively. Data was then collected using an interview schedule and analyzed using content analysis where themes were aggregated and interpreted. The study documented the findings in four categories namely the current status of UHC Implementation, the challenges of UHC, the global best practices for UHC Intervention and the recommendations. The study found out that UHC is currently being implemented under the Social Health Insurance Act. The study also found out that inadequate health financing, inadequate human resource and the shortage of medicines in public hospitals during the pilot phase of the UHC program in Nyeri County was a barrier to the implementation of UHC. The findings also revealed that in Kenya there was a common goal to ensure accessible, equitable and affordability of health care services through for instance free maternal health care, free primary health care services, free cancer medication among others. The study further found out that citizens have to make monthly contributions to the Social Health Insurance Fund in order to access health care services and proposed that UHC services should be budgeted for in the same manner that education was budgeted for in the national budget. The findings suggest that UHC is a commendable approach to provide health care services despite the limitations currently facing the health care system in Kenya and Nyeri County in particular. The implication is that there is need for more funding and further research.

Table of Contents

Declaration ii
Abstract iii
Annextures vii
Acknowledgment viii
Dedication ix
Acronyms x
List of figures xi
List of tables xii
Definition of Terms xiii
CHAPTER ONE 1
1.0 Introduction 1
1.1 Background Information 1
1.1.1 Universal Health Care 2
1.1.2 Health Policies in Kenya 2
1.1.3 Health Care Policy Reforms and Interventions 4
1.2 UHC in County Governments 5
1.3 Research Problem 6
1.4 Research Objectives 8
1.5 Research Questions 8
1.6 Significance of the study 8
CHAPTER TWO: LITERATURE REVIEW 10
2.0 Introduction 10
2.1.0 Theoretical Review 10
2.1.1 Incremental Theory 10
2.1.2 Institutional Theory 11
2.2 Literature Review 11
2.2.1 Design of UHC Policies 11
2.2.2 Challenges to UHC Interventions 17
2.2.3 Universal Best Practices for UHC Interventions 21
2.3 Research Gap 24
2.4 Conceptual Framework 27
CHAPTER THREE: RESEARCH METHODOLOGY 29
3.0 Introduction 29
3.1 Research Design 29
3.2 Study Site 30
3.3 Target Population 30

VT OMNES VNVM SINT

3.4 Sampling 30
3.4.1 Sampling Procedure........ 30
3.4.2 Sample size Determination 31
3.5 Data Collection........ 31
3.6 Data Analysis 32
3.7 Ethical considerations........ 32
CHAPTER FOUR: PRESENTATION OF FINDINGS 33
4.0 Introduction 33
4.1 Response rate........ 33
4.2 Demographic Information 33
4.3 An appraisal of the implementation of the UHC Policy 34
4.4 Challenges to UHC Intervention 36
4.4.1 There was a high demand of UHC services over the National Hospital Insurance Fund services in Nyeri County as the UHC Services were offered free 36
4.4.2 Lack of adequate financing reduced the piloting period of the UHC program in Nyeri County from 4 years to 1 year 37
4.4.3 Lack of adequate financing........ 37
4.4.4 Errors made by community health promoters when registering UHC beneficiaries could take days to rectify whereas the UHC recipient was in urgent need of UHC services........ 38
4.4.5 Poor coverage of the N.H.I.F........ 39
4.4.6 Limited Coverage for critical services........ 40
4.4.7 Long waiting times for UHC recipients in need of x-ray services........ 40
4.4.8 Long queues and long waiting times for UHC recipients in Nyeri town 40
4.4.9 The Implementation of UHC during the pilot phase was not feasible 41
4.4.10 Preference of private hospitals as opposed to public hospitals constrained equitable access to health care services........ 41
4.4.11 If one lacked their national Identification card, one could not access UHC services 42
4.4.12 UHC beneficiaries were required to pay for specialized services........ 42
4.4.13 Shortage of medicines during the pilot phase of the UHC program in the selected County 42
4.4.14 The inability to register for UHC services in the selected County if a person lacked their birth certificate 43
4.4.15 The inability to access UHC services if your name did not reflect in the records 43
4.4.16 The inability to access UHC services when there was system failure in the selected County 44
4.4.17 The presence of corruption during the pilot phase of the UHC program in the selected County 44
4.4.18 Lack of qualified health care personnel to manage complicated cases such as terminal illnesses 45
4.4.19 Poor Road networks 45
4.4.20 Level 2 and 3 health care facilities that offered UHC having poor infrastructure and equipment 46

4.4.21 Primary health care facilities that lacked the required health information and management systems 46
4.5 Global best practices that supported implementation of UHC in Nyeri County 47
4.5.1 The introduction of the free maternal care program to aid in the realization of universal health care 47
4.5.2 The adoption of a primary health care approach 48
4.5.3 The involvement of government and developmental partners in addressing inequity and social inclusion in health service delivery as a global best practice that supported implementation of UHC 49
4.5.4 Having a tax-based system would help in the realization of UHC 49
4.5.5 The adoption of a mechanism whereby the citizens paid premiums to access UHC services. 50
CHAPTER FIVE:DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS. 51
5.0 Introduction 51
5.1 Summary of findings 51
5.2 Discussion of findings 52
5.2.1 Status of the UHC policy framework in Nyeri County 52
5.2.2 Challenges emanating from implementation of the UHC policy framework in Nyeri County 53
5.3 Major gaps of the Study 56
5.4 Conclusion 57
5.5 Recommendations 58
5.6 Limitation of the Study 60
5.7 Areas for further research 60
REFERENCES 61
Annextures 79
Annexture 1 79
Annexture 2 80
Annexture 5 84
A. Ministry of Health Research Participants 84
B. Academic/Think Tank Research Participant 84
E INGOs/NGOs Research Participants 86
E. INGO/ NGO’S Research Participants 86
Annexture 6: 87
Annexture 7 89

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Annextures:

Annexture 1- Research Introduction Letter

Annexture 2 - Strathmore University Institutional Scientific Ethics Review Committee approval

Annexture 3- Ammended SU-ISERC ethical approval

Annexture 4- Nacosti ethical approval

Annexure 5 - Interview Schedule

Annexure 6 – Consent Form

Annexure 7 - Map of the Study Area

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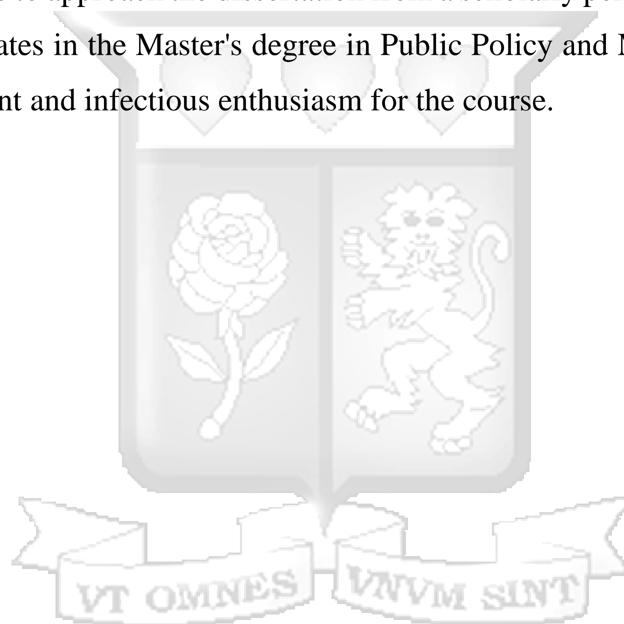

Dedication

This dissertation is dedicated to my progenitors Dr. Gichuhi and Mrs. Gichuhi for their overwhelming support during my entire education. I will forever remain grateful to them.

I do extend my dedication to my siblings Barbara, Nancy, and Terry for their indirect contribution.

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You are all special to me and may the Almighty God bless you.

Acronyms

CDF – Constituency Development Fund

CoK - Constitution of Kenya

CSO- Civil Society Organisation

FMS – Free Maternity Services

GDP – Gross Domestic Product

GoK- Government of Kenya

HHS- Health and Human Services

HISP – Health Insurance Subsidy for the poor

HSSF – Health Sector Services Fund

ICT - Information and Communication Technology

KDHS – Kenya Demographic and Health Survey

LASDAP- Local Authority Service Delivery Action Plan

LMIC's – Low- and Middle-Income Countries

MCAs – Members of the County Assembly

MOH – The Ministry of Health

NCD – Non-Communicable Disease

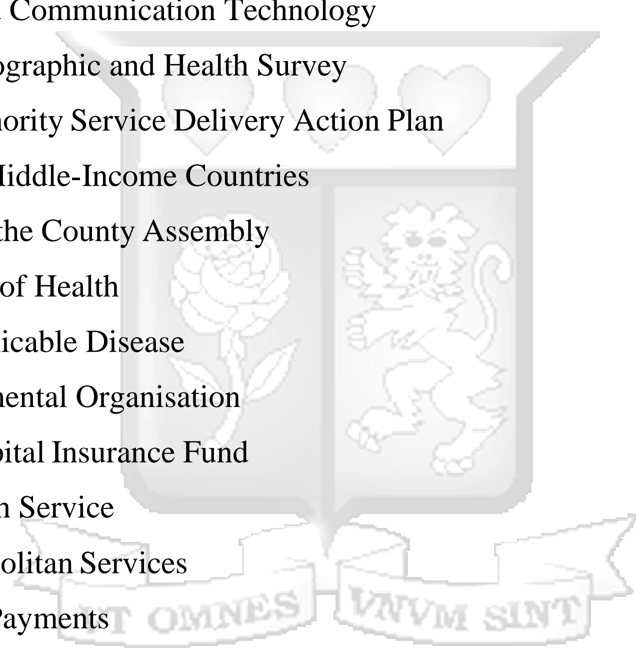
NGO – Non- governmental Organisation

NHIF – National Hospital Insurance Fund

NHS - National Health Service

NMS- Nairobi Metropolitan Services

OOP- Out of Pocket Payments



P.H.C- Primary Health Care

SDG's –Sustainable development Goals

SHA - Social Health Authority

SHIF-Social Health Insurance Fund

THE – Total Health Expenditure

UHC – Universal Health Coverage

UNGA – United Nations General Assembly

WHO – The World Health Organization

List of figures

Figure 1 Conceptual framework…... 27

List of tables

Table 4.1 Respondents response rate.. 33

Table 4.2 Research participants education qualification 34

Definition of Terms

Blueprint: A strategy that expounds how something might be attained.

Co-pay: An amount that an Insurance Policy holder is required to remit out of pocket intended for services received. After the co-pay, the insurance company will pay the remaining costs.

Co-insurance: This is the amount an insured must pay against a claim after the deductible is satisfied.

Health Financing System: This is the task of a health system concerned with the utilization, accumulation, and allocation of cash to cover the health requirements of the persons, individually and collectively, in the health scheme.

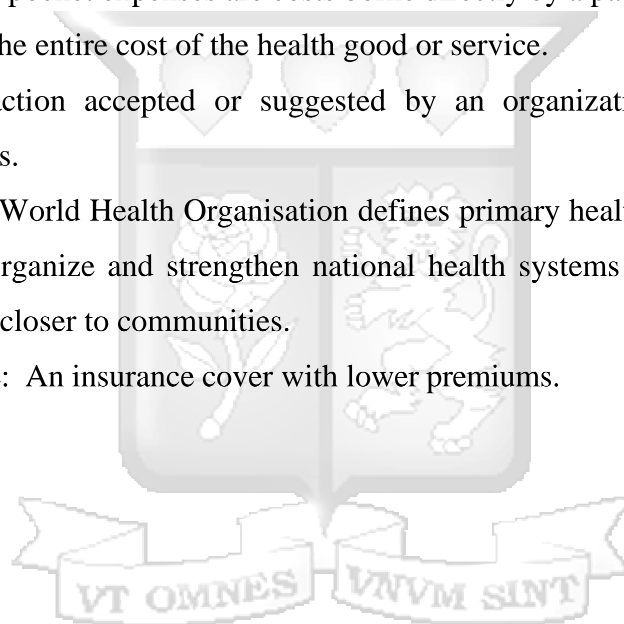
Kakwani index: An assessment of how health care expenses diverge from proportionality.

Out-of-pocket: Out-of-pocket expenses are costs borne directly by a patient where insurance cover does not cover the entire cost of the health good or service.

Policy: A code of action accepted or suggested by an organization or individual to implement their targets.

Primary Health Care: World Health Organisation defines primary health care as a whole-of-society approach to organize and strengthen national health systems to bring services for health and well-being closer to communities.

Subsidized health care: An insurance cover with lower premiums.



CHAPTER ONE

1.0 Introduction

This Chapter highlighted: the background of the study, defined the problem of the study, suggested the purpose and objectives of the study and elaborated the significance of the study in the area of the study.

1.1 Background Information

Kenya continues to experience increasing inequality in access to health care services. The Universal Health Coverage (UHC) strategy was adopted to curb this situation through providing of equitable and affordable health care access to all citizens (Giorgio Laura and Salari Paola, 2019).

The Government of Kenya (Gok) incorporated UHC as a pillar of health under the big four agenda creating a future pathway to access of basic healthcare services to all Kenyans without the risk of financial catastrophe (UHC Policy brief, 2016). Through this framework, there were a number of actionable policy objects that were derived from the WHO recommendation which included provision of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care (WHO, 2021).

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While data of UHC documentation is currently ongoing by individual researchers in Kenya, a case in point Elizabeth Nyawira, Yvonne Macharia, Kenneth Munge and Edwine Barasa in their paper Examining the implementation experience of the UHC pilot in Kenya published in the year 2024, there is no scientific data or evidence to show the benefits of the ongoing roll out of the UHC program. However, this study seeks to validate these assertions. Although Kenya is currently rolling out the UHC policy countrywide, there has been no reliable data to elaborate the status of the UHC policy in the country right from inception, pilot of the UHC program to its current countrywide roll out. It is against this backdrop that the researcher has undertaken to appraise the implementation of the UHC policy, its challenges and possible policy options with Nyeri County as the case study.

1.1.1 Universal Health Care

UHC has been defined to be the access of individuals to effective essential health care services inclusive of affordable medicines without going into financial ruin (WHO, 2021). UHC denotes the fairness of access and monetary risk protection. It is similarly grounded on the concept of equity in financing; that persons contribute based on the capability to pay rather than according to whether they fell ill (Wanjiru Karanja, 2014).

There are Ministry of health (MOH) strategic policy provisions that supported the roll-out of UHC, a case in point the community health strategy 2020-2025. The strategy supported UHC policy action through the following key interventions: increasing sustainable financing for community health; strengthening delivery of integrated comprehensive and high-quality community health services and increasing availability, quality, demand and utilization of data. There were a number of interventions that had been taken in an attempt to realize UHC strategy. These interventions ranged from removal of user fees in public hospitals for expectant mothers under the Linda mama program that is a free maternity scheme, increasing the number of health facilities offering UHC services, a case in point the Othaya level six hospital in Nyeri County built in 2018 and the introduction of health insurance subsidies for the poor and elderly.

1.1.2 Health Policies in Kenya

The policy documents that guided the health sector in Kenya were: the 2010 Constitution under article 43(1)(a) that provided that everyone had a right to the highest attainable standard of health which included the right to health care services (CoK, 2010), health care financing policy that aimed to increase government expenditure of health to 15% as per the Abuja declaration of the overall government expenditure to address funding gaps in preventative services and to make progress in reproductive health such as maternal health and family planning (Healthcare Financing Policy, n.d) and the communicable disease policy that was likened to the UHC interventions by advocating for a strengthened multi- sectoral collaboration in budgeting and allocation of resources at all levels as well as posit control of communicable disease programs within the framework of approved UHC health care through the NHIF, which is now the Social health insurance fund (Communicable Disease Policy, n.d). The Kenya Health Sector Strategic and Investment Plan was yet another

document that guided the Ministry of Health in the implementation of health services. The Strategic Plan described the medium-term priorities intended to facilitate the attainment of the Kenya Health Policy goals. The policy encompassed the role of other implementation stakeholders such as health development partners, sub-national government and cross- cutting departments of national government to address the health care agenda in Kenya. The other policy document that guided the ministry of health, health care provision was the Kenya Community Health Strategy 2020. The goal of the policy was to expand service delivery to all citizens through an integrated, participatory and sustainable community health services to realize the goal of UHC (Kenya Community Health Strategy). Beyond the general policies that guided MOH health care provision in Kenya, there were specific policy guidelines that supported the roll out of UHC. Some of them included the following: the Revised Non-communicable Disease policy and the Communicable Diseases Policy.

Revised Non-Communicable Disease Policy: Non-communicable diseases (NCD) have been defined to be long-term illnesses that are as a result of genetic, physiological, environmental and behavioral conditions, for example cancer and diabetes. Nyeri County was chosen as a pilot county for UHC due to the rising number of cases reported of persons suffering from non-communicable diseases. The NCD disease burden in Kenya has been rising exponentially and the government of Kenya through MOH revised the NCD policy to focus on screening, treating and management of NCD's in Kenya (Revised Non-Communicable Disease Policy).

Communicable Disease Policy: Communicable diseases are illnesses that stem from an infection, presence and growth of pathogenic biological agents for instance diarrhea and Tuberculosis. Kisumu was selected as a Pilot County for UHC due to the high number of cases reported of persons suffering from communicable diseases. The major challenge for Kenya to contain the burden of communicable diseases was related to inadequate financing for instance the Kenya Health Budget stood at below 6% while it should have been at 15%. The purpose of this policy was to provide strategic guidelines to enable government to realize adequate financing and investments so as to reduce the rate of infections arising from communicable diseases (Communicable Disease Policy).

1.1.3 Health Care Policy Reforms and Interventions

The UHC policy has been adopted by many countries in the world. Some of the countries that have implemented health care policy reforms include Zambia, Uganda and Ireland. In the case of Zambia there has been the removal of user fees in primary health care facilities leading to both an increase in the use of health care services in level one to level three health care facilities and in the use of curative health care services among the people in the lower income bracket (Masiye F and Kaonga O, 2016). In Uganda there was also the removal of user fees leading to an increase in the access of health care services and in the rise of the use of lower-level public hospitals among the poor in society (Odokonyero T, Mwesigye F et al, 2017). In Ireland in the year 2013, it stepped up its efforts to improve coverage of UHC by increasing its citizens access to health care services through its General Practitioner visit card program. This program offered universal access to primary health care at no charge. This ensured that the indigents had access to equitable health care services (Department of Health,2023).

In Kenya, the government pledged to realize UHC by 2030. The country's robust political promise was exemplified in the big 4 agenda of the previous administration of Hon. Uhuru Kenyatta. The administration undertook a demographic and health survey that supported decision making and implementation (HERU Policy 2019). However, the findings suggested that population coverage was a bit low and characterized by inequality.

There were subsequently reforms made related to the progress made in increasing population coverage with both healthcare services, and financial risk protection. The abolition of all fees at local and secondary level [county referral] health facilities for instance widely expanded access to health services in the four pilot counties that were selected because of the high prevalence of communicable and non- communicable diseases, high population density, high maternal mortality, and high incidence of road traffic injuries. This implied that government efforts to expand access to priority healthcare services and reduce financial barriers were bearing fruits. This was captured in policies like the user fee removal and free maternity policies of 2013 (WHO, 2020).

In the year 2013, about 24 million Kenyans did not have access to essential healthcare services, and 14 million Kenyans were not protected from the harmful effects of out-of- pocket healthcare payments. Nevertheless, Kenya was halfway through (52%) its UHC journey by 2014, though, it still had a long way to go to achieve 100% population coverage with both needed healthcare services and financial risk protection mechanisms (HERU Policy, 2019).

The Ministry of Health acknowledged a need to improve the quality of health care provision by expanding the human resource base, better links between local and higher- level health facilities, funding and supply of medical commodities, coordination and management. The government is now scaling up UHC based on the experiences from the pilot phase and it will focus on further reforming its national hospital insurance fund (the now social health insurance fund), establishing a mandatory UHC scheme, adopting an essential package of health services, and providing health coverage for an initial 1 million low-income households to be biometrically registered (WHO, 2020).

While the slow progress towards UHC was perhaps symptomatic of weaknesses in all health system functions, the government needed to expand its reform policies to address the gaps such as consistent underfunding of the health sector; health system over reliance on donor funds and out of pocket payments; persistent reliance on voluntary payments to the NHIF as a pathway to UHC and improve healthcare purchasing in a way that was strategic and did not compromise equity, quality and efficiency.

1.2 UHC in County Governments

Williamson & Mulaki, (2015) advanced that "devolution was a form of administrative decentralization or the relocation of authority from central government to subordinate levels of government for a variety of public functions including health care". A case in point, article 43(1) of Constitution of Kenya (CoK) 2010, stated that a person had the right to the highest standard of health which included the right to health care services. Article 232 of CoK 2010 provided an extensive appropriate framework for the values and principles of public service delivery which were inclusive, rapid, unprejudiced, fair on delivery of services and participation of all stakeholders in policymaking. These principles were also echoed under section 7 of the Public Service Act. Consequently, the Government of Kenya (GoK)

through the Social Health Insurance Fund (SHIF) promoted UHC at National and Sub-national government (NHIF, 2015).

Nyeri County was a pilot county for access to subsidized healthcare. The county's UHC registration was inaugurated on November 12th, 2018 and a month later, a total of 457,524 Nyeri citizens had been registered for UHC (Muchiri, 2018). The program sought to ensure that 850,000 of the families in the Nyeri region had access to primary health care (PHC) services at sub- national level (County government of Nyeri, 2019). However, given the fact that there was no evidence to show how much had been realized in the implementation of the Kenya UHC policy 2020-2030 at the sub-national level, specifically in Nyeri County, this study therefore sought to assess the implementation of the UHC Policy in Nyeri County, clearly identify the challenges and propose policy options.

1.3 Research Problem

UHC is enshrined in the 1948 World Health Organisation Constitution that conceives health as a basic human right (World Health Organisation, 2023). This was as a result of sustained campaigns by civil society that argued that an increase in health care costs could lead to a rise in citizens out of pocket expense which was a barrier to equitable access to health care services (OECD, 2022). For instance, in Europe, 15% of health care costs as of the year 2023, were paid through out-of-pocket (ibid) with some states in Eastern Europe and Central Asia having more than 50% of their health care expenses being paid through out-of-pocket (European Observatory on health systems and policies, 2022 a). This showed that out-of- pocket payment was the most used mode of payment for access to health care services for many citizens (Chuma J and Okungu V, 2011).

The World Health Organization (WHO) has consistently warned that out-of-pocket payment can result to catastrophic health expenditure particularly among the impoverished.

In a study carried out in some European Countries, it was found that public hospitals particularly those in the countryside had poor infrastructure and they lacked adequate health care workers and this posed as a barrier to the access of health care services (World Health Organisation,2021b). That notwithstanding, most high-income countries have been able to offer to their citizens universal access to health care services that are affordable, equitable

and of good quality at no charge. In middle- and lower-income countries particularly in Africa though, countries are yet to offer such health care services. A case in point, a study carried out in Africa revealed that even where health services were supposed to be free, they were covered by health insurance schemes, thus indirectly citizens were still making out-of- pocket payments (Kwarteng A et al, 2021).

In Kenya, many patients do not have access to health care services despite being enrolled under the newly introduced Social Health Insurance Fund (SHIF). This is because of delays in registering persons taken ill, delays in processing of patients and in some circumstances requiring making out-of-pocket payments in order to access the said health care services (Abuso V, 2024). Today Kenya's health expenditure is 4.6% of the GDP and this has been found to be low in comparison to the World Health Organization's minimum government health expenditure of 5% (Cytonn, 2024). This remains a barrier to attaining UHC as it is key to have a public health system that is well funded and it can therefore offer equitable and affordable health care to Kenyans (Cytonn, 2024). In addition, while insurance is an alternative source of health care financing in Kenya, it has been found to have low insurance uptake with only 5% of the impoverished having an insurance cover compared to 41% of the wealthy (Ndegi, 2018). In circumstances where families lacked adequate resources, some Kenyans did not go to hospital at all (Cytonn,2024).

It was against this background that the World Health Organisation recommended that all countries should embrace a primary health care approach as a means of achieving UHC (Sacks Emma et al, 2020). Kenya has adopted primary health care which is provided for in the Primary Health Care Fund. Through this fund, Kenyans can access health care services in Primary Health Care (PHC) facilities at no cost thus ensuring that every Kenyan can access equitable health care services (Ministry of health, 2023). However, PHC in Kenya also remains underfunded resulting in poor service delivery (Musuva Ann, 2023). It was noted that some PHC facilities especially in Western Kenya were poorly staffed with some only having one nurse and in the absence of the nurse, the health facility would be closed (Musuva Ann, 2023).

Primary Health Care services also remain inaccessible to many Kenyans (Olago A et al,2023) and for those citizens that can access primary health care, they do not receive equitable health care services because of poor staff capacity, lack of infrastructure and poor equipment in

primary health care facilities (Kruk M et al,2017). Similarly, whereas the UHC program was launched in the year 2018 in 4 pilot counties, nothing is known about the progress made towards the implementation of the UHC program in the country since then. Secondly, while online literature indicates the implementation of the program took off and it is now being rolled out throughout the country, there was limited data related to UHC registration of beneficiaries in pilot counties specifically Nyeri county and in the Ministry of Health websites. There was also nothing concrete known about the utilization of UHC among low- income households in Kenya particularly in Nyeri County in terms of demographic distribution (County Government of Nyeri, 2024). This study therefore sought to assess the current status of UHC policy implementation, challenges and policy options in Nyeri Referral Hospital, situated in Nyeri County Kenya.

1.4 Research Objectives

General Objective:

To undertake an assessment of the implementation of the UHC policy in Nyeri County.

Specific Objectives:

i. To assess the status of the UHC policy implementation in Nyeri County.
ii. To identify challenges emanating from the implementation of the UHC policy in Nyeri County.
iii. To draw lessons from global best practice in the implementation of the UHC policies.
iv. To suggest policy options to optimize UHC uptake in Nyeri County.

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1.5 Research Questions

i. What is the status of the UHC Policy implementation in Nyeri County?
ii. What are the challenges experienced by healthcare providers in the implementation of the UHC policy framework in Nyeri?
iii. What lessons from global best practices can be drawn in the implementation of the UHC policies?
iv. What are the possible policy options to improve UHC uptake in Nyeri County?

1.6 Significance of the study

This study is significant because it will document new knowledge about UHC implementation, helping policy makers, researchers and implementers articulate the health

care policy in such a way that they address critical concerns within the health care system in Kenya. This study also sought to assess the status of the implementation of the UHC policy in the selected county. Some of the important research questions that the study attempted to answer would also contribute knowledge to enable policymakers and implementers put in place suitable mechanism that could translate into equitable and unbiased access of health care for all citizens including those experiencing financial hardships in Kenya. The study would similarly provide future reference for academics and scholars pursing investigations on similar topics.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This section comprised of theories, literature review and conceptual framework of the study. It examined two theories to explain the study empirically namely: the incremental theory and the institutional theory. The chapter further reviewed relevant scientific literature of studies undertaken within the area of study. Against the above, theoretical and literature review, the researcher formulated the conceptual framework to demonstrate the linkages between the independent and dependent variables of the study.

2.1.0 Theoretical Review

This study was anchored on the incremental and institutional theory to explain the context of the study.

2.1.1 Incremental Theory

This was a policy process theory coined by Charles Lindblom in the 1950's (Hayes M,2023). According to the incremental theory, policy makers make small changes to a policy instead of formulating a new policy. This is preferred by policy makers because: (i) making huge changes to a policy is a difficult task and by introducing small changes to a policy, opposition from different groups is reduced and (ii) the current policy has the force of law and it is better to make small changes instead of adopting a new policy (Encyclopedia of Violence, peace and conflict,2022). The incremental theory is also preferred because it is stable as introducing small changes to a policy maintains the stability of policies and it is not as risky because smaller amendments to a policy are faster to implement and have a lower probability of being unsuccessful.

Incrementalism is hence concerned with the improvement of policy problems rather than the analysis of abstract concepts such as social justice. This theory is relevant to this study as it shows the piecemeal transition of the UHC program being developed from a gradual process. A case in point is the UHC program evolving from previous policies through the UHC policy brief. The UHC policy 2020-2030 was also a modification of the UHC policy brief. Prior to the UHC policy brief, there were other modifications of the health care policy to increase access to health care that started with the National Hospital Insurance Fund in

the year 1966 followed by the cost-sharing program introduced in the year 1989- 1994 and the Linda Mama program of the year 2013.

2.1.2 Institutional Theory

This theory argues that institutional structures are crucial in the adoption of public policies because they provide context for policy formulation which is considered with other factors of politics like groups and public opinion (Anyebe A, 2018). The institutional theory studies the role played by institutions in policy making and it analyses how institutions influence policy outcome (Mahmud R, 2017). The rational choice institutional approach would best apply in this study. This is because the rational choice approach of institutionalism argues that policy makers make rational choices based on the outcome of alternatives and choose decisions that will result in maximum benefits.

Thus, this theory informs the study through article 43 (1) of the Constitution (which is an institution as laws are institutions) which provides that every Kenyan has a right to access the highest standard of health. Secondly, the rational choice institutional approach guided policy makers to formulate policies that led to the removal of user fees in public hospitals as an intervention to make health care accessible to all Kenyans. In addition, the same institutional structures also introduced the free maternal health care program and the National Hospital Insurance fund to offer equitable, accessible and affordable health care services.

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2.2 Literature Review

The Literature review was discussed in three perspectives i.e. globally, continentally and regionally. The global perspective drew case studies from Japan in East Asia, Thailand in South East Asia and Turkey in Europe. The continental perspective drew case studies mainly from Africa specifically from Tunisia and Ghana and the Regional perspective drew case studies from Uganda and Rwanda.

2.2.1 Design of UHC Policies

Globally, the concept of UHC was first derived from WHO constitution of 1948 that announced health to be a human right (World Health Organization, 2020). The Organisation has since committed itself to attaining the highest standards for health through partnership

with other actors as recently seen in 2018 when WHO partnered with UNICEF and the Ministry of Health of Kazakhstan to recommit itself to Alma-Ata declaration of universal health care. The conference involved a range of participants varying from civil society, academicians and health practitioners who were engaged in primary health care.

Also, United Nation' General Assembly came up with "International covenant on Economic, Social and Cultural Rights" which was a legal framework to ensure that every resident got access to affordable health care. Thus, the international community of which Kenya was a signatory of the covenant was obliged to implement UHC which in part would be achieved through social solidarity. (Stuckler D, 2010). That notwithstanding, the implementation of these treaties seemed rather difficult as currently there was a worrying trend whereby at least half of the world's population did not have full access to essential health services and about 12% of the world's population (approximately 930 million people) spent at least 10% of their household budget to pay for health care. The failure to actualize UHC was attributed to the high poverty levels whereby the poor were more prone to malnutrition and were highly exposed to diseases due to environmental conditions yet they were without subscription to health insurance. As a result of this, they ended up spending out of pocket to pay for medical expenses that pushed them further down the poverty line. However, if more focus was made on UHC, through reforms such as subsidized insurance cover for the elderly population and the deprived in society, it would assist countries reach their development goals which in turn would end extreme poverty.

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Thus, although countries had ratified these international conventions on universal health care, states had an obligation to create legal entitlements for their citizens so as to achieve the global goal of UHC (Barcena A, 2014). To achieve this, states needed not only focus on health provisions but on other social determinates structures of health such as sanitation (with an emphasis on portable water), education (particularly on gender equality) housing and power relations (Allegri, 2015). In that breath therefore, the responsibility of UHC ought to be mandated by national laws whereby policy makers must ensure that there were mechanisms in place that would enable equitable access of health care for their citizens including the low-income members of society (Mc Intyre, 2012). In doing this, policy makers should address the twin issue of delivering basic package of quality health services and the financing and management of health services in ways that would enable

affordability and accessibility of those services particularly to those in need the most. Thailand is an example of a country that offers equitable and affordable health care services to all its citizens (Think Global Health, 2020). In the year 2013, a health care policy was adopted that covered migrants giving them health rights similar to Thai citizens (International Health Partnership,2021). It could therefore be argued that UHC would lead to the realization of sustainable development goal 3.8 of attaining UHC which in part would be achieved through financial risk protection and providing access to quality essential health care services. Through this, it would reduce the current statistic whereby about 90 million people are globally impoverished due to out-of-pocket medical expenses (World Bank, 2020).

The importance of UHC has gained momentum in the recent years whereby states have had meetings through international organizations with the intention of affirming their political commitment to the implementation of UHC. In 2019, the United Nations held a high-level consultation meeting attended by head of states, policy makers and political leaders whereby a declaration to commitment to UHC was 100% approved by member states. Further, the "Global Action Plan for Healthy Lives and Well-being for All" (GAP) was launched by World Bank in May 2020 so as to support countries in the delivery and attainment of sustainable development goal 3 target 8 (World Bank, 2020). Through such international forums, the researcher was of the view that enhancement of political momentum will assist in the attainment of UHC. Political goodwill was thus crucial for the realization of UHC. Japan is an example of a country that attained UHC in the 1960's as a result of strong political support. Before the year 1958, employers were required to remit more than 50% of their employees' premiums to the Employees Health Insurance program thereby insuring their employees. In the year 1958, the National Health Insurance law was adopted and under this law citizens not covered by Employees' Health Insurance were required to register for the Community-Based Health Insurance Program that covered all residents including those in the informal sector.

Under the National Health Insurance Law, all cities were required to offer health insurance and cover 50% of the citizens health expenses. The dedication of the county government officials and the politicians who passed the community- based health insurance program was the reason for the success of this program and by the year 1961, 75% of Japanese citizens had access to equitable and affordable health care services (International health Partnership,

2021).

Similarly, in Turkey, the 2003 Health Transformation program that covered the impoverished and the unemployed, brought all the Turkey Health Insurance Schemes into one Insurance program therefore providing better coverage and access. This program also had government political support as the government allocated more money to its health sector leading to enhanced access to health care services. The Country's dedication to realizing UHC hence led to an increase in the health personnel offering UHC services in the urban areas and in the countryside, an improvement in the amount of funds allocated to the health sector in the national budget and enhanced financial protection.

While the literature showed that there was relative success of UHC implementation in Japan, Thailand and Turkey, being a representation of the global context, there was no evidence of such progress in Kenya and specifically in Nyeri County. This therefore justified the interest to investigate the status of UHC policy implementation in Nyeri County, Kenya.

In Africa, African states have over the recent years focused in investing in health systems as they appreciate the connection between a healthy population and economic growth. World Bank conducted research which indicated that the poverty rate declined from 56% in 1990 to 43% in 2012 despite the growing population rate (World Bank, 2016). Although this is a step in the right direction, there was still need for African states to come up with long term inclusive growth interventions.

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Focusing on the countries health care would enable the continent improve its economic growth as there was still high child mortality rate which was in part contributed by malnutrition. In Tunisia for instance, article 38 of the constitution provided that Tunisian citizens had a right to health care and the very poor citizens in Tunisia had a right to access free health care under the UHC program (The 2014 Tunisian Constitution). According to a survey carried out in the year 2017, 65% of the population were registered for the UHC Program (World Health Organisation, 2018) and policies and strategies were also developed with an aim of providing citizens with equitable and affordable health care (Salman,2017). For instance, the government implemented this through construction of 108 public hospitals and of the 108 public health hospitals, 31 were specialist facilities (Giusti et al, 2023).

According to the World Bank (2017), to address African citizens need to have equitable health care, African States should adopt a primary health care approach that focused on reproductive, maternal and new born health services. Further, the government and non- governmental organizations needed to deal with the growing burden of chronic diseases such as diabetes, high blood pressure, cancer, obesity among others caused by unhealthy lifestyle. To address this challenges, African countries need to hasten the progress towards UHC. Ghana for example had made strides in the realization of UHC by embracing a primary health care approach that enhanced access to promotive and preventive health services at the grassroot level. It also established the National Health Insurance Scheme which facilitated community-based health planning for access to emergency services, maternal health services and pharmaceutical commodities and medicines. This scheme was reported to have increased access to health care to many Ghanaian citizens and guaranteed financial protection by lowering citizens out of-pocket expenses (Alhassan et al, 2016). Under the same insurance scheme, expectant women, the very poor and the elderly were not required to make any contribution consequently leading to more equitable and affordable health care. This also led to more vulnerable citizens registering for the National Health Insurance Scheme (Palermo,2019).

There was also a positive outlook as many African countries integrated UHC as a goal in their national health strategies. For example, Morocco had a subsidized health care regime known as "Regime d'assistance medicale" (RAMED) which was based on UHC policy that was piloted in 2008 under the support of King Mohamed VI. This Program provided social protection and health programs to low-income households by expanding health insurance coverage and creating a fund that was financed by the public to cover services for the poor (Chen, Dorothee ,2018).

While the literature reviewed demonstrated that the UHC program in Tunisia and Ghana was working. There was no evidence to show progressive implementation of UHC in Kenya and particularly Nyeri County in the context of the global and continental perspective.

In East Africa, the East African member states together with development partners came together to formulate and enforce policies that would address both the health and demographic policies that hinder economic growth in the region (Maleche, 2017). East African Community (EAC) which was the regional intergovernmental organization came up

with up the resource mobilization strategy 2018-2023 of "East African Community Universal Health and HIV Coverage (UHHC)". This policy documents sought to harmonize national health policies through the exchange of information on health issues among member states particularly on HIV-AIDS (UHHC, 2018-2023).

Furthermore, member's states of EAC also ratified various international treaties that provided the right to health which gave inclusivity to all its citizens to enjoy the highest standard of physical and mental health (WHO, 2008). Thus, the governments had an obligation to ensure that there was a proper health care service whereby there was adequate health care facilities that were financially and geographically accessible to all and that the citizens did not face discrimination on gender basis. Investing in a country's health infrastructure was therefore a way UHC could be attained. Rwanda for example, was one of the East African States that had the highest percentage of citizens insured as 90% of its citizens were insured. Political goodwill and better investments in the country's infrastructure was what enabled Rwanda to quickly scale up its national UHC thus surpassing the 70% recommended service threshold for attainment of UHC coverage. The legislators passed the health financing strategic plan that made it mandatory to register for health insurance (Management sciences for health, 2016). Premiums were also made to the insurance scheme based on the citizens income and it had a progressive taxation system. The Rwandan government also allocated 17% of its budget to the health sector which surpassed the Abuja Declaration requirement for governments to allocate 15% of its budget to the health sector. The Rwandese government also invested in its health infrastructure as the Country's 30 districts each had 15 general practioners who carried out basic surgeries. Furthermore, Rwanda made health care accessible to the residents residing in the countryside through its 45,000 community health care promoters.

In Uganda yet another East African country, despite the existence of political goodwill on the attainment of the sustainable development goal (with the achievement of UHC being one of the sustainable development goals), implementation of UHC was at a snail's pace. Nannini et al (2022) gave the reason for this as the government giving priority to sectors that drove the economy and the provision of health services was at the bottom of the country's agenda. Evidence of this was shown when the Country's health expenditure decreased from 5.1% in the year 2000 to 3.8% nineteen years later which was below the World Health Organization's

recommended minimum of 5% Gross Domestic Product in order to achieve UHC. Out of pocket expenses also continued to be high (Zikasooka et al, 2014) thereby posing as a barrier to the provision of financial protection to Ugandan citizens (Eusebio Cidalia, Bakola M and Stuckler D, 2022). A need was seen to have political support for the UHC program and to hold the government accountable. A case in point, the National Resistance Movement Organisation (NRMO) won the election in 2021 because its manifesto among other promises, dedicated to deliver UHC that was termed as health care services for all offered at no cost. Upon coming to power though this was not one of the projects given priority by the government (Nannini M, Biggeri M and Putato G, 2022).

There was a need to pursue policies that were sensitive to minority groups and their respective culture within the East African Community while pursuing the actualization of UHC (United Nations, 2016). This was particularly important as the high poverty rate in East Africa had contributed to the region having some of the worst health numbers in the world. World Bank conducted research in 2015 where it estimated that the maternal mortality ratio was as follows in the respective member states: Burundi was 710 per 100,000 live births; Kenya was at 510 per 100,000 live births, Rwanda at 290 per 100,000 live births; Uganda at 343 per 100,000 live births and Tanzania at 398 per 100,000 live births, these were in comparison to the global average of 221 as at the time of conducting the research (WHO, 2015). To address the issue of mortality rate, WHO recommended that member states should formulate and adopt policies that dealt with issues of the lack of adequate skilled birth attendants. Furthermore, the member states needed to also come up with policies that would address the health care service consumers and issues that addressed welfare needs of health care workers such as having decent work standards and ensuring that there was basic labor protection regulations and law (Maleche, 2017).

2.2.2 Challenges to UHC Interventions

Although UHC was admirable as it sought to provide affordable access to health care to everyone despite their ability to pay, it failed to factor in the health and resource inequalities among individuals and states respectively. Thus, for a country to be able to effectively respond to its citizen's health care needs, it must have adequate financial resources and have comprehensive medical and administrative infrastructures to implement UHC (Holmes, 2012). Japan for instance despite the milestones achieved in the attainment of UHC is facing

challenges as it does not have adequate financial resources to provide equitable health care to all its citizens. This is because it has a big number of ageing citizens and the contributions remitted by Japanese citizens towards the UHC program was inadequate as 30% of its population was comprised of the elderly who were retired.

This meant that the elderly citizens did not make any contributions to universal health insurance (Hsiao Wc, 2011) and the premiums made for social health insurance therefore could not offer equitable and accessible health care services to all Japanese citizens. This situation even worsened because of a big budget deficit that made it difficult to increase the amount allocated to the health sector from taxes imposed on citizens (Prof Ikegami et al,2011). In Thailand as well, a huge number of the elderly population not paying premiums towards the UHC program was a barrier to the attainment of UHC.

A rising burden of non-communicable diseases such as chronic illnesses thereby leading to an increase in citizens out-of-pocket expenses as reported in Turkey was also a barrier to the achievement of UHC (Ozdamar O and Giovanis E,2018). It was of concern to note that there was only about 5 -10% of people in Sub-Saharan Africa and South Asia that had any insurance coverage (Niessen and Khan, 2016). For example, in Ghana there was poor coverage of the UHC program as 60% of Ghanaian citizens had not registered for the National Health Insurance Fund which was the fund through which UHC was offered and in Cambodia only 20% of its citizens were covered under the public funded insurance scheme leaving the rest of the population to cater for their medical expenses out of their pockets especially if they did not have a third-party medical insurance (Augustine D Asante, 2019). This was in comparison to Germany that had a well-funded statutory health insurance company "AOK Baden-Württemberg" significantly reducing the financial exposure of its citizens whereby only 11.3% of health care costs was attributed to out-of-pocket expenses (WHO, 2017).

The lack of proper infrastructure and strong administrative structures similarly made it difficult for implementation of the right to health care. In Rwanda for instance, the Community Based Health Insurance that was an insurance scheme where UHC services were offered had been plagued with perpetual monetary deficits since 2013 (Nyandekwe M et al,2020).

It was established that, as developing countries working population were mostly employed in informal enterprises, it became difficult for the state to have a strong tax base. As a result of this, the government means of raising revenue such as income and consumer tax reduced making it difficult for the state to fund medical and administrative structures for implementation of UHC (Savedoff W, 2012). Consequently, the lack of financial and skilled human resources led to low-income countries requiring financial and development assistance. In Tunisia for instance, the lack of adequate health care personnel offering UHC services was cited as an impediment to the realization of UHC. In addition to this, in Tunisia newly licensed health care personnel shunned working in public hospitals where UHC services were offered. This high unemployment rates due to preference for employment in private hospitals or in foreign states led to shortage of health care personnel in public hospitals (Sivanu S and Sengupta S,2023).

It was noted that even though the intention of UHC was to expand health coverage, this did not necessarily equate to greater depth of coverage and equity of service access. Therefore, UHC would not automatically shield people from out-of-pocket payments for medical expenses as experienced in China whereby in 1995 China's economic growth led to an increase in health care where 80% of the rural population was uninsured (Li et al, 2015). However, in 2011 despite 95% of the population being insured well within UHC goals, the out-of-pocket expenditure of the citizens remained high as inpatient care still placed a large proportion of the financial burden on its citizens (Yu, 2015).

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The state policymakers of UHC should take into consideration enlarging the range of services provided by UHC such that there are various options ranging from preventive to palliative care particularly on the key diseases that affect its citizens. For example, Mexico through a public insurance program "Seguro popular" between 2004-2008 tripled the interventions covered resulting to a doubling of the number of Mexicans having medical insurance cover as at 2015 (Iniguez, 2018). Such interventions would be better as they ensure affordable access to health care for everyone despite their financial ability to pay.

In the African continent, the major challenge in achieving UHC has been said to be insufficient domestic financing by African states in the health sector leading to insufficient infrastructure and administrative structures (Niessen and Khan, 2016). Thus, there was high out-pocket payment due to the increase in health expenditure resulting to high poverty rates

among African citizens. Over the last twenty years, health expenditure in middle-income African countries has rapidly increased particularly on HIV/AIDS spending in both households and development assistance (ibid).

This was despite a decline in government spending in the health sector as regrettably half of the countries in the region had reduced the total government spending on health care despite population growth and the growing burden of chronic diseases. The statistics in Congo for example showed that 90% of healthcare costs was funded out-of-pocket which had resulted in the payees liquidating their assets so as to meet the unexpected healthcare expenses (ibid).

In 2001, Heads of African States pledged under the Abuja declaration to allocate at least 15% of their annual budget to improve the health sector. However, as of date only Rwanda that allocated 17% of its national budget to the health sector and South Africa that in 2018/2019 allocated R200 billion in national and provincial health programs which was 13% of its public resources (UNICEF 2018/2019) came close to meeting this target (UNICEF 2018/2019). The lack of sufficient budget allocation in health care led to shortage in critical input areas such as the necessary human resources in the health sector (World Bank, 2020). Further, the lack of proper infrastructure and administrative structures has inhibited the implementation of UHC. For example, the weak tax administration systems and information processing units in Ghana contributed to the poor collection of insurance premiums whereas the researcher established that insurance premiums was necessary for the sustenance of a comprehensive health care system (Heredia et al, 2015).

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Although there was an increase in health service coverage, there was limited coverage for critical services. For example, the continent had seen an improvement in maternal and child health services due to an increase in antenatal and skilled birth attendances; however, access to TB, HIV and malaria services was still low. This coverage gap was an inhabitant to the continent achieving the 2030 sustainable development goal of having basic access to essential health services (World Bank, 2020).

In the East Africa region, the EAC member states had ratified various treaties and formulated various policies so as to implement their citizens right to health as discussed in 2.2.1 above, these initiatives however achieved little success in attainment of UHC. In

Uganda for instance, there was low quality of health care in public hospitals offering UHC services leading many Ugandan citizens to seek access to health care services at private hospitals where they were required to make out of pocket payment (Zikusooka CM et al,2014) and lack of political commitment where there was no single legislation formulated on UHC (Eusebio C et al,2022). The inability of East African States to attain UHC was attributed to the member state governments' inability to fund their respective health care system and their citizens' extreme poverty making it difficult for them to join an insurance scheme and if they were a member, being unable to pay the premiums when they fell due.

However, this could be solved if the East African States raised sufficient revenue to finance the health sector through efficient revenue collection and utilization. Once this was done, the respective states could reduce the population that was uninsured by identifying the poor and providing subsidized health insurance coverage for them. Through such initiatives, access to quality health care particularly in rural areas would be achieved (Chukwuemeka, 2018).

In Kenya, the lack of adequate health care personnel, poor health infrastructure and an inadequate health information management system (Muriithi E, 2020) were cited as hurdles faced by the country in its attempt to attain UHC. The health sector was also under funded with a study conducted in the year 2020 revealing that 11.1% of the country's budget was allocated to the health sector falling short of the Abuja declaration requirement that at least 15% of a country's national budget be allocated to the health sector (Kenya Health Financing Strategy 2020-2030). This meant that there were still high out-of-pocket payments made by Kenyan citizens when accessing health care services.

2.2.3 Universal Best Practices for UHC Interventions

World Health Organization online fact sheet showed that the international community had welcomed UHC through various health financing policies with the aim of improving the quality of health care by making it more accessible and affordable to all people (WHO, 2019). For example, Nepal introduced user fee exemption in delivery care with the intention of prioritizing health service utilization through reducing maternal and neonatal mortality. Although this approach was noble, research had indicated that this increased uptake but did not proportionately reduce mortality rate as the quality of the care also needed to be improved to achieve the intended goal. Thus, the government should focus on upgrading

health facilities and improving the quality of services of health care providers which can be achieved through finding replacement of lost revenue due to the removal of user fees which was a source of revenue for the health facilities (Laurel E. Hatt, 2013).

Other health financing policies that were introduced included health insurance which the researcher has made reference to throughout this dissertation and result based financing (RBF). RBF was introduced in various low- and middle-income countries whereby health care providers were reimbursed either through vouchers or conditional cash transfers based on a pre-defined quantity or quality output. Thus, health workers had financial incentives to provide health care services efficiently and effectively. For example, the performance-based financing was introduced in several rural health facilities in Tajikistan whereby the Ministry of Health in conjunction with the Ministry of Finance dispersed quarterly supplementary funds to the health centers based on their quality and quantity of services particularly on maternal, child health and non-communicable diseases. These payments had been used as staff bonuses in the past as records showed that in the year 2015-2016, 2,180 health workers received bonuses based on their performance (RBF Health.org).

Results based financing also produced favorable results in African states as performance incentives such as bonuses motivated health workers to achieve their targets. Similarly, poor patients and low-income households increased their demand for health services when they received financial rewards for adopting health – promoting practices. For example, in Rwanda there was 33% increase between 2001 to 2004 in curative care services when the national government increased payment to specialized health and NGO curative care service providers (WHO, 2018).

Governments were advised to focus on sustaining sufficient financing for health care by mobilizing collection of funds through pooling prepaid funds as health financing was integral to the attainment of UHC (Ekman, 2014). This would enable equitable access and affordability of health care which as of date has been lacking leading to impoverishment of millions of people worldwide particularly the aged and those suffering from chronic diseases. Through focus of health financing, governments hoped to attain their political commitments to UHC whereby their citizens would have access to quality health services without going to financial ruin (Savedoff, 2012).

The study also found that that when policy makers were coming up with health financing structures, they should have consulted UHC stakeholders so as to ensure that the political and economic state of a country were taken into account. This was to ensure that the incentives adopted expanded the fiscal space thus enabling the government increase its budgetary allocation and spending on health care.

African states over the past twenty years have adopted various strategies to improve access to affordable and quality health services. For example, Morocco under the RAMED program offered subsidized health care services to impoverished citizens seeking access to health care services in government hospitals under the UHC program (Chen Dorothee,2018) and the Ethiopian government introduced community health insurance scheme whose members' pooled resources in a collective fund which was managed by members who primarily were in the informal sector and Woreda Health Bureau. Due to this, there was an increase in health care utilization particularly in family planning programs which had improved reproductive health particularly in rural areas (Girma Kassie, 2019).

Further, user fee exemption has also been improvised in the continent as policy makers realized that planning deficiencies and underfunding in health facilities inhibited access to health care particularly in rural areas.

Financial participation of users and involvement of the community was viewed as a more comprehensive approach in attainment of UHC (Valery Ridde, 2012). For example, in Benin the community was involved in financing of local operation costs such as medicines despite its various international partners who were also involved in strengthening the health system. This cost-sharing approach was deemed more effective and efficient in Africa as health workers were more accountable to provide accessible and quality health care to the community (Rudolf Knippenberg, 2013).

In conclusion, African States should adopt interventions that are applicable to their unique social, political and economic realities. Through this, the governments would be able to attain UHC having adopted a participative decision-making approach through prioritizing of health care by setting legitimate and consistent decisions (Smith pc, 2015).

2.3 Research Gap

Country	Previous Study	What they found	What is the gap?
Japan	A study was conducted by Professor Ikegami Naoki et al in the year 2011 on the Japanese UHC Program: evolution, achievements and challenges.	The study found that 98% of Japanese citizens had access to equitable and affordable health care services by the year 1961 through the employee based and community-based insurance schemes that offered UHC services.	The ageing population in Japan accounted for 30% of the population in Japan's UHC program. This meant the elderly population was growing and they did not make any contributions to the UHC program making it difficult to offer equitable and affordable health services to all Japanese citizens.
Thailand	A study was conducted by World Bank in the year 2024 on closing the health gap for the elderly in Thailand.	Thailand has three insurance schemes providing UHC services. This has led to the increase in utilization of health services by Thai citizens and reduced out-of-pocket expenses thereby lowering citizens catastrophic health care expenditure.	Despite Thailand realizing UHC in the year 2002, there has been low uptake of UHC services by the elderly. This was because the elderly citizens were highly dependent on care takers to take them to public hospitals where UHC services were offered. This meant that elderly persons without care givers did not have access to UHC services that were offered only in public hospitals.
Turkey	There was a study conducted by Oznur Ozdamar and Giovani's in the year 2018 on health care reforms in	In Turkey, there was a reduction of out-of-pocket expenses and catastrophic health expenses for the	There was a strain on the health infrastructure due to Turkey's growing ageing population because the ageing population did not make contributions to the UHC program.

	Turkey, achievements and challenges.	impoverished who had registered for the UHC program.	
Tunisia	There was a study carried out by the World Health Organisation in the year 2018 on Tunisia's health system profile.	80% of citizens had an insurance cover and government hospitals providing UHC services had good health care infrastructure.	There was a shortage of health care personnel in lower-level public hospitals that offered UHC services. Despite being registered for the UHC program, citizens still incurred high out-of-pocket payments when they were seeking health care services.
Ghana	There was a study carried out by Kipo-Sunyehzi in the year 2020 on Ghana's journey towards UHC.	The National Health Insurance Scheme was developed to make health care services accessible to all Ghanaians and to reduce inequalities in health care access between the haves and the have nots.	60% of Ghanaians had not registered for the National Health Insurance Scheme which was where UHC services were offered. Most of Ghanaians were hence not covered by the UHC program despite it costing 2 cedis to register for the UHC program.
Rwanda	There was a study conducted by Nyandekwe Medard et al in the year 2020 on universal health insurance in Rwanda. Major challenges and solutions for financial sustainability.	Rwanda attained UHC in the year 2019 under the community-based health insurance scheme.	The community-based health insurance scheme has been plagued with perpetual monetary deficits since the year 2013. Due to this the government was forced to make payments of the community-based health insurance scheme to public hospitals and there was a concern that the community-based health insurance scheme was not sustainable.
Uganda	There was a study carried	The government	As much as the government

	out by Eusebio Cidalia et al in the year 2022 on how to achieve UHC: a case study of Uganda using the political process model.	removed user fees in public hospitals in the year 2001. This enabled Ugandan citizens to access low-cost health care services.	removed user fees in the year 2001, the average cost of health care still remained high among the average Ugandans seeking health care services in public hospitals. This was because of lack of essential treatment commodities and medicines in government hospitals. Public hospitals also offered very poor quality of health care services under the UHC program because of the shortage of health care personnel.
Kenya	There was a study conducted by Muriithi Esther in the year 2020 on investing in primary health care: challenges in achieving UHC in Kenya.	Kenya adopted primary health care as a vehicle to the realization of UHC.	In the Kenyan context, primary health care facilities were reported to be underfunded by the National Government and citizens thus received compromised quality of health care services in level 1-level 3 health care facilities. It was also still not known if implementation of the UHC program was addressing the objectives for which it was intended to. The research gap therefore was that there was no empirical evidence to support or determine the exact status of UHC implementation in Kenya. This was why the researcher was motivated to undertake this investigation to ascertain the true reflection of UHC implementation in Nyeri County and in Kenya in general.

2.4 Conceptual Framework

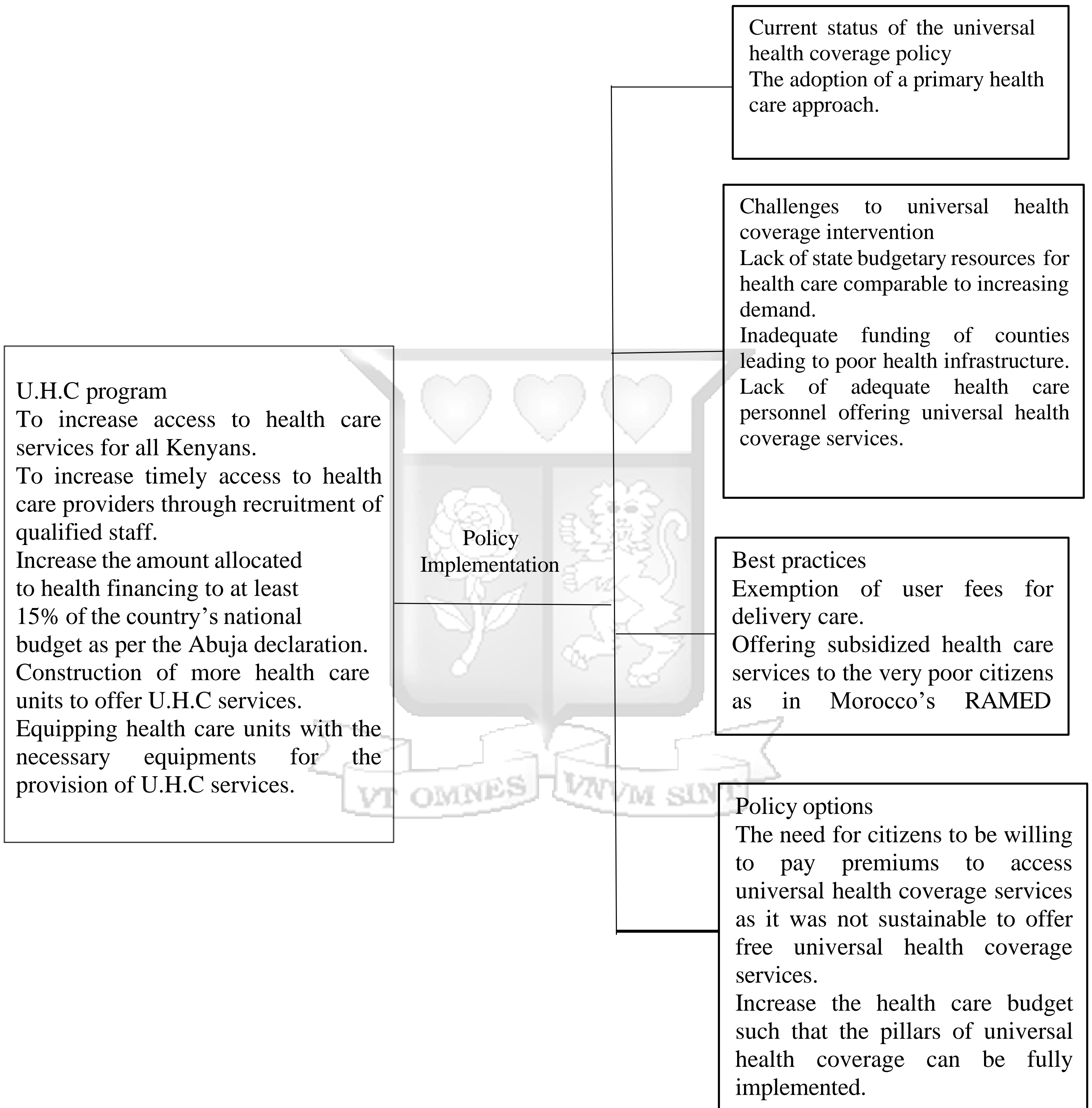
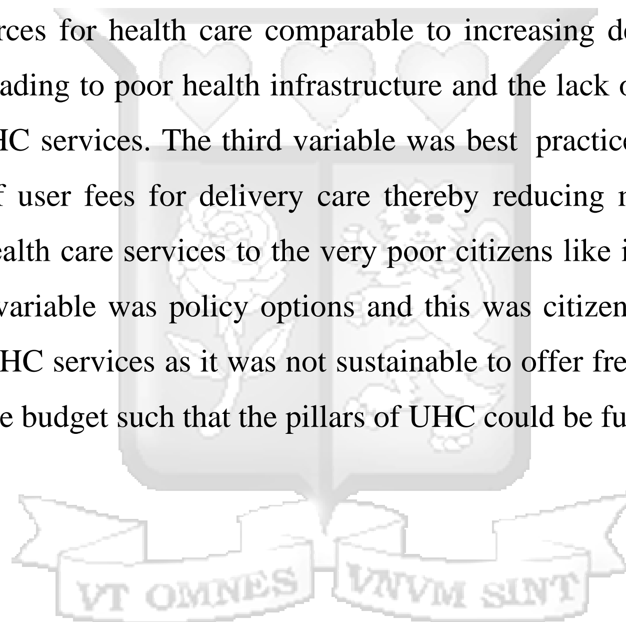


Figure 1 Conceptual Framework

In the conceptual framework above, the UHC program was the independent variable. Under the UHC program it aimed: to increase access to health care services for all Kenyans, to increase timely access to health care providers through the recruitment of qualified staff, to increase the amount allocated to health care financing to at least 15% of the country's national budget as per the Abuja declaration, to construct more health units to offer UHC services and to equip health care units with the necessary equipments for the provision of UHC services. Policy Implementation was the intermediary variable and the dependent variables were the current status of the UHC policy, challenges to UHC intervention, best practices and policy options. The first dependent variable was the current status of the UHC Policy in Kenya and this was the adoption of a primary health care approach in the year 2022 as a means to realize UHC. The second variable was the challenges to UHC intervention and this was the lack of state budgetary resources for health care comparable to increasing demand, the inadequate funding of counties leading to poor health infrastructure and the lack of adequate health care personnel offering UHC services. The third variable was best practices and under this there was the exemption of user fees for delivery care thereby reducing maternal mortality and offering subsidized health care services to the very poor citizens like in Morocco's RAMED program. The fourth variable was policy options and this was citizens being willing to pay premiums to access UHC services as it was not sustainable to offer free UHC services and to increase the health care budget such that the pillars of UHC could be fully implemented.



CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

This section described how the research was undertaken. This included a description of the research design, study site, target population, sampling process, data collection, data analysis and ethical consideration procedures.

3.1 Research Design

According to K Reid and B Happel (2012), they define exploratory research design as a design that allowed the researcher to explore a topic with limited coverage within the literature and allowed the participants of the study to contribute to the development of new knowledge in that area. Since UHC program was a relatively new area of health care intervention in Kenya and it was not extensively researched, exploratory research design was the most suitable approach to enable the research find out the status of UHC implementation in the area of study. To gain the new knowledge about the area of study, the research tools were administered to low- income households who were the direct beneficiaries of UHC services and key informants who were health care providers, implementors, researchers and policy makers. The exploratory research design was applicable to this study because it framed the data collection in such a way that the researcher interacted with the respondents in a more detailed way to gain deeper perspectives of the study.

According to a study conducted by Ranse et al (2012) as reported by Hunter D et al, (2019), exploratory design involved the use of semi-structured interviews to collect data from a sample of the population. This effectively enabled the researcher to appraise the status of UHC implementation in Nyeri County given the qualitative nature of the study. Thus, the researcher used interview schedules to collect data. Furthermore, the choice of using semi-structured interviews allowed the researcher to interact with the respondents as well as probe for more clarity unlike questionnaires which were limited to just closed ended responses. In total, there were 65 research participants interviewed because of the limited knowledge about the subject in the area of study. The researcher had an open mind and focused on establishing the status of UHC implementation with the expectation that the findings would inform future policy outcomes (Question Pro, 2020)

3.2 Study Site

Of the four pilot counties of the UHC program, the researcher chose Nyeri County as the study site because it was the only county that was reported as a performing UHC implementing partner of Ministry of Health (M.O.H) during the pilot phase. Nyeri County is located in the Central part of Kenya. It has a population of 759,164 as per the 2019 census. The County is bordered by Kirinyaga county to the East and Nyandarua to the West, Muranga to the South, Laikipia to the North and Meru to the North East. The County has eight sub counties and 30 wards. The specific site of the study was at Nyeri Level 5 hospital located in Nyeri Central, Rware ward. There are 5 wards in Nyeri Central namely Kiganjo/Mathira ward, Rware ward, Gatitu / Muruguru ward, Ruring'u ward and Kamakwa/ Mukaro ward. Nyeri central has a population of 140, 338 spread across the five wards mentioned above who were the direct beneficiaries of the UHC program during the pilot phase at Nyeri level 5 hospital. The main economic activity of residents of Nyeri Central sub county was small scale farming.

3.3 Target Population

The target population were residents of Nyeri central sub-county with a population of 140, 338 residents perceived to be the direct beneficiaries of the pilot phase of the UHC program (Nyeri County Government website, 2024). This population excluded key informants from the department of health sitting at the National Government and Non-Governmental Organisations headquartered in Nairobi. The research participants of the study were identified through the register of beneficiaries of UHC services during the pilot phase obtained from community health promoters' resident in Nyeri Central and employees of Nyeri Level 5 hospital. The key informants were sought from Nyeri Level 5 hospital, Nyeri County Department of Health, National Government Department of Health and Non- governmental Organisation (AMREF, Kenyan Network of Cancer organizations' and NCD Alliance of Kenya).

3.4 Sampling

3.4.1 Sampling Procedure

Sampling is a process of selecting elements from a cluster to establish a basis for appraising phenomenon to draw a meaningful conclusion (Easton, V. J. & McColl, J. H., 2007). The researcher selected a sample of 70 respondents from: MOH at the national government in particular the Department of Strategic Oversight and Monitoring, County Executive Committee Member for Health, health care providers, Nyeri Level V Hospital, beneficiaries

of the UHC program in the selected County during the pilot phase and NGO's so as to establish the status of UHC implementation in Nyeri County. The respondents were both homogenous and heterogeneous so as to capture a wide range of data related to the subject of study. According to the National Library of medicine (2017), homogenous purposive sampling were samples intentionally limited to specific social demographic sub-groups while heterogenous purposive sampling were samples open to all socio demographic sub groups.

To be able to select respondents with both homogenous and heterogenous characteristics, the researcher used a purposive sampling technique to select research participants and key informants based on the following criteria: (a) participation in the UHC pilot program, (b) knowledge of the subject under study, (c) residency in the area of study and (d) being registered in the government data base as a UHC beneficiary.

3.4.2 Sample size Determination

Purposive sampling is a deliberate choice of a research participant or informant due to the qualities they possess. It is a non-random technique that does not need under lying theories or a set of research participants or informants. The researcher simply decides what needs to be known and sets out to find the people who can and are willing to provide the information by virtue of knowledge or experience (Bernard 2002, Lewis & shephard 2006). Once the sample size had been determined using the above criteria in section 3.4.1, purposive sampling technique was used to identify research participants and key informants. The researcher thus purposively selected respondents on the ground that they understood what UHC was about, they had provided services under UHC and had accessed health care services through UHC. The above were the common characteristics that informed the basis of selecting the research respondents purposively.

3.5 Data Collection

This study used both primary and secondary data. Primary data was collected using an interview schedule formulated from the researcher's research objectives. An Interview schedule is a list containing a set of semi-structured questions that are prepared by the interviewer to serve as a guide for the researcher to collect information about the status of UHC policy implementation in Nyeri County.

It was preferred because it was an affordable way to gather data from small unit of research

participants selected as key informants. In order to obtain information from all research participants who were involved in the oversight of UHC, key experts on matters relating to UHC from the selected institutions as mentioned in 3.3 above were interviewed. Secondary data was collected from: the Government of Kenya publications particularly the Ministry of Health publications, WHO publications and Kenya National Bureau of Statistics publications.

3.6 Data Analysis

Content analysis approach was used to analyze information because the data was largely qualitative. The researcher interpreted connection among the themes emerging from the study (Columbia public health, 2020) by: identifying the research questions, choice of the samples, determination of the type of analysis, reduction of the text to categories and coding patterns of words (Colorado State University,2024).

This approach was also preferred because it provided a systematic approach of analyzing various texts, making it essential for understanding analyzing themes of the study. This allowed deeper insights and structured framework to obtain reliable data and validation of the findings thus minimizing the bias often seen in subjective interpretation of data. The researcher's choice of the above approach for data analysis had been informed by various researchers' reviews (Weber, 1990) who indicated that it was simple and suitable for analyzing data collected from expert research participants (Wanjiru, 2014).

3.7 Ethical considerations

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Under the ethical considerations, the confidentiality of the study was protected by getting an authorization from the university allowing the researcher to conduct the study. The researcher therefore strived to get a research introduction letter from the University. The researcher also obtained ethical approval from the Strathmore University Institutional Ethics Review Committee (SU-IERC) and Nacosti before collecting data. The researcher also sought to get consents from the relevant participants through a contract (consent form). The data that the researcher obtained during the period of this study was similarly treated with in confidence and the researcher in appreciation of the sensitive nature of the information received, did not mention the names of the respondents in this study (Kaiser Karen,2009).

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.0 Introduction

This chapter was based on qualitative data analysis obtained from interview schedules administered on health care professionals regarding implementation of UHC in Nyeri County. This chapter included a response rate, demographic information, an appraisal of the UHC policy, challenges to UHC intervention and global best practices. Through interviews conducted, a finding was made that though progress had been made towards realizing UHC in Nyeri, financial challenges and lack of adequate funds that reduced the piloting of the UHC program in the selected county from 4 years to 1 year were the main restrictions in attaining UHC in the county.

4.1 Response rate

Table 4.1 Respondents response rate

	Frequency	Percentage
Response	65	92.86%
Non-response	5	7.14%
Total	70	100%

From 70 research participants sampled and interview schedules administered, 65 research participants responded, translating into a response rate of 92.86%. This was a good response rate because Mugenda and Mugenda (2003) advised that a response rate of 50% was acceptable and a response rate of 70% was excellent.

4.2 Demographic Information

The research participants in the study were drawn from the following categories and the distribution was as follows: 1 research participant from the County Department of health, 1 research participant from the Ministry of health, 1 research participant from Nyeri level 5 hospital, 1 health care provider, 1 research participant from a non-governmental Organisation and 60 UHC beneficiaries.

Table 4.2 Research participants Education Qualification

	Frequency	Percentage
Diploma	1	1.5%
Bachelors	60	92.3%
Masters	2	3.1%
Doctor of Philosophy	2	3.1%
Total	65	100%

From the table above 1.5% of the research participants had a diploma, 92.3% had a bachelor's degree, 3.1% had a master's degree and 3.1% had a doctor of philosophy as the highest level of education qualification. The table shows that all research participants had a minimum qualification of a diploma and the highest with a doctorate degree. Some of the research participants had a high level of education qualification. They would hence be relied on to give an informed opinion as required in this study.

4.3 An appraisal of the implementation of the UHC Policy

UHC was piloted in four counties and Nyeri County was among them. To this, research participant A 2 informed the researcher that level 1 and level 2 hospitals in Nyeri County did not charge for the UHC services during the pilot phase and level 4 and 5 hospitals did abolish user fees. This therefore meant that Nyeri residents who had been registered for the UHC program during the pilot phase could access UHC services in level 4 and 5 hospitals without being charged.

Although the universal health program was required to run for 4 years having being launched in 2018 and was thus to end in the year 2022, Research Participants A2 and C2 did inform the researcher that the pilot phase only ran for one year due to underfunding of the program by the national government. To aid in this, Research Participant D1 did inform the researcher that AMREF which is a health care provider in the year 2020-2021 helped to identify 20% of the most vulnerable citizens in all the counties. The government then stepped in and supported the 154,541 individuals who form 20% of the most vulnerable citizens. Although the government failed to follow up on the retention rate of the residents who were covered, it did provide the financial support as was made provision for in the budget for the financial year 2020-2021.

With regards to policy, Research Participant A3 notified the researcher that the Kenya UHC Policy 2020-2030 was launched as an ad-hoc policy response to scale up access to equitable and affordable health care in Kenya. It thus was the overarching UHC policy in Kenya.

Further, research participant D1 informed the researcher that in the year 2023, there were four laws that were passed that supported the realization of UHC. The laws included: the Primary Health Care Act, Digital Health Act, Facility Improvement Financing Act and Social Health Insurance Act. The researcher learnt that the UHC program was being provided for under the Social Health Insurance Act. The Acts above were therefore intended to enable the realization of UHC on an economic ground in the sense that (i) the primary health act supported the establishment of health care infrastructure specifically in level two and level three hospitals which became services centers for administration of health care services making the services accessible to vulnerable grassroot population in Nyeri county and Kenya at large.; (ii) while the digital health act had been purposed for health care data management as currently utilized in level four , five and six facilities for, in-patient and out-patient data collection and planning for health care financing etc., this Act would also empower the lower health units (i.e. level, 1, 2 and 3 hospitals) to report to the center to make timely disease surveillance reporting to the center which in turn would also enable the center to activate timely responses. As a result, it was the community that stood to benefit the most. (iii) The facility improvement financing act was introduced to ensure that there was adequate financing for health care facilities across the counties and (iv) the social health insurance act would deal with citizens access to equitable, affordable and quality health care services.

The Four Laws were similarly intended to enable realization of UHC on a legal ground such that (i) the primary health care act emphasized on the need for Kenya to adopt UHC. It also provided for community health promoters who ensured that UHC services were accessible at the grassroot level; (ii) the digital health act addressed the problem of inadequate funding of public hospitals by the national government (iii) the facility improvement financing act intended to enhance financial administration of government hospitals and (iv) the social health insurance act aimed to offer financial protection to its members by ensuring that their access to health care services did not cause them to suffer financial ruin. The Act also aimed to offer affordable, equitable and quality health care services to its members.

Finally, it was important to point out that Research participants A3 and D1 emphasized the fact that under the Social Health Insurance Act, a salient feature of this Act was that it would make it mandatory for every household to participate in the financing of UHC at 2.75% of their gross salary in households whose income was derived from salaried employment whilst households whose income was not derived from salaried employment would be required to make a minimum monthly contribution of Kshs 300 in a graduated arrangement based on their contribution ability. This therefore implied that UHC services would not be offered entirely for free and there had to be some kind of pre-contribution from prospective beneficiaries.

In summarizing on the UHC policy, the researcher observed that the importance of UHC could not be overlooked in how it had met the needs of the vulnerable Nyeri residents. With this, it improved equity by providing financial protection thus reducing direct expenses for households on health care.

The study concluded that in order to attain UHC in Nyeri, both National and County government ought to focus on establishing a functional health system that is well financed where essential medicines and technology were accessible. If this was done, there would be sustainable development in Nyeri county due to the reduced poverty as a consequence of the Nyeri residents being productive and households would therefore not divert their income so as to seek health care services.

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4.4 Challenges to UHC Intervention

4.4.1 There was a high demand of UHC services over the National Hospital Insurance Fund services in Nyeri County as the UHC Services were offered free.

The researcher was informed by research participant A2 that during the pilot phase of the UHC program in Nyeri County, many Nyeri residents stopped paying for an NHIF cover. During the pilot phase of the UHC program it was noted by research participant A2 that there was reduced subscription for NHIF because UHC services were offered free. For example, during the pilot phase of the UHC program in Nyeri County, the percentage of Nyeri residents who made their contributions to the then National Hospital Insurance Fund decreased from 90% to just 15% of Nyeri residents. In Nyeri County one was required to present their national identification card during the registration process of the UHC program

and provided a Nyeri resident presented their national identification card when going to a public hospital they could access UHC services for free. This therefore meant that although there were Nyeri residents that were not making their NHIF contributions they still had access to UHC services such as free medicines in public hospitals.

This illustrated that demand of UHC service was more than double compared to available space to provide health care and staff to respond to the health care needs. There was hence higher demand for UHC services which was affected by lack of adequate staff and space to provide adequate services.

4.4.2 Lack of adequate financing reduced the piloting period of the UHC program in Nyeri County from 4 years to 1 year

Research participant A2 and C2 also informed the researcher that the Pilot phase for Nyeri County only ran for a year because of financial constraints. The money allocated for the UHC program in Nyeri County during the pilot phase also could only sustain the UHC program for a year. This also affected the registration of targeted participants. The pilot phase for Nyeri's UHC program could hence have been said to have run for a year because of financial reasons. This is due to the fact that Nyeri County lacked the financial ability to sustain services such as doctors' consultation, out-patient facilities, in-patient facilities, laboratory services, some x-ray services and medicines that were offered for free.

Given the situation that there was no funding for three years during the pilot phase it meant that all the UHC health care services were paralyzed meaning that there was no service provided for the 457,524 beneficiaries (Muchiri,2018) for the three years resulting into high cost of access of health care services.

4.4.3 Lack of adequate financing

Although in 4.4.2 funding was discussed, it was also further cited by research participant A1, A2, E1 and C2 that inadequate financing remained a serious challenge faced by the program. Research participant A1 for instance indicated that the pilot phase of the UHC program in Nyeri county was underfunded. The study established that in the year 2019, the national government that was the institution funding the UHC program spent Kshs 2,150,533,208,460 on Nyeri County's UHC program as opposed to Kshs 8,602,132,833,840 during the initial start of the program for the area of the study. Research Participant A2

reiterated that the financial constraints were exacerbated by the fact that the health care services in the county of study at the pilot phase was said to be free. Research participant A2 further stated that this brought an issue with sustainability as some people stopped paying for NHIF as they would still receive free medicines including cancer treatment medicines which were generally very expensive.

Research participant A2 did point out that this challenge would have been mitigated if the 70: 30 rule would have been observed whereby 70% of Nyeri residents would pay for themselves whilst the 30% of the very vulnerable individuals who were unable to pay for themselves would be paid for by the government and this approach would cater for 100% of their costs. Research participants A1, A2, E1 and C2 equally agreed and were of the view that this approach would have been a more sustainable way of attaining UHC in Nyeri county.

That notwithstanding, there is generally insufficient financing of the Kenyan health care sector as the country's expenses on health care is usually 4% of gross domestic product spending on health which is below the recommended minimum of 5% G.D.P spending on health. It is also below the recommended percentage of 15% as endorsed by Abuja declaration and 12% as proposed by Kenya health care professionals. For instance, Kenya's budget on UHC in the year 2019/2020 was Kshs. 50 billion which was 9.1% of the national budget. This amount was however reduced to Kshs. 47.7 billion which was 7.37% of the country's budget in the financial year 2020/2021 because Kenya was categorized as a lower middle-income country.

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4.4.4 Errors made by community health promoters when registering UHC beneficiaries could take days to rectify whereas the UHC recipient was in urgent need of UHC services

Research participant C4 averred that among the challenges experienced in implementing the UHC program was that when the community health promoters were registering the residents in Nyeri County for UHC, they sometimes made an error. The error was made in the names, age and contacts. When the research participant went to hospital to correct the error, it would take days to rectify it yet the UHC recipient may have been in urgent need of health care services.

Errors made by community health promoters during the registration of UHC beneficiaries thus impeded the access to UHC services as the time taken to identify the actual beneficiaries was tedious and time consuming.

4.4.5 Poor coverage of the N.H.I.F

Research participants A1, A2 and E1 also advised that inadequate coverage of the NHIF was another obstacle in attaining UHC. The study established that although NHIF was a contributory insurance scheme, it was only compulsory for salaried employees but optional for non-salaried employees. Today 4.5 million Kenyans in formal and informal sector are beneficiaries of N.H.I.F. From 4.5 million residents covered by the NHIF, 98% of the formal sector populace were covered compared to only 16% of the informal sector populace. This therefore became a hindrance in realizing UHC as there were more informal workers in Kenya and particularly in Nyeri County. The study revealed that the statistics showed that the informal workers comprised of 83% of the country's workforce.

This implied that UHC was not accessible to all. UHC was more accessible to persons in the formal sector. There was a need to have a health care program accessible to all irrespective of the persons gender or educational qualifications. With regards to poor coverage under the National Hospital Insurance Fund, research participant E1 suggested that although NHIF was the institution mandated to deal with the financing of UHC through medical insurance, all Kenyans must have the NHIF cover. To this he indicated that persons in the informal sector must pay and get a subsidized card. This was viewed to be a challenge as for informal workers it was not mandatory to have an NHIF insurance cover. The remedy to informal workers not enrolling for the UHC program could be the need to have more sensitization and awareness programs targeting the informal workers on the benefits of enrolling for the UHC program.

The study established that while during the pilot stage, accessing UHC services was not tagged to being a subscribed member of the N.H.I.F, after the pilot stage this became compulsory. This meant that prospective beneficiaries with a national identification card but not subscribed to the Social Health Authority which was formerly the NHIF could have barred some Kenyans from accessing UHC services.

4.4.6 Limited Coverage for critical services

Another issue that research participants A2 and C2 brought up was the limited coverage for critical services. To this, the study established that although there was an uptake in certain services such as maternal health services that was attributed to an increase in antenatal and skilled birth attendances there was still low access to services such as TB, HIV and malaria.

This limitation barred Nyeri county from achieving its sustainable development goal of providing access to essential health services.

4.4.7 Long waiting times for UHC recipients in need of x-ray services

Research participant C5 asserted the fact that during the pilot phase of the UHC program in Nyeri County, if one was in need of x-ray services and was a UHC recipient, the patient would wait for a very long period of time before being attended to.

This implied that as UHC services were provided free, the beneficiaries did not have equal opportunity to access certain health care services unless they paid in cash to access health care services. This hindered the principle of equitable access to health care services by Nyeri residents.

4.4.8 Long queues and long waiting times for UHC recipients in Nyeri town

Research participant C6, C7, C9, C11, C30, C31, C32, C42, C43, C50, C51 and C55 pointed out the fact that in the selected County UHC services were offered free and there were hence few doctors available to treat the patients under the UHC program. There was as a result of this, long queues and patients seeking UHC services had to wait for very long before being served.

The long queues could have been as a result of: having inadequate health care providers assigned to the UHC program, there being a very high demand for the UHC services and low supply and people in Nyeri County being impoverished and hence not being able to pay for health services.

4.4.9 The Implementation of UHC during the pilot phase was not feasible

Arguments were advanced by research participant A3 that the implementation of the UHC program was not feasible or sustainable. The study revealed that in the past, the manner in which UHC was implemented was not sustainable because services such as maternal health care, doctor's consultation, treatment, the purchase of medicines in public hospitals, laboratory services and some x-ray services were offered free of charge to the residents.

The feasibility was as a result of three factors i.e. lack of adequate health facilities and equipment, lack of adequate human resource and the outlined criteria to access UHC services. A combination of this factors hindered access to the health care services by the beneficiaries.

4.4.10 Preference of private hospitals as opposed to public hospitals constrained equitable access to health care services.

Research participant A3 was of the view that during the initial phase of UHC, there may have been a struggle between public and private hospitals as UHC was only offered in public hospitals. However, private hospitals have been known to provide better health care services. The Public hospitals have also been known to have bureaucracy and this includes how they work. Research participant A3 stated that ''Most Kenyan residents when given an option between going to a public or private hospital, they would go to a private hospital''.

Research participant A3 further reiterated that public hospitals were very bureaucratic, some had infrastructure that was run-down and inadequate health care personnel to provide UHC services and all the mentioned reasons were a barrier to the realization of UHC. The research participant argued that although the private hospitals were pricier than the public hospitals, they offered better health care services.

Even though private sector health care providers were most sought after by health care seekers despite their exorbitant health care charges but this was only for a few well to do health care seekers who had the means to afford. This implies that majority of the would-be health care seekers in need of the same quality health care service could not afford to foot the bill in a private hospital, thus exposing them to perpetual poor health care services in public hospitals.

4.4.11 If one lacked their national Identification card, one could not access UHC services

Research Participant C14, C28 and C54 pointed out the fact that in the selected county, you were required to have a National Identification card to access UHC services. During the registration of UHC recipients in Nyeri town, Nyeri residents ideally should have been issued with a UHC card to enable them access UHC services seam- lessly. However, this was not the case in Nyeri county for reasons the researcher was not able to establish. In turn, to access UHC services, the beneficiaries were required to present their national identification card in absence of the UHC card that was not issued to them.

This cause of action created multiple challenges. The first challenge was that minors during the UHC pilot phase could not access UHC services. Those who had lost their national identification cards and foreign nationals were also locked out of accessing UHC services.

4.4.12 UHC beneficiaries were required to pay for specialized services

Research participant C16 and C22 pointed out the fact that the pilot phase of the UHC program in the selected county did not provide for access to specialized services such as x- rays of the head and some laboratory services in public hospitals. In such circumstances, the UHC beneficiaries had to go to private hospitals to seek these specialized services and they were charged very expensively for the same.

The findings thus indicated that UHC services during the pilot phase were not holistic as envisaged by the framers of the policy.

4.4.13 Shortage of medicines during the pilot phase of the UHC program in the selected County

Research participant C29, C39, C40, C42, C46, C59 and D1 reiterated the fact that during the pilot phase of the UHC program in the selected county, public hospitals lacked some medicines needed by the UHC recipients. When the public hospitals lacked medicines, they were unable to respond to issues faced by the community. The public hospitals also had to refer patients to other health facilities such as to private hospitals when they lacked medicines. The UHC recipients were hence forced to dig deeper into their pockets to access the said medicines in private hospitals.

This implied that the UHC program was hurriedly implemented without a proper health care framework and adequate financing strategy. Such circumstances indicate the motivation to address the interest of the political class and yet disenfranchising the implementation arm of government. Case in point is where the Nation Media Group an online news-wire reported in 2020 how an ambitious upgrade of the Kenya's health system to fight cancer resulted into a shame of multi-billion cancer medical equipment lying idle at county governments (Nation Media Group ,2020).

4.4.14 The inability to register for UHC services in the selected County if a person lacked their birth certificate

Research participant C19 pointed out the fact that during the registration process of UHC in the selected county, one needed to produce documents such as a copy of one's birth certificate. Without this document you could not be registered for the UHC program.

In national interest, it was fair to give law abiding citizens first priority access to public services. However, it was also disenfranchising to needy persons being denied the same services. This negated both national and international laws that promoted human rights like equitable, quality and affordable health care services. This also called for continued advocacy to dialogue on legislation that could bridge the gaps which discriminated isolated health care seekers to access to health care services.

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4.4.15 The inability to access UHC services if your name did not reflect in the records

Research participants C21, C34 and C35 notified the researcher that if you were registered for the UHC program but your name did not reflect in the records, you could not access UHC services during the pilot phase.

The findings suggested that among the reasons why the pilot phase of UHC was not as successful was that some potential beneficiaries' names were either not registered or were omitted from the official data base. The findings also suggested that there may have been poor turn-out of prospective UHC beneficiaries to register at designated registration centers. For instance, out of 850,000 residents who should have registered for the UHC services in Nyeri County, only 457,524 residents registered according to available data (Muchiri, 2018). This translated to approximately 50% of residents who registered for the UHC program.

This trend resulted into unregistered prospects being denied UHC services at the critical time they were in need of the said services. However, what was not known was that if there was deliberate or poor mobilization of the prospects to register for UHC services or did they deliberately refuse to report for registration.

4.4.16 The inability to access UHC services when there was system failure in the selected County

Research participant C37, C39 and C48 informed the researcher that sometimes in the selected County, a recipient of UHC services would go to a public hospital to seek UHC services only to be told that the systems were down. During this period, one would not be able to access any UHC services. To access health services then, a person was required to pay in cash.

Possibly as a result of poor design of systems and processes, the systems inability to respond to changing patient demographics or lack of user involvement and inadequate use of health care information systems, there may have been system failure. These multiple factors crippled performance of health care providers when there was a system failure and limited access to health care services to intended beneficiaries. This system concern called for a rapid assessment of the entire UHC program so that it could be tailored to meet the needs of the prospective beneficiaries in Nyeri County.

4.4.17 The presence of corruption during the pilot phase of the UHC program in the selected County

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Research participants C53 and C58 notified the researcher that during the pilot phase of the UHC program in Nyeri County there was corruption. He reiterated the fact that if you gave something small to the health care personnel during the pilot phase, then you would be attended to quicker.

As a result of the incidences of petty corruption where patients were asked for little tokens by health care providers in order to be given preference to access of UHC services resulted into negative perception from the beneficiaries and bad image in the case of health care institutions tasked with making free access to health care services.

4.4.18 Lack of qualified health care personnel to manage complicated cases such as terminal illnesses

Research participant D1 informed the researcher that over the years, there was an increase in terminal diseases such as hypertension and cancer cases. Health care providers such as AMREF however lacked the capacity to address the mentioned illnesses and needed to undergo training and this was yet another challenge experienced.

In depth investigation by the researcher could not establish with evidence why the poorly capacitated health care providers were not retrained to handle such complicated conditions or why the government did not undertake any measures to deploy qualified staff in Nyeri county. The inadequate supply of qualified health care providers could be explained as a result of poor wages, poor welfare programs and competitiveness of the private sector.

4.4.19 Poor Road networks

Research participant D1 averred that poor road networks obstructed access to UHC services. In Nyeri County for example a health care provider wanted to access a health care facility in Nyeri County but was unable to do so because of the poor road networks.

With poor road networks, there was a delay in the supply of medicines and vaccines and this could have affected service delivery in the public health care facilities. This could also have affected the access to preventive, promotive and curative health care services. This kind of challenge of poor road networks was not only unique to Nyeri County but to most regions in Kenya and although the government was making necessary steps to improve the road network throughout the country, more focus had been geared towards National roads as opposed to the feeder roads used by the most vulnerable communities.

This inadequate development of public infrastructure specifically roads, supply of power, clean water as well as health service centers could also have gradually hindered effective access and provision of health care services in the selected county.

4.4.20 Level 2 and 3 health care facilities that offered UHC having poor infrastructure and equipment

Another obstacle that research participants A1, A2, C2, D1 and E1 brought up was that public hospitals that offered UHC program in Nyeri county had infrastructure that was run down and had limited appropriate equipment. To this, the research participants indicated that poor infrastructure had impacted negatively on health care as well as the ability of the county to retain crucial personnel particularly specialized health workers in the public service. Research participant D1 averred that public hospitals had infrastructure that was run down and in some instances lacked crucial medical equipment. In the provision of health care services, there were norms and standards that were to be abided by. The norms and standards tended to define what was expected within a health care facility. Under infrastructure for example, a health care facility should have a maternal room and if it lacked it then it was missing out on the standards expected to be upheld in a health care facility. Most of the level 2 and 3 facilities (dispensaries and health centers) that offered UHC services failed to meet the operational norms. They were also found to lack the required human resource to operate the level 2 and 3 health care facility as well as the necessary medical equipment to operate a level 2 and 3 health care facility. An example of lacking the necessary medical equipment was that there were health care facilities that did not have a stethoscope, a maternal room or a laboratory person. This had the effect of limiting the health services that the health care facility could offer.

Against the above findings, the researcher observed that there were other indirect factors that could be associated with poor retooling of health care units. For example, complex procurement processes of equipment, the time required by manufacturers to deliver certain equipment and also laxity in updating health care equipment inventory by technical personnel in the health care system among other factors. These factors directly affected timely diagnosis and treatment of health care seekers through the UHC framework in Nyeri county.

4.4.21 Primary health care facilities that lacked the required health information and management systems

Research participant D1 emphasized the fact that our primary health care facilities lacked the required health information and management systems. Most of the level two and three

hospitals were found to be paper based and heavily relied on paper records. They however lacked electronic records. This alluded to the fact that our level two and three hospitals were not able to adequately exchange information when the patient was seeking care from one level of hospital to another. Research participant D1 informed the researcher that most of the electronic medical records were found in level four, five and six hospitals.

When a referral was made from a level two or three hospital to a level four hospital, the patient would carry a referral note that was paper based. This referral note was prone to wear and tear and could also be misplaced before the patient arrived at the level four hospital. The effect of the patient misplacing his referral note or having a worn-out referral note was that the patient would need to have a fresh diagnosis done and chances of misdiagnosis were high. The patient would also need to pay more when having fresh tests and diagnosis done. This disrupted the continuity of care for the patient. The continuity of care for a patient was also disrupted when paper records that were prone to wear and tear, were not backed up in an Electronic medical record or Health Information Management system. There was hence a need to have a functioning health information management system that allowed data collection and sharing across all health units in the county.

In conclusion, the researcher did observe that although there were various laws and policies regarding citizen's and Nyeri residents' right to health, there had been a challenge in attaining UHC in the county. There was a need for Nyeri residents, civil society and all interested parties to demand for accountability from both sub-national and national governments to implement the UHC policy framework to the letter.

4.5 Global best practices that supported implementation of UHC in Nyeri County.

4.5.1 The introduction of the free maternal care program to aid in the realization of universal health care

Research participant A3 made the researcher aware of the fact that African states had introduced health financing reforms that reduced their citizens level of out-of-pocket payments. An example was Tanzania and Morocco that removed user fees for deliveries in public hospitals. Ghana adopted this policy as well but opted to have the removal of user fees for deliveries in both public hospitals and private hospitals. With regards to deliveries, a free caesarian section policy was implemented in all public hospitals in Mali.

In Uganda, there was the removal of the user fees policy for expectant mothers in all public hospitals whereas in Burkina Faso there was the removal of user fees for all expectant women in public and some private hospitals.

In Kenya there was the free maternal care policy (the Linda Mama Program) that covered pre-natal, post-partum care and complications arising from a woman being expectant for a period of one year. This policy has aided in the attainment of universal health care as it removed the financial barrier to access of maternal health care services faced by expectant women and increased prenatal care intake.

4.5.2 The adoption of a primary health care approach

Research participant D1 enlightened the researcher on the fact that the World Health Organisation recommended that primary health care should be used as a vehicle to attain universal health care. He also reiterated that the World Health Organisation had averred that through primary health care 90% of universal health care interventions could be attained. In Thailand for instance, every resident had a right to access vital health care services. These services included preventive and curative health services. UHC services in Thailand also included expensive health care services such as kidney replacement therapy and cancer and this reduced out-of-pocket expenses for insured Thailand residents. UHC also led to an increase in the life expectancy of Thailand citizens from 71.8 years to 74.2 years. A decrease in infant mortality from above 100 per 1000 live births to 9.5 per 1000 live births was also reported as a result of the country embracing the UHC program.

Research participant D1 further asserted that primary health care in Thailand was found to be effective for patients as they were able to access health care services at a lower cost at a primary health care facility. An argument was advanced under primary health care that when a medical team was headed by a primary care physician, there would be a decrease in health care costs incurred and an improvement in an invalid's health noted. Primary health care was said to make key services such as preventive and curative services available to recipients of all health care schemes in Thailand. The community wide approach of the primary health care system such as in Kenya the use of community health promoters in Nyeri county who registered residents for the UHC program and were instrumental in the delivery of primary health care, reduced the gap between the haves and have -nots in the

access to health care services. Primary health care in Thailand hence was said to offer affordable and equitable care and improved the quality of care for invalids in Thailand.

4.5.3 The involvement of government and developmental partners in addressing inequity and social inclusion in health service delivery as a global best practice that supported implementation of UHC

Japan was an example of a country that had an outstanding health care system. Having strong leadership could be one of the reasons that the country attained universal health care. After the second world war, Japanese legislators decided to reconstruct the health insurance framework that offered coverage for all Japanese residents. Research participant D1 enlightened the researcher on the fact that a state that aimed to attain UHC should have financial resources and Japan after the second world war had a high economic growth rate and this could be one of the reasons that the state attained UHC in the year 1961.

In Japan, there was the employee-based plans and the community-based health insurance program. The employee- based plans was for employers and they were required to offer their employees a health insurance cover and community- based health insurance was for residents not covered by the employee-based plans. The National Health Insurance law made it essential for all Japanese residents not covered by the employee-based plans to be registered for the community-based health insurance program by the year 1961 and as a result of the success of this, Japan achieved UHC in the same year. The involvement of government and development partners was hence crucial in addressing inequity and social inclusion in health service delivery.

4.5.4 Having a tax-based system would help in the realization of UHC

Research participant A3 asserted that having a tax-based system would lead to the attainment of universal health care. Case in point, Malaysia attained UHC in 1980's through taxes. The taxes imposed on its citizens were thus used to finance public health services. Malaysia's UHC program covered promotive, preventive and curative health care services. The researcher learnt that Malays could access UHC services at a minimal fee whereas for the impoverished and vulnerable, UHC services were offered free. In Malaysia 80% of the public facilities were also funded by the government through tax. Malaysian health services could hence be said to be funded through the payment of tax.

Public health services in the named country were also subsidized by the government and

primary care services were offered at a minimum fee in medical centers.

4.5.5 The adoption of a mechanism whereby the citizens paid premiums to access UHC services.

Research participant A3 made the researcher aware of the fact that the adoption of a mechanism where citizens paid premiums to access UHC services for instance in Israel was a global best practice that supported the implementation of universal health care.

UHC in Israel was compulsory and it was funded through taxes imposed on its citizens. This was through an income tax that was imposed on citizens who were required to pay a health tax of 5% of their salaried income. The National health insurance law was the law that provided for UHC and its aim was to guarantee that no Israeli lacked access to health care services as a result of lacking funds to pay for the health services sought. In Israel, the UHC program covered maternal health care, curative care, primary care and the cost of medication. Israel was regarded to be one of the states that had been successful in the attainment of universal health care, they having attained UHC in the year 1995. A number of mechanisms for guaranteeing access to UHC were adopted. This included having legislation such as the National Health Insurance law that made it mandatory for Israelis to enroll for a health insurance fund (In Kenya from 1st October in the year 2024 under the Social Health Insurance Act, all Kenyans were required to register as plan members) and the adoption of electronic medical records. The adoption of electronic medical records ensured that patients information was not lost when the invalid was transferred from one level hospital to another and an example could be a patient being transferred from a level three hospital to a level four hospital. As a result of the UHC program, Israelis had a high life expectancy and low infant mortality rate.

CHAPTER FIVE: DISCUSSION OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter detailed a summary and discussion of the findings, major gaps of the study, conclusions, recommendation, limitation of the study and areas for further research.

5.1 Summary of findings

The first research question provided analysis of the UHC policy framework in Nyeri County. From the Interview schedules conducted, the researcher found out that the pilot phase for the UHC program was launched in the year 2018 and should have been implemented in four years. The research however established that in the year 2019, the national government that was the organ funding the UHC program spent Kshs 2,150,533,208,460 on Nyeri County's UHC program as opposed to Kshs 8,602,132,833,840 that would have been the total cost spent by the national government during the initial start of the program for the area of study. In Nyeri county the researcher consequently observed that the implementation of the UHC program only lasted for a year because of financial reasons. During the end of the pilot phase of the UHC program (which was in the year 2022), the Kenya UHC policy which was a new UHC policy was launched. This policy could be said to be the key UHC policy in Kenya. The researcher also established that a year later (in the year 2023) four laws were passed to collectively support the attainment of the UHC program in Kenya.

As for the second research question, the researcher investigated the challenges in implementing the UHC policy in Nyeri County. The findings revealed that among other reasons were financial constraints, inadequacy in national insurance coverage and implementation of the UHC program in the selected county not being feasible were factors that had stalled implementation of UHC in Nyeri.

Finally, the third research question examined the global best practices considered as support mechanisms that would enable the attainment of UHC in Nyeri county. The researcher found out that adoption of P.H.C as a standard global best practice could lead to the attainment of UHC (World Health Organisation,2023). This was supported by the assertion that 90% of health care interventions were easily realized through primary health care (World Health

Organisation,2023).

The study further found out that having a tax-based system was another potential global practice that could lead to successful implementation of universal health care. For instance, citizens could contribute to health care financing using the N.H.I.F. However, this law has since been repealed by the Social Health Insurance Act. The researcher learnt that it was not feasible to offer UHC services free including not charging beneficiaries a fee during registration to access UHC services. The researcher established that in Kenya, under the Social Health Insurance Act, workers in the formal sector would be charged 2.75% of their salaried income whereas workers in the informal sector would be charged a minimum of Kshs 300 per month.

5.2 Discussion of findings

5.2.1 Status of the UHC policy framework in Nyeri County

This study was informed by two theoretical perspectives namely the incremental theory and the institutional theory. From the incremental perspective, the theory explains that the formulation of the UHC policy was an incremental process that evolved from numerous government actions for over six decades. This evolution started with the NHIF program in 1966 followed by the cost sharing program in 1989, the Linda mama program in 2013 and the pilot phase of the UHC program in 2018 and subsequent roll out countrywide in 2023. The above milestones confirmed theoretically that the incremental theory informed UHC policy formulation and implementation to make health care equitable and accessible to all Kenyans.

On the other hand, also the institutional perspective was used to also explain UHC policy formulation in the context of legislative and policy making approach where law makers, the executive or the Judiciary undertook necessary courses of action relevant to adoption and roll out of UHC. The institutional actions undertaken to implement UHC are informed by other institutional frameworks adopted since independence which included the NHIF program of 1966 and the NHIF Act of 1998 enacted by parliament, the cost sharing policy of 1989 adopted by cabinet and the Linda Mama policy designed and adopted by the Ministry of Health in collaboration with the office of the First Lady. The above illustrates how the UHC policy was institutionally formulated and implemented as a program that evolved over a period of time purposed to address the health care gaps specifically access to timely,

equitable, quality and affordable health care.

The perspectives discussed above linked theory to the discussions to establish the status of the UHC policy framework with regards to implementation in Nyeri county. A case in point, Makoni's (2023) recent study on reforms in the health care sector, supported the view that UHC policy was proceeded by other government policy actions such as the Primary Health Care; Digital Health; Facility Improvement Financing and Social Health Insurance Legislations of 2023 both incrementally and institutionally. These legislations were enacted to strengthen the UHC program in Kenya including S.H.I.F and S.H.A of 2024.

Furthermore, KIPPRA policy brief number 14/2023-2024, also concurred with the findings of this study that UHC like Kenya Community Health Policy (KCHP) promoted quality community health services at level 1 health care facilities. The other policy that supported the roll out of UHC was the Kenya Health Financing Strategy (KHFS) that purposed to raise resources needed to enable citizens have access to quality health care services and guarantee there was value for money in the management of Kenya's resources. Similarly, the Kenya primary health care strategic framework 2019-2024 provided guidelines on how to implement programs in order to enhance primary health care in Kenya (Wilkista Lore and Thuo Susan,2023).

5.2.2 Challenges emanating from implementation of the UHC policy framework in Nyeri County

Through the incremental theoretical perspective, the study was able to define the health care system service delivery gaps which resulted into formulation of UHC policy as an intervention to make health care accessible to all Kenyans. These gaps were identified through progressive and piecemeal modification of government health care policies that had been made since independence. This implies that the changes introduced in the UHC policy were intended to address the shortcomings of previous government health care policies that did not wholistically address health care accessibility, equity and affordability. It was these progressive changes that represented the transitionary incrementalism of health care policy shift starting with the NHIF of 1966 to piloting UHC in 2018 and countrywide roll out in 2023. It was important to highlight that the major challenges leading to incremental policy shifts were the pursuit of the best possible ways for sustainable health care financing,

equitable access to health care services by all citizens, reduction of the ratio of the patient to qualified health care workers as well as proper salary remuneration for health care workers among others. The above was further supported by the assertions of D Collins et al (1996) why the government shifted from NHIF to the cost-sharing policy was due to the high demand for health care services and the limited public resources. The government similarly shifted from the cost-sharing policy to the Linda Mama policy. The cost-sharing policy necessitated shared contribution between the national government and beneficiaries seeking health care services at a public hospital whereas there were Kenyans unable to make any payment to access health care services. The government subsequently shifted to the pilot phase of UHC program from the Linda Mama Program because the Linda Mama program offered free access to maternal health care services but this access was only to women.

From the institutional aspect, the players that played a role from the 1966 NHIF program was the then Attorney General Honourable Charles Njonjo who wrote a proposal in the year 1963 to have a health scheme that offered equitable health services to all Kenyans, the principles that played a role in the cost-sharing program was the Ministry of Health, the actors that played a role in the Linda Mama program was the Ministry of Health, the National Health Insurance Fund, the sub national government and public hospitals and the actors that played a role in the Pilot phase of the UHC program was the Kenyan government.

The second research question identified challenges emanating from the implementation of UHC in Nyeri County. Wanjiru Karanja (2014) concurred with the study that attainment of UHC in Nyeri county was faced with challenges such as inadequate financing and poor health systems. Specifically, with regards to the poor health systems, the findings indicated that some of the public hospitals providing UHC services had poor infrastructure and lacked the necessary numbers of health care personnel and were thus understaffed.

Wairimu Mwaniki and Ogoti Leon (2024) also echoed the findings of the study that there was a lack of adequate human resource for health which was an impediment to implementing UHC. Kenya has also not adhered to international standards, health care human resource structure for instance, the doctor to invalid ratio should be 1: 1000 whereas Kenya's doctor to invalid ratio was 1:6505. The nurse to invalid ratio according to the World Health Organisation should be 1:120 whereas the current nurse to invalid ratio was 1:1250.

5.2.3 Global best practices towards the attainment of UHC in Nyeri County

From the incremental perspective, across all countries globally there has been systematic piecemeal action that shows similar characteristics towards realizing the United Nation's global policy for universal access to health care for all. There is hence an incremental objective towards realizing UHC globally.

From the institutional perspective, UHC originated from the United Nations with the World Health Organisation being an arm of the United Nations. The World Health Organisation also mobilized Heads of States and Health Ministers to buy into UHC and there were activities among the 193 member states to adopt the 2030 Agenda for Sustainable Development and to support and adopt UHC. There were also series of meetings that took place. This was hence an institutional process that involved governments participating. It is through this processes that Kenya was involved and adopted and signed the United Nations Treaty for Sustainable Development and subsequently co-opted it into health care system as a national response to make health care accessible, equitable and affordable. This started with a pilot in four counties among which was the area of study before it was rolled out country wide in the year 2023.

The third research question identified global best practices towards the achievement of UHC in Nyeri County and the study revealed that the removal of user fees for delivery care in the year 2013 was an example of a global best practice that would reduce child mortality, make health care more equitable and accessible and reduce the barrier in the access to maternal care in the country. The free caesarian policy in Mali (Clemence Schantz et al, 2020) was for instance similar to Kenya's free maternal health care program as it had similar characteristics to Kenya's Linda Mama program. The Burkina Faso program as well where there was the abolition of user fees for women seeking maternal health care services in public hospitals (Bicaba Frank et al, 2020) was also similar to Kenya's Linda Mama program as it offered free maternal health care services.

The study found that the adoption of the primary health care approach was yet another global best practice that supported the attainment of UHC in Nyeri County. In Kenya, Amref a health care provider adopted the last mile service delivery mobile clinic that provided primary health care services to the most vulnerable and marginalized population.

The study also established that the involvement of the government and development partners in addressing inequity and social inclusion in health service delivery was also a global best practice that supported the implementation of UHC. In Kenya in the year 2019 when statistics for health insurance was released, the statistics for health insurance for most Kenyans was poor as only 8.4% of citizens had health insurance in the said year. The Kenyan government working with Amref a health care provider, increased the health insurance coverage for 20% of the most vulnerable citizens across the 47 counties. The government thus gave an insurance cover to the most needy citizens in the year 2020-2021.

5.3 Major gaps of the Study

There were a number of gaps that the study revealed. The Primary Health Act of 2023 provided for a number of ways to achieve UHC in Kenya. Unfortunately, the Health sector in Kenya remains poorly funded with under equipped primary health care facilities thus poor quality of health care services (Musuva Anne, 2023).

There was also uncertainty on whether health care services in a level 5 hospital for instance the Nyeri County referral hospital was to be offered free to Nyeri residents only or to all Kenyans under the UHC program. It was also not provided for how referrals to level 6 public hospitals would be made during the pilot phase and as a result of this, UHC beneficiaries from the pilot counties who required specialized health care had difficulties accessing the same in national referral hospitals (Nyawira Elizabeth et al,2024).

There was also no openness on the services covered by the UHC pilot phase and due to this UHC beneficiaries had to pay for some services such as X-ray services for the head, some laboratory services and for cancer treatment that were not offered free thereby incurring out - of-pocket expenses (Nyawira Elizabeth et al, 2024).

The study also revealed that there was no budget accountability and this was a persistent gap experienced by the sub national government as they often received money less than what they had budgeted for. For instance, in Kisumu, the sub national assembly accepted Kshs 261,000 for each quarter for health activities. This money however has not been received to date (Ibid).

Finally, during the pilot phase of the UHC program, there was an increase in the demand for health care services and an inadequate number of health care personnel which was yet another gap. As a result of the inadequate number of health care personnel, there was an increased workload that led to an unmotivated staff that had an effect on the quality of health care services offered to health care seekers.

5.4 Conclusion

The researcher found out that UHC to some extent met the needs of the vulnerable population as UHC covered the needy Nyeri residents. One research participant for instance stated that during the pilot phase of the UHC program, his UHC cover paid for his hospital bill which was Kshs 100,000. UHC also met the needs of the vulnerable population as under the Public Health Fund, the government would pay 100% for citizens unable to make any contribution to the fund. The study established that UHC in Nyeri County was implemented within the framework conceptualized as it made health care services accessible.

On the other hand, the researcher noted that the UHC program was not sustainable as it was very expensive to offer the health care services for free in the selected County. While the UHC was not wholly sustainable, there was a need for cost-sharing between the government and citizens.

The study found that given the experience of past government policies and government's inability to commit to its policies, it is likely that those who cannot afford to contribute to the program may not benefit from UHC services.

Finally focus ought to have been on public participation by both the national and subnational government particularly on health care expenses so that citizens did not misuse the UHC program. If this was done it would move the county forward towards realization of UHC (National Council for population and development, 2018).

5.5 Recommendations

From the analysis, it can be concluded that offering UHC services free in the selected county was not feasible. The citizens needed to be willing to support the UHC program by making monthly contributions to access UHC services because the program only ran for a year in the area of study because of inadequate financing. The recommendation therefore was that there should have been a mechanism to guarantee that everyone was able to pay to access UHC services. This was because it was notable that Nyeri county could not sustain its UHC program during even the pilot as government through its NHIF kitty could not fund doctor's consultation, treatment services for both out-patient and in-patient, some x-ray and laboratory services that were supposed to be offered free to the beneficiaries.

The findings revealed that UHC beneficiaries were looked down upon and attended to last whereas the patients paying in cash to access health care services were attended to first. The recommendation to this shortcoming was that the government needed to put in place appropriate guidelines that made health services equitably accessible to both paid-up and unpaid health care seekers.

The study revealed that there was disproportionate patient to health care provider ratio a case in point in 2017, Kenya had 24 doctors per 100,000 of the populaces and 172 nurses per 100,000 of the populaces compared to the WHO requirements of 21.7 doctors per 100,000 of the populaces and 228 nurses per 100,000 of the populaces. This showed that there was a shortage of health care personnel (National council for population and development, 2019). As a recommendation there was a need to enforce government commitments to hire adequate health care personnel, improve on their renumeration and welfare benefits.

Distribution of personnel also showed that more health care workers were found in the urban centers yet more than 50% of the populace and impoverished residents resided in the rural areas. It was hence shown that the distribution of health care workers was inequitable. To address this challenge, the researcher suggested that to make the countryside more appealing, the National and County Government should provide competitive and attractive retention packages to the health care workers posted in the rural areas (Ministry of health, 2013).

To realize the tenets of UHC program in the county under study, the researcher recommended

that there was a need to have an optimal package that ensured that everyone benefited from the health care services for especially Kenyan citizens who could not afford paid health care services.

The study further found that there was a need to ensure that the quality of health care services offered in government hospitals offering the UHC program was good.

In addition, the government should focus on preventative health as opposed to curative health services. An example of doing so was instead of waiting for a person to suffer from the malaria illness, a person could clear the bushes where they lived or ensure that they cleared the water bodies where they lived to reduce chances of suffering from malaria (Dr. Peter Gichuhi,2024) that had been noted to be one of the illnesses covered under the UHC program. Nutrition was yet another area that could be considered under preventative health. If you had good nutrition and a lifestyle that was non-sedentary such as making exercises a routine, you could avoid non-communicable diseases such as diabetes. The researcher was also of the view that there was a need to have an increased effort made towards promotive and preventive health as opposed to curative health as when a lot of government funds was spent on curative services that made health care access very expensive. This would not be the case if government funds was spent on promotive and preventive health services. If we focused on curative health care services for instance, we may not get funds to build cancer centers with cancer becoming an issue that has affected many persons throughout the world. If we invested in preventive health care services however, we would have fewer sick persons.

The Ministry of Health also needed to introduce in-country system's monitoring and evaluation to track the UHC indicators. This was because Kenya did not keep data on the progress of UHC at a central area. There was a need to introduce In-country monitoring and evaluation systems so as to track the progress made in attaining UHC as well as improve the uptake.

It was proposed that UHC should be included in the annual budget the same manner that of education was budgeted for. A substantial amount of money should hence be allocated in the budget to cater for UHC services.

Finally, it was suggested that policy makers come up with national health financial

accountability mechanisms that acted as safety nets against disenfranchising the beneficiaries of UHC (Fahim SM, Bhuayan TA, Hassan MZ et al,2019). If this was well done, it could contribute to more favorable terms in budgetary allocation in the health sector as it would enhance proper utilization of the allocated funds. The study under this point found that we needed to diversify the funding mechanisms for attaining universal health care. This was because historically speaking, the existing funding was activity based for instance, we could fund how many people we trained on UHC mitigation yet we did not measure the outcome or result of the training given. We needed to shift from activity-based financing to result based financing to accelerate efforts in realizing UHC implementation and sustainability.

5.6 Limitation of the Study

It was difficult for the researcher to access UHC beneficiaries during the pilot phase in the selected County and the researcher had to contract a community health promoter to help identify the UHC beneficiaries.

5.7 Areas for further research

The researcher identified many possible research areas in the study. However, what stood out most that seemed to require an urgent investigation was in area of health care financing specific to UHC program. The researcher also learnt that the lack of adequate financing for the UHC program in Nyeri county by the national government was one of the main challenges experienced by the selected county in its efforts to realize universal health care.

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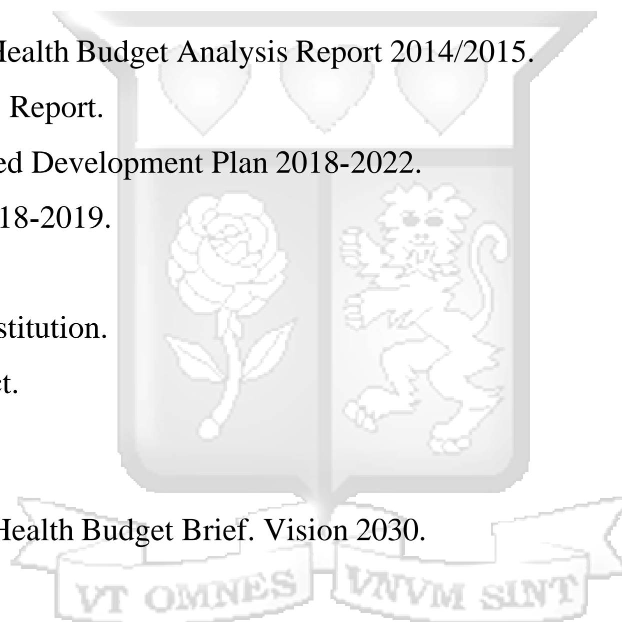


Annextures:

Annexture 1

Ole Sangale Rd, Madaraka Estate,
P.O Box 59857 00200, Nairobi, Kenya.
Cell: +254 703 414/6/7, Twitter: @SBSKenya
Email: info@sbs.ac.ke or vist www.sbs.strathmore.edu

Tuesday, 02 May 2023

To Whom It May Concern,

RE: FACILITATION OF RESEARCH – GICHUHI LILIAN WACU

This is to introduce Lilian Wacu who is a **Master's in Public Policy and Management** (MPPM) student at Strathmore University Business School, admission number MPPM 114528. As part of our MPPM Program, Lilian is expected to do applied research and undertake a project. This is in partial fulfilment of the requirements of the MPPM course. To this effect, she would like to request for appropriate data from your organization.

Lilian is undertaking a research paper on **"An Appraisal of the UHC Policy: Challenges and Policy Options, A Case of Nyeri County."** The information obtained from your organization shall be treated confidentially and shall be used for academic purposes only.

Our MPPM Program seeks to establish links with industry, and one of these ways is by directing our research to areas that would be of direct use to industry. We would be glad to share our findings with you after the research, and we trust that you will find them of great interest and of practical value to your organization.

We appreciate your support and shall be willing to provide any further information if required.

Yours Faithfully,

Njoki Kiagiri.

Manager – Graduate Programs.

Strathmore University Business School

Strathmore Business School is a Proud member of:

AACSB

Annexture 2

22nd February 2023

Ms Gichuhi Lilian Wacu,
lilian.wacu@strathmore.edu

Dear Ms Gichuhi,

RE: An Appraisal of the Universal Health Care Policy: Challenges and Policy Options, A case of Nyeri County.

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU- master's** research proposal. Your application reference number is **SU-ISERC1590/23.** The approval period is from **22nd February 2023 to 21st February 2024.**

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, and MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 48 hours of notification
iv. Any changes, anticipated or otherwise, that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 48 hours
v. Clearance for the export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) https://research-portal.nacosti.go.ke/ and obtain other clearances needed.

Yours sincerely,

for: **Dr Ben Ngoye,**
Secretary; SU-ISERC

Cc: Mr Ambrose Rachier,
Chairperson; SU-ISERC

Ole Sangale Rd, Madaraka Estate. PO Box 59857-00200, Nairobi, Kenya. Tel +254 (0)703 034000
Email admissions@strathmore.edu www.strathmore.edu

8th March 2024

Ms Gichuhi Lilian Wacu,
lilian.wacu@strathmore.edu

Dear Ms Gichuhi,

REF: SU-ISERC2033/24 (*AMENDMENT*) PROPOSAL **"An Appraisal of the Universal Health Care Policy: Challenges and Policy Options, a Case of Nyeri County"**

I refer to your application for the approval of a proposed amendment submitted on 16th February 2024. We acknowledge receipt of the following submitted documents for amendment.

a) Amendment Cover letter
b) Amended Study Proposal
c) Informed Consent Form and document outlining participation conditions
d) Study budget
e) Study tools
f) CV(s) of investigators

The committee noted the following amendment

> ***1) Sample size:*** *Sample size has changed from 15 research participants to 69 research participants.*

The Committee concluded that the suggested amendments are justified and will not increase the participants' risk. The proposed changes have therefore been approved for implementation**.** You may continue with your study.

You are required to submit any further changes to this protocol version to SU-ISERC for review and approval before implementing any additional changes.

Yours sincerely,

Mr Ambrose Rachier,
Chairperson; SU-ISERC

STRATHMORE UNIVERSITY INSTITUTIONAL SCIENTIFIC AND ETHICAL REVIEW COMMITTEE
(SU-ISERC)
12-Mar-2024
Email:ethicsreview@strathmore.edu
P.O BOX 59857-00200
NAIROBI-KENYA

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **918550**

Date of Issue: **29/April/2023**

RESEARCH LICENSE

This is to Certify that Miss.. Lilian Wacu Gichuhi of Strathmore University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nyeri on the topic: An appraisal of the Universal health care: Challenges and policy options, A case of Nyeri County. for the period ending : 29/April/2024.

License No: **NACOSTI/P/23/25552**

918550
Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

National Commision for Science, Technology and Innovation -

THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)

Legal Notice No. 108: The Science, Technology and Innovation (Research Licensing) Regulations, 2014

The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was the established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

CONDITIONS OF THE RESEARCH LICENSE

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
    i. Endanger national security
    ii. Adversely affect the lives of Kenyans
    iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
    iv. Result in exploitation of intellectual property rights of communities in Kenya
    v. Adversely affect the environment
    vi. Adversely affect the rights of communities
    vii. Endanger public safety and national cohesion
    viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. The license any rights thereunder are non-transferable
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

National Commission for Science, Technology and
Innovation(NACOSTI),
Off Waiyaki Way, Upper Kabete,
P. O. Box 30623 - 00100 Nairobi, KENYA
Telephone: 020 4007000, 0713788787, 0735404245
E-mail: dg@nacosti.go.ke
Website: www.nacosti.go.ke

Annexture 5
INTERVIEW SCHEDULE

A. Ministry of Health Research Participants

Q: What is the status of the UHC policy framework in the selected County?

Q: How is UHC currently being financed?

Q: Are the most vulnerable people covered?

Q: Does UHC improve equity to access of health care to vulnerable population?

Q: What is the implementation progress of UHC so far?

Q: What are the successes in implementing UHC so far?

Q: What are the challenges experienced in implementing UHC so far?

Q: What global best practices support implementation of UHC?

Q: Is UHC a viable health policy to gain public support?

Q: What is your opinion regarding progressive implementation of UHC?

Q: Do you think financial constraints is a barrier to the realization of UHC?

Q: Do you think human resource shortage is a barrier to the realization of UHC?

Q: Do you think technical capacity is a barrier to the realization of UHC?

Q: What is your overall recommendation of universal health care?

Q: What are the possible policy options to improve UHC uptake?

B. Academic/Think Tank Research Participant

Q: What does UHC mean to you?

Q: What is needed to achieve it?

Q: What is the implementation progress of UHC so far?

Q: How is UHC currently being financed?

Q: Are the most vulnerable people covered?

Q: What are the successes experienced in implementing UHC so far?

Q: What are the challenges experienced in implementing UHC so far?

Q: What global best practices support implementation of UHC?

Q: What are the possible policy options to improve UHC uptake?

Q: What is your overall recommendation of universal health care?

Q: Does UHC improve equity to access of health care to vulnerable population?

Q: What is the role of civil society in the implementation of UHC?

Q: How can we measure UHC?

C. Beneficiaries Of Nyeri County's UHC Program during the pilot phase research participants.

Q: Are you a resident of Nyeri County?

Q: Were you a resident of Nyeri County during the year 2018-2022?

Q: Where were you accessing health services during this time? (Were you attending a public hospital or attending a private hospital?)

Q: Do you know anyone who was accessing services from a public hospital during the year 2018-2022?

Q: Are there any successes that have been registered during the implementation of UHC so far?

Q: Are there any difficulties facing the rolling out of UHC in Nyeri county

Q: What are the possible policy options to improve UHC uptake?

Q: What are your recommendations on how best to achieve UHC in Kenya?

Q: Does UHC meet the needs of the vulnerable populations?

Q: What services have been included in UHC?

Q: Do you think financial constraints is a barrier to the realization of UHC?

Q: What are the possible solutions in achieving UHC?

D: Health Care Providers Research Participants

Q: What is the status of the UHC Policy framework in the Country?

Q: Are the most vulnerable people covered?

Q: What is the implementation progress of UHC so far?

Q: What are the successes in implementing UHC so far?

Q: What are the challenges experienced by health care providers in implementing universal health care?

Q: What are the global best practices that support implementation of UHC?

Q: What are the possible policy options to improve UHC uptake?

Q: What measures have been put in place to include the informal workers?

Q: What are the recommendations on how best to achieve UHC in Kenya?

E INGOs/NGOs Research Participants

Q: What is the status of the UHC Policy framework in the selected County?

Q: What are the current UHC policy measures in the country?

Q: What are the challenges experienced in attaining UHC in the country?

Q: What are the recommendations on how best to achieve UHC in Kenya?

Q: What global best practices support the implementation of UHC?

Q: What is being done now to achieve UHC?

Q: Can it achieve UHC?

Q: If it cannot achieve UHC, why?

Q: What services have been included in UHC?

Q: How is this currently being financed?

Q: Are the most vulnerable people covered?

Q: Does UHC improve equity to access of health care to vulnerable population?

Q: What are the possible policy options to improve UHC uptake?

Q: Is UHC a viable health policy to gain public support?

E. INGO/ NGO'S Research Participants

Q: Is phasing the roll out of UHC implementation an excuse for Government of Kenya not to fulfill immediate access to health care?

Q: What is the role of civil society in the implementation of UHC?

Q: How can we measure UHC?

Annexture 6:

Consent form

My name is Lilian Wacu Gichuhi. I am a Masters student from Strathmore University. I am conducting a study titled “an appraisal of the UHC policy: challenges and policy options.” The information will be used as part of my study requirements for fulfillment of award of Master’s Degree in Public Policy.

Procedures to be followed by participants in this study will require that I ask you questions and record the information on an interview schedule. You have the right to refuse participation in this study. Please remember that participation in this study is voluntary and you may also ask questions related to the study any time. You may refuse to respond to any questions and you may stop me from asking you questions at any time. There are no consequences attached to your refusal to participate.

Discomforts

Some of the questions asked are on personal subjects and may make you uncomfortable. If this happens, you may refuse to answer the questions. The study may take about 15 minutes of your time.

Benefits

If you participate in this study, you will help me to analyse UHC among low-income households in Kenya as well as challenges, emerging issues and policy options.

Rewards:

Kindly note that there are no rewards attached to your participation in this study.

Confidentiality:

The information obtained will be confidential and your name will not be recorded in the Interview schedule.

Contact information

If you have any questions, you may contact: Dr. Bernadette Wanjala on 0738448743.

Participant’s statement.

The above information regarding my participation in the study is clear to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction. My participation in this study is entirely voluntary. I understand the information will be confidential and I can refuse to answer the questions that make me feel uncomfortable.

I………………………………………..agree [ ]/do not agree [ ] to participate in this study.

Signature or Thumbprint……………………………….

Date………………………………………….

Investigator’s statement:

I, the undersigned, have explained to the volunteer in a language s/he understands the information to be acquired from him/her and any anticipated discomforts.

Name of Interviewer: Lilian Wacu Gichuhi

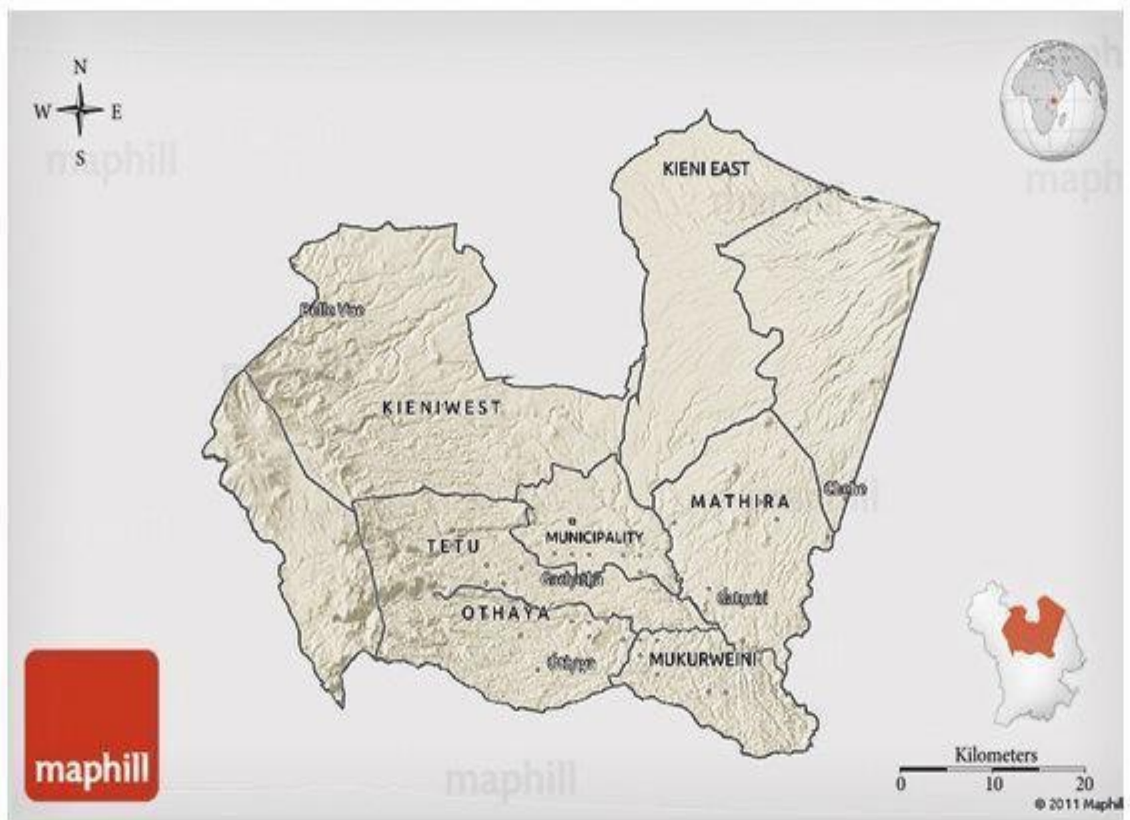
Signature……………………………………………………

Date…………………………………………….

Phone: 0724 668336 Email: lilianwacu@gmail.com

VT OMNES VNVM SINT

Annexture 7:



Map of Nyeri County