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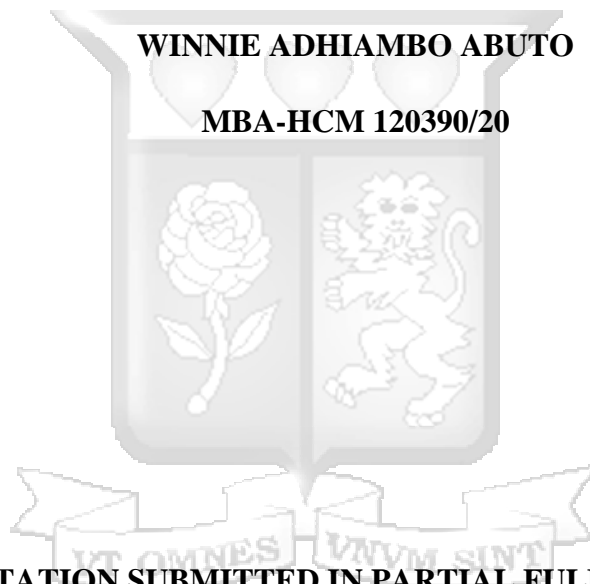
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**HEALTH WORKERS' PERCEPTIONS TOWARDS IMPLEMENTATION OF
UNIVERSAL HEALTH COVERAGE PILOT AT MACHAKOS LEVEL 5
HOSPITAL IN KENYA.**

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MBA-HCM 120390/20



**A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTERS IN BUSINESS
ADMINISTRATION- HEALTHCARE MANAGEMENT OF STRATHMORE
UNIVERSITY**

JULY 2023

DECLARATION

I declare that this work has not been previously submitted and approved for the award of a degree by this or any other University. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made in the dissertation itself.

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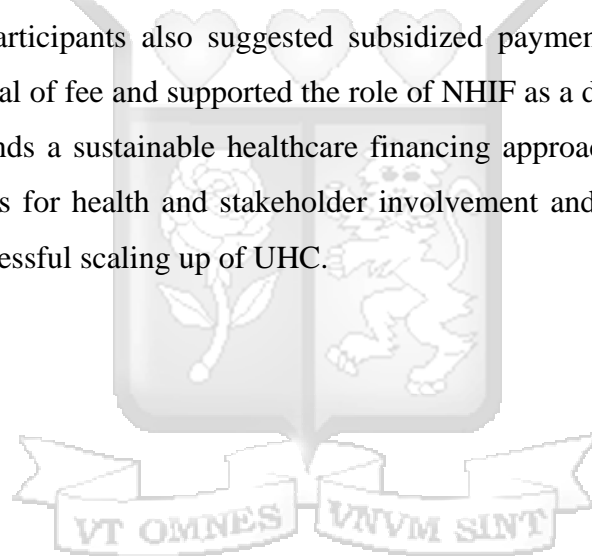
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ABSTRACT

This study explores the perceptions of frontline healthcare workers on the implementation of Universal Health Coverage (UHC) pilot in Machakos County, Kenya. UHC is an initiative that aims to provide quality healthcare services to individuals and communities without financial hardship. The pilot was launched in December 2018 in four counties as part of President Kenyatta's Big Four Agenda for socio-economic development and was intended to run for one year. The study employed a qualitative design using in-depth interviews with frontline healthcare workers in Machakos Level 5 Hospital. The findings revealed that the participants had a positive attitude towards UHC, but also faced various challenges such as inadequate funding, human resources and misuse of services by patients. The participants also suggested subsidized payments from users instead of complete removal of fee and supported the role of NHIF as a driver of the program. The study recommends a sustainable healthcare financing approach, provision of adequate human resources for health and stakeholder involvement and sensitization in decision making for successful scaling up of UHC.



DEDICATION

This work is dedicated to my loving family for their love and support.



ACKNOWLEDGEMENT

I am grateful to the Almighty God for His grace, provision and making way for me to complete my studies.

Special thanks to my mother and siblings for their overwhelming support and cheering me on even when the going was tough. To friends who were invested like family I say thank you too.

Sincere gratitude to my supervisor, Mr. Eric Tama and Dr Joseph Onyango for their relentless effort, guidance, encouragement and mentorship without which I would not have made it this far. I am equally thankful to the dedicated faculty especially and staff at Strathmore Business School for their support.

I cannot fail to mention my colleagues and especially my syndicate group members; the journey was shortened and exciting because you were part of it.

I am indebted to the healthcare workers at Machakos Level 5 Hospital for their availability and willingness to participate in the study and for the rich experiences they shared.

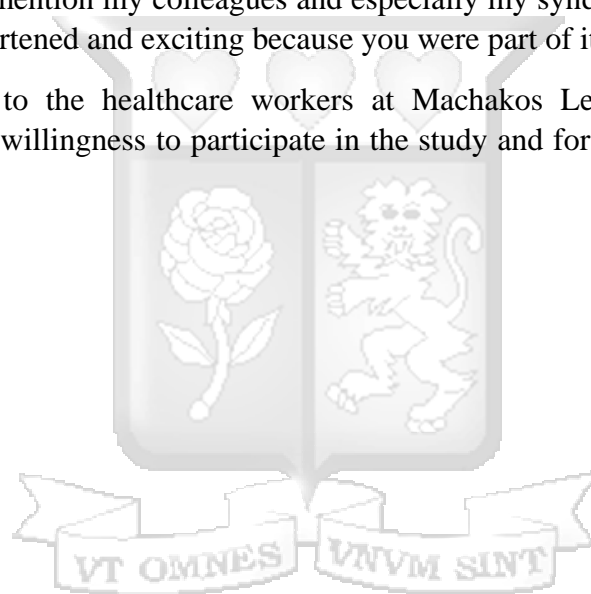


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LIST OF ACRONYMS

CBHI	Community Based Health Insurance
IDIs	In-depth Interviews
IRB	Institutional Review Board
LMICs	Low and Middle Income Countries
ML5H	Machakos level 5 Hospital
MMS	Ministry of Medical Services,
MOH	Ministry of Health
MPH	Ministry of Public Health
NACOSTI	National Commission for Science, Technology and Innovation
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
OECD	Organization for Economic Co-operation and Development
OOP	Out of Pocket
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter dwells on the background to the study by introducing the concept of Universal Health Coverage (UHC) and progress towards its achievement. Further, the overview of Machakos Level 5 Hospital in Machakos County is outlined, followed by problem statement, objectives of the study and research questions. The chapter concludes by discussing the significance of the study.

1.2 Background

Health is a human right according to Article 25 of the Universal Declaration of Human Rights (General Assembly of the United Nations, 1948). The right to health doesn't necessarily mean the right to be healthy and secondly it does not mean having expensive services that poor governments may not sustain. However, governments are expected to have policies and plans in place to achieve this right. Many countries have ratified the UDHR including Kenya where health as a fundamental human right is guaranteed in the constitution. Article 43 (1) (a) of the constitution of Kenya provides that, "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care access to healthcare (Constitution of Kenya, 2010).

Universal Health Coverage (UHC) is defined as everyone having access to the entire spectrum of quality healthcare services (including prevention, promotion, treatment, and rehabilitation) that they need without suffering financial hardship (WHO, 2021). The policy objective of UHC is to ensure that every person (population coverage) enjoys sufficient coverage through prepaid financing (financial risk protection) and have access to needed health services (WHO, 2010).

There have been several historical trends and developments in providing the right to healthcare culminating to UHC. These include the 1978 Alma-Ata declaration, that identified primary healthcare as key to the attainment of the goal of 'Health for All', the 1986 Ottawa charter for health promotion and sustainable development goal (SDG) three

whose aim is to ensure healthy lives and promote well-being for all ages (Nnaji et al., 2021). UHC was taken on as a target of the SDGs set in 2015, hoping that countries will achieve this by 2030 (Nnaji et al., 2021).

In 2005, WHO member states endorsed the ambitious UHC as a critical goal. They declared that health systems be developed further to ensure access to necessary services while providing protection against financial risk (Otambo et al., 2020). 25 wealthiest nations now have some form of UHC with exception of the United States of America (Nyandekwe et al., 2014). UHC was taken on as a target of the Sustainable Development Goals (SDG) set in 2015, with the hope that countries will achieve this by 2030 (Nnaji et al., 2021). During the United Nations High-level Meeting on Universal Health Coverage (UHC) held in 2019, world leaders reiterated their support for UHC and agreed to achieve UHC by 2030 (UHC2030, 2021).

Although protecting individuals from catastrophic health expenditure and impoverishment is a UHC objective, it is common to see people impoverished due to spending on healthcare, especially when there are unexpected illnesses in the family (Sanogo et al., 2019). A 2010 study across more than 100 countries showed that more than 808 million people suffered catastrophic health expenditure and about 122 million people were impoverished as a result (Wagstaff et al., 2018). In Kenya, households spend more than a tenth of their budget on healthcare bills; the burden is highest among people with low incomes. Approximately 1.48 million Kenyans are impoverished due to spending on healthcare (Chuma & Maina, 2012).

Many countries are already putting efforts towards UHC (WHO, 2010) by developing policies, increasing budgetary allocation to health and strengthening their health systems (UHC2030, 2021) but access to quality healthcare and impoverishment due to out-of-pocket (OOP) spending is still a big challenge especially in developing countries. More than 100 million people worldwide are pushed into poverty annually due to OOP healthcare payments (WHO, 2010). Approximately 400 million people worldwide cannot access the healthcare (Dalinjong et al., 2017). In Africa, only 43% expectant women attend the recommended antenatal visits and 49% are attended to by skilled birth attendants as of 2014 (Sanogo et al, 2019). Implementation of UHC has faced many

challenges with some of the barriers being inadequate financial and human resources as well as inefficient use of available resources (Chelagat et al., 2021).

The COVID-19 pandemic has heightened the need to build resilient and equitable health systems that will ensure health needs of communities are met (OECD, 2021); (United Nations, 2020). Progress towards achieving UHC over the past several years has been counteracted by the pandemic making the chances of achieving the goal of having 1 billion more people benefiting from UHC by 2023 to be slim (UHC2030, 2021).

1.3 Machakos Level 5 Hospital

Machakos Level 5 Hospital is a county referral hospital in Machakos County in Kenya, that was established in 1922 to serve soldiers who fought in World War 1. It became a health centre in 1945 and was later upgraded to a district hospital. In 2008 it was elevated to level 5 status. Level 5 Hospitals are secondary facilities that deliver assorted health services and training for various groups of health workers. It provides both in-patient and outpatient services, including specialized medical services. Its proximity to Mombasa highway makes it have a high burden of road traffic accidents and trauma patients.

Machakos County was selected for the pilot to evaluate the country's readiness to respond to emergencies resulting from accidents. Approximately 280,000 households in Machakos county were registered for UHC using M-tiba mobile application. The County Government of Machakos supported the initiative by a) increasing the number of healthcare workers including hiring consultants from Kenyatta National Hospital to reduce referral costs; b) training and sensitizing county executive and assembly leadership, county and sub-county health management teams and the community; and c) renovating some health facilities, acquiring advanced life support ambulances and medical equipment (Nzei et al., 2022).

1.4 Problem Statement

The implementation of UHC is a major policy goal in many countries, including Kenya, where a pilot program was launched in four counties in 2018. Successful implementation of UHC is evaluated by the populations' ability to access quality healthcare services without suffering catastrophic expenditure that lead to impoverishment.

The delivery of the mentioned quality health services requires among other important inputs, a health workforce that is purposefully trained, with a range of skills and the competence to address the majority of the health needs of the population.

Health workforce is one of three principle health system inputs, with the other two major inputs being physical capital and consumables. As arguably the most important of the health system inputs, the success of UHC depend largely upon the knowledge, skills and motivation of these health workers as well as adequate number that is distributed equitably in the country.

The vital role health workforce plays mean their views on any policy implementation cannot be ignored. Lack of their input can lead to policy gaps between what was planned and what occurs (Buse et al., 2012a).

Evidence shows that top-down approach was used for UHC pilot as consultations with healthcare practitioners in the four pilot counties were limited (People Health Movement, 2020). In top-down approach to policy implementation policies are set at higher levels by policymakers and are then communicated to subordinate levels charged with the technical, managerial, and administrative tasks of implementing the policy. (Owino et al., 2020) posits that “the Kenyan UHC has so far ‘mimicked’ paternalistic past with decisions being taken at the top and communicated as a *fait accompli*”. Some of the problems associated with the Top-down approach is that when there is lack of buy-in from implementers, the policy is likely to fail. (Buse et al., 2012b).

There have been reports of decreased morale and low performance from healthcare workers implementing almost similar policies as UHC in Kenya (Lang’at & Mwanri, 2015) and Burundi (Nimpagaritse & Bertone, 2011). Other policies aligning to UHC such as free maternal healthcare and removal of user fees at primary care facilities, have been met with resistance by nurses in Kenya (Koon et al., 2017). Increased uptake of free maternity services in Kenya led to an increased workload of healthcare workers without proper incentives, contributing to free maternity policy implementation, among other factors.(Pyone et al., 2017)

Even though there have been studies on UHC in Kenya, most have focused on the aspects of financing, uptake of services and experiences of the consumers with little attention being paid to exploring the experiences of frontline health workers. This qualitative study aimed to fill this knowledge gap by exploring how frontline health workers, specifically in Machakos Level 5 Hospital, experienced and defined gaps in the UHC pilot. The rationale was to ensure that future scaling of UHC will be aligned with actual needs on the ground.

1.5 Study Objectives

1.5.1 Broad objective

To assess the perceptions of frontline health workers towards UHC pilot implementation at Machakos Level 5 Hospital in Machakos Kenya.

1.5.2 Specific Objectives

1. To explore UHC policy fidelity from the perspective of frontline health workers
2. To find out the views of frontline health workers on the effects of UHC pilot on health services provision
3. To explore the barriers to and facilitators of the UHC pilot implementation from the perspective of frontline health workers

1.6 Research Questions

1. What are the views of healthcare workers on fidelity to UHC pilot directive?
2. What are the effects of UHC pilot on service provision as perceived by the frontline healthcare workers?
3. What are the barriers and facilitators of UHC pilot program implementation as identified by frontline health workers?

1.7 Scope and of the Study

The study aimed to assess the perceptions of frontline health workers on UHC pilot implementation. The study targeted frontline workers included nurses, doctors, and clinical officers working both inpatient and outpatient and frontline workers from

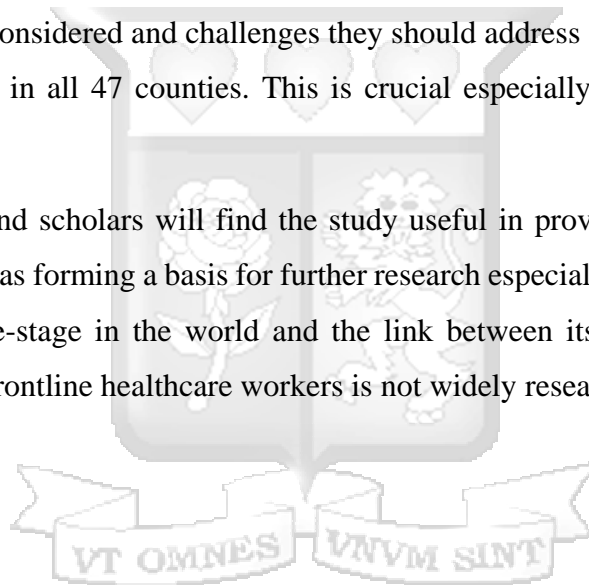
pharmacy, laboratory, radiology, and dental departments at Machakos Level 5 hospital who were present during the UHC pilot phase.

1.8 Significance of the study

There are varied lessons that practitioners, administrators, policy makers and scholars can draw from the experiences of frontline workers on UHC pilot implementation. This study will inform Machakos level 5 hospital and other public hospital management teams on areas of improvement in order to enhance quality care as well as improve health workers' welfare.

Policy makers at both national and county levels will draw important lessons on factors that need to be considered and challenges they should address as the country is on a path of scaling UHC in all 47 counties. This is crucial especially in planning for resource allocation.

Academicians and scholars will find the study useful in providing literature for future research as well as forming a basis for further research especially given that UHC agenda has taken centre-stage in the world and the link between its implementation and the experiences of frontline healthcare workers is not widely researched.



CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter covers more literature on UHC in the region and locally, theoretical framework that the study will be anchored on and conceptual framework. It also presents empirical review of literature focusing on the role and perceptions of healthcare workers on UHC and related policies implementation.

2.2 UHC in Low- and Middle-Income Countries (LMICs)

As in other countries globally, many low- and middle-income countries (LMICs) have begun health system reforms designed to expand financing for health and replace out of pocket payments as a way of ensuring financial risk (Lagomarsino et al., 2012). However, there is evidence of varied paths to UHC that depend mostly on historical, economic and political aspects of a particular country (Savedoff et al., 2012).

Encouraging progress has been reported in some low and middle-income countries, including Thailand, Sri Lanka, Rwanda, Cuba, Colombia and Chile (Higashi & Khuong, 2011). However, for countries in Sub-Saharan Africa countries, UHC remains a major challenge, with majority of the population struggling with increasing proportion of Out-Of-Pocket (OOP) expenditure for health services (Nyandekwe et al., 2014). In Malawi, service provision has had several gaps resulting in geographical inequities in population coverage, financial protection, and access to quality health (Abihiro et al., 2014). Ghana's National Health Insurance Scheme (NHIS) has been as the main strategy of bridging financial access barriers and providing social risk protection which have contributed to decline in under-five mortality rates by about one-third since 1990 (Nyonator et al., 2014). Rwanda has made significant progress towards achieving UHC by implementing Community Based Health Insurance and is considered not far from Achieving UHC but there are questions as to whether their CBHI model is sustainable (Nyandekwe et al., 2014).

2.3 UHC in Kenya

Kenya has made a commitment to achieve Universal Health Coverage (UHC) by the year 2030 (MOH, 2020). The government of Kenya launched UHC in 2013 as part of President Kenyatta's Big Four Agenda for enhancing socio-economic development (Government of Kenya, 2018).

A pilot dubbed Afya Care was conducted between 2018 and 2019 in four out of 47 counties; Machakos, Isiolo, Nyeri and Kisumu. The four pilot counties were selected through evidence-based approach considering their respective disease burden. Machakos was selected due to increased number of road traffic accidents along Mombasa Road; Kisumu due to high incidences of communicable diseases; Nyeri because of increased cases of non-communicable diseases; and lastly Isiolo because of high maternal mortality rate (Nzwili, 2018). During the pilot, user fees in public facilities was removed, commodities were being secured through KEMSA, conditional grants were provided to the four counties in an effort to strengthen their primary health care interventions, and additional healthcare workers were employed as well as scaling up the use of Community Health Volunteers (CHV's) (Nyawira et al., 2021).

Although the pilot showed an increase in outpatient service utilisation by 20%, (MOH, 2020), the quality of services deteriorated due to a lack of adequate resources to match demand. This is consistent with the caution that health policy scholars have given against abrupt removal of fees for service delivery (Gilson & McIntyre, 2005) since increased utilization of services have been found to be unsustainable following removal of fees (McPake et al., 2013). The pilot in Kisumu and Nyeri counties ended prematurely due to the same reason (Mwaniki & Ogoti, 2021). Despite this, the government of Kenya embarked on scaling up UHC in all the 47 counties based on the experience from the pilot with the final goal of reaching 100% population coverage by 2022 (Nzwili, 2018).

A number of policies aligning with the UHC have been introduced earlier such as free maternal health care, removal of user fees from primary care facilities, and governance reforms within National Health Insurance Fund (NHIF) (Abuya et al., 2015). Some of the NHIF reforms include: the introduction of the Civil Servants Scheme for government employees plus their dependents, basic benefit package for NHIF members was

expanded, NHIF inpatient reimbursement rate was increased, and the introduction of a Health Insurance Subsidy for the poor (E. Barasa et al., 2018).

The country's UHC policy which was disseminated towards the end of the year 2020 outlines 4 objectives; increase access to health services b) ensure health services are quality c) ensure individuals and households are protected from the financial risks and d) strengthen the responsiveness of the health system (Nyawira et al., 2021). Implementation of the policy encountered challenges, the major one being the COVID-19 pandemic and other bottlenecks identified during the pilot study.

Health financing in Kenya is considered regressive (Munge & Briggs, 2014) and only 10% of the population is covered by health insurance (E. Barasa et al., 2021). Constrained fiscal space for health (only 2.3% of Kenya's gross domestic is allocated to health) has further made the goal of achieving UHC a challenge (Mbau et al., 2020). An estimated 4.5% Kenyans suffered catastrophic health expenditure in 2013 meaning a lot needs to be done to protect Kenyans from financial risk (E. W. Barasa et al., 2017).

Extending coverage to the poorest, while increasing public investment in health by coming up with health financing models that are sustainable have been put forward as the best ways to reduce health inequalities in order to achieve UHC (WHO, 2010).

2.4 Theoretical Review: Street Level Bureaucracy Theory

Street level bureaucracy was coined by Michael Lipsky in 1980 who termed public service workers such teachers, nurses, police officers etc. tasked with policy implementation as street level bureaucrats (SLB). These SLBs interact with directly with citizens in the process of implementing policy directives and have discretion over the kind of services to offer, how the services are offered and the type of benefits and sanctions allocated to the citizens. He further argues that the SLB's work is usually highly scripted in order to achieve policy objectives and often requires some level of improvising to respond to particular needs of individuals seeking services (Lipsky, 1980).

According to (Gilson & McIntyre, 2005), 'SLBS lack time, information or other resources to respond to the highest standards of decision making in their field to each individual case.' He also notes that inadequate resources, increasing demand for services, unclear

and conflicting policy objectives and organizational goals are some of the issues that put pressure on SLBs hence the need for development of routines and modifications on how they perform their tasks. Gilson further states eventually the decisions made, routines established and devices invented by SLBs to manage the difficulties they face become the public policies they carry out or as (Ramani et al., 2020) puts it, ‘a version of the policy that appears to fit in with their everyday realities and contextual constraints’ is implemented instead

Lipsky, (2010) argues that even though SLBs are committed to serving the public, the demands of their work challenge this commitment hence as a way of coping they have to devise ways to offer services in masses which in turn distort service ideals on place SLBs in a position to manipulate citizens (Lipsky, 2010). The citizens, who Lipsky refer to as ‘bureaucratic subjects’ are then forced to strike a balance between asserting their rights and conforming SLBs way of doing things.

Gilson (2005) highlights three main contributions SLB theory: firstly, SLBs have discretion and power in implementation of a policy therefore citizens experience of policy is dependent on how SLB will implement it, secondly SLBs practices and attitudes are influenced by their work environment and lastly, attempts to control SLB behaviour only undermine their responsiveness to the citizens they serve.

A study by (Ramani et al., 2020) on doctors as street level bureaucrats found that doctors reported facing several obstacles in the implementation of primary care- including the lack of resources, the imposing of programs that they did not find meaningful to them, inadequate support from the institution to improve processes and lastly professional disinterest in their assigned roles. The study further shows that many doctors ‘routinized’ care, became resigned, risk-averse and felt a deep loss of professional identity, all which were not conducive to the delivery of good primary care.

Street level bureaucracy theory has been chosen for this study since it sheds much light on how frontline health workers (agents) interpret and implement policy directives from policy makers. It also helps in explaining why policy outcomes do not always represent what was intended due to modifications that implementers must make to cope.

2.5 Empirical review

2.5.1 Role of frontline Healthcare Workers in health Policy Implementation

Frontline healthcare workers are considered the policy actors on the ground tasked with implementation. According Lipsky (2010) actual implementation of a policy depends on the front line workers aligning themselves with the guidelines and policy briefs. The way actors continuously make sense of a policy affects how the policy will be implemented (Schwartz-Shea & Yanow, 2012).

Front line workers (actors) usually face a dilemma while implementing policy in the local context due to several reasons such complexity in the policy itself, inadequate resources to implement the policy, and inability of the policy to address issues on the ground (Lipsky, 2010).

One of the strategies frontline workers, who are also referred to as street-level bureaucrats, use when there is lack of clarity on how a policy should be implemented is practicing discretion (Hupe & Buffat, 2014). In this regard the street level bureaucrats determine how the users experience the services (Gaede, 2016).

Decision-making on health policies for UHC appears to be led by governments in top-down structures (UHC2030, 2021). Top down approaches to policy implementation lack ownership and may not reflect local contexts (Kirton & Kickbusch, 2019). Policy implementers' input during policy development is vital to ensure buy in and policy relevance.

In a study done in Kenya to determine perception of nurses on UHC before the pilot phase was initiated, some nurses described the Ministry of Health as disorganized, out-of-touch with frontline workers, and not conversant with policy implementation challenges from past experiences (Koon et al., 2017). Mitchel et al (2020) also argued that policy makers may not know the realities on the ground, therefore directives sent from the top, usually lack congruence with conditions on the ground.

There is also a general assumption that when policies are communicated, the implementers would understand and implement it without any (Sabatier, 1986). Frontline workers are

important sources of information given that they are in direct contact with communities and experience first-hand the gaps in service delivery (Sharma et al., 2021).

2.5.2 Perceptions of Frontline healthcare workers on UHC and removal of user fees policies

A study done in South Africa by (Wilkinson et al., 2001) on effects of removing user fee for healthcare services found that although the idea was supported by health workers, clinical nurses felt they were spending less time with each patient and were more exhausted than before, due to increase in numbers of those seeking healthcare services.

An evaluation of delivery fee exemption scheme in Ghana by (Witter et al., 2007) revealed that the exemption resulted in increased facility deliveries, particularly for the poor, but getting payments from the government was a challenge and unreliable. Healthcare workers that responded in the study reported that although their workload increased, it did not affect their morale or ability to cope.

A similar study conducted in Niger by (Ridde & Diarra, 2009) that was evaluating user fee abolition for pregnant women and children under five years showed that local decision makers and the population favoured abolition but were concerned about its sustainability. However, health workers were opposed to providing free services. The view that abolishment of user fee is welcome but sustainability poses a challenge is also shared by (Maini et al., 2014) through a similar study done in Democratic republic of Congo.

Even though evidence suggests that abolishing user fee is effective in increasing access to healthcare services, the implementation is still a huge challenge especially in low and middle income countries.

A study done in Malawi to assess gaps in UHC reported that health facilities were unevenly distributed and that public-private service level agreements were poorly implemented, leading to geographical inequities in population coverage and financial protection (Abihiro et al., 2014).

A study done in South Africa and Tanzania on perspective of different actors including healthcare workers on UHC concluded that it is not health system strengthening that is needed to realize UHC but rather health system transformation (Mitchel et al, 2020).

A study that focused on importance of social marketing for UHC done in Kisumu county after the UHC pilot, revealed that health workers were not given an opportunity to participate in policy formulation and instead were ordered to implement the program despite lack of resources (Otambo et al., 2020). The same study also concluded that social marketing is vital for success of any new policy.

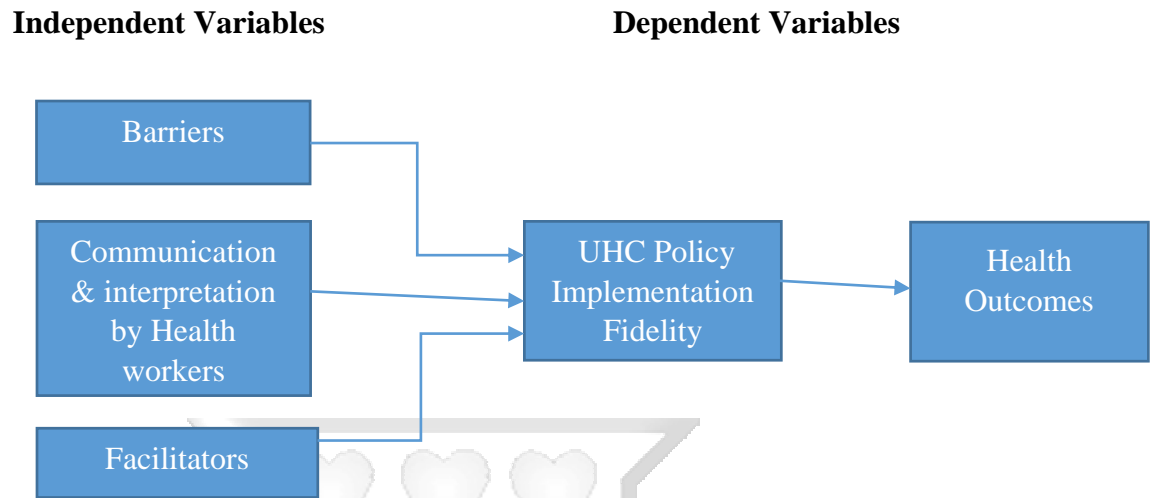
A survey on UHC pilot implementation among a variety of stakeholders including healthcare workers was conducted by People Health Movement in 2020. It showed there were governance issues including limited citizen participation, poor planning, policy gaps, lack of accountability and inadequate resources. The same survey reported that healthcare workers were not included in the policy formulation process (People Health Movement, 2020).

When assessing perceptions of Kenyan nurses on UHC before the pilot, Koon et al (2016), found that nurses felt excluded from participation in policy matters despite being the majority of healthcare workers. A similar finding has been reiterated from a study done in South Africa (Walker & Gilson, 2004).

From the above studies, it is apparent that most policy makers have adopted a top-down approach to implementation of policy and that frontline health worker's inputs are not sought during policy formulation. It is also important to note that similar barriers were observed across the different studies. The studies also focused on different aspects such as the general understanding of UHC and barriers and none highlighted policy fidelity.

2.6 Conceptual Framework

Figure 1: Conceptual Framework



Fidelity to policy implementation is dependent on a) implementer's interpretation or how they make sense of the policy, b) facilitators or enablers such as adequate resources and c) barriers. These three factors result in modification of policy (actors use discretion) before it is implemented hence outcomes will be varied depending with the extent of modification.

2.5 Research Gap

Based on the review, there is limited evidence frontline health workers' views on UHC implementation. Most of the studies done focused on multiple stakeholders' views that combined different actors and only a handful of healthcare workers, hence it is not possible to make a generalized view of healthcare workers. While there are related studies done in Kenya and around the world, they only focused on nurses leaving out the other cadres. It is therefore important to get a wide range of views from different cadres of frontline healthcare workers to have a comprehensive understanding of policy issues that need to be addressed.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology that was used in carrying out the study. It covers, the study design, population of interest, sampling techniques, data collection & analysis and ethical considerations.

3.2 Study design

The study employed exploratory qualitative design to explore the frontline healthcare workers' perceptions on UHC pilot implementation. A qualitative method is a naturalistic inquiry that aims to study individuals in their natural setting and is less obtrusive than a quantitative method (Bowling, 2010). The method was appropriate for this study because it allowed participants themselves to explain how, why, or what they were thinking, feeling, and experiencing during the pilot phase in order to identify themes and patterns that can be difficult to quantify.

3.3 Study Setting

The study was conducted at Machakos Level 5 hospital, a public hospital under the Ministry of Health Kenya. It is a teaching and referral hospital serving not only Machakos County but also the neighbouring counties of Kitui, Makueni, Kajiado and Nairobi. It has a bed capacity of 507 and provides both inpatient and outpatient services including specialized services such as oncology and dialysis.

3.4 Target Population

The study targeted frontline health care providers including doctors, clinical officers, nurses, radiographers, laboratory technicians/technologist and pharmacist/pharmacy technicians that were providing services during the pilot at Machakos Level 5 Hospital. The focus was on these cadres since they make up the majority of the healthcare workers that were responsible for implementing UHC pilot by providing diagnostic, clinical and nursing care as well as administration of the facility.

3.5 Sample size and sampling procedure

Sampling is the process by which a relatively small number of individuals, objects, or events are selected and analysed to find out something about the entire population from which it was selected. Sample size determination in a qualitative study is usually guided by the principle of saturation. Saturation occurs when adding more participants to the study does not result in obtaining additional perspectives or information (Sandelowski, 1995). However, (Braun & Clarke, 2016) recommend a sample size of at least 12 participants for qualitative study.

Both purposive and convenient sampling techniques were used to select 16 participants. Convenience sampling is a non-probability sampling technique that involves selecting participants according to their availability. It is considered easy to implement and less costly (Polit & Beck, 2004). This technique was used to select participants who were available to prevent interruption to service provision. Purposive sampling on the other hand involves sampling a group of people with particular characteristics or have knowledge vital to the study (Bowling, 2010). It was used to select only participants that were present during the entire UHC pilot period since they were better placed to share perspectives based on their experiences.

Participants were drawn from the mentioned cadres and from different hospital departments to ensure diversity of views on the topic.

3.6 Inclusion and Exclusion Criteria

3.6.1 Inclusion Criteria

Participants i.e. doctors, clinical officers, nurses, radiographers, laboratory technicians/technologist and pharmacist/pharmacy technicians who were working at the hospital during the pilot phase and have given their consent.

3.6.2 Exclusion criteria

Health workers that were absent during the pilot phase, those that were be off-duty or on leave during data collection and those that declined to consent to participate in the study.

3.7 Data collection method and Research Instrument

To explore their perspectives, qualitative data was collected using face to face in-depth interviews with health workers working at Machakos Level 5 hospital who met the inclusion criteria. These interviews were conducted using topic guides which were formulated guided by the study objectives. (Appendix I). Questions explored perspectives on policy fidelity, barriers & facilitators and effects of UHC pilot on service provision. The study tool was peer reviewed by colleagues and the supervisor to ensure the questions were clear, easy to understand and ensure consistency in the terminology used. Apart from researcher's notes, the interviews were audiotaped using a recorder with consent from participants, fully transcribed, and coded. The interviews were conducted at times that were convenient to participants and they took approximately 30-40 minutes.

3.8 Data management and Analysis

The interview recordings were transcribed then organized and coded using Nvivo software. A framework approach method was used to thematically analyse the qualitative data. The analysis process involved initial reading of the interview transcripts and notes to have a general overview of the data then a preliminary thematic framework was developed based on the study objectives and on other themes that became evident from the data. The data was then organized into relevant groups and coded based on themes after which interpretation was done to highlight relevant messages.

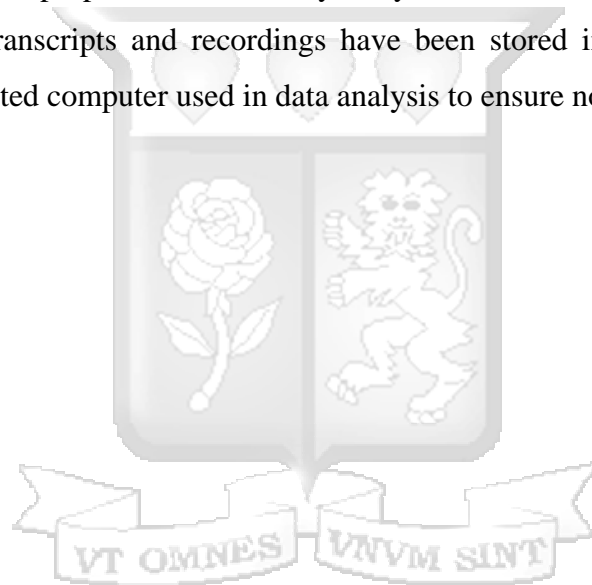
3.9 Research validity and Reliability

The study tool was peer-reviewed by colleagues to ensure the questions are clear, easily understood and that there is consistency in terminology used, expert opinion was sought from my research supervisors.

To ensure reliability, adopted theoretical triangulation, that is other related research were analysed and presented as a literature review to back the results claims of the data collection and analysis process.

3.10 Ethical Issues in Research

Ethical approval was obtained from Strathmore University's Institutional Review Board (IRB), and from NACOSTI (Permit number 794315). Permission was granted from the Machakos County Director of Medical Services and Research to conduct the study at Machakos Level 5 Hospital. Participants were informed that participation was voluntary and that they were free to withdraw from the study at any time. Informed consent was obtained before conducting and recording the interviews. Further, to enhance confidentiality, research participants were not required to include their names in the questionnaires. They were kept anonymous and their details confidential. Data was collected for the purpose of the study only. Interviews were conducted at their convenience. Transcripts and recordings have been stored in a lockable cabinet and password protected computer used in data analysis to ensure no unauthorized access.



CHAPTER 4: PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter contains information about the participants and outlines the study findings and interpretation of the data collected. The data was analyzed using thematic analysis which.

4.2 Study Participants

A total of 16 participants were interviewed across different cadres and departments as outlined in Table 1 below.

Table 1: List of study participants

Cadre	Number	Department(s)
Nurse	8	OPD, Maternity, Theatre, Inpatient
Clinical officer	3	OPD, Inpatient
Medical Officer	1	Inpatient
Dentist/Dental Assistant	1	Dental
Radiologist/Radiographer	1	Radiology
Laboratory Technician/Technologist	1	Laboratory
Pharmacist/Pharmaceutical Technologist	1	Main Pharmacy
Total	16	-

4.3 Data Analysis

Interview data were transcribed in English and exported into NVivo -a qualitative analysis software -for content management. Framework approach was used for analysis. First, the researcher read through the transcripts to familiarize with the data then developed a preliminary thematic framework from the study objectives and from themes

emerging from the data. The transcripts were then coded to classify all of the data so that it can be compared systematically with other parts of the data. The codes were thereafter organized into thematic groups which were used as a framework for analysis and interpretation.

4.4 Results

The following were the findings presented as per themes and subthemes were apparent. Verbatim quotes are used to illustrate the point made, and a short description of the category of respondent is given to aid interpretation of the findings.

4.4.1 Supply-side Challenges

Participants reported a number of supply-side related challenges at the beginning of the pilot which hampered the implementation process. These challenges included inadequate funding to sustain service delivery and inadequate human resources for health.

4.4.1.1 Funding for service delivery

Providers reported that there was inadequate funding to sustain service delivery as reimbursements to the county hospitals were either not made in time, were incomplete and there were inconsistencies in how they were made, making planning difficult. This affected service delivery.

“It reached a point whereby there was limited funding and the hospital was not able to buy supplies and medicines so it created a situation whereby we were not able to proceed with offering the services as we intended because we run short of medicines and supplies.” (Dental Health professional)

“Yes, there was free healthcare but everything was in a mess. Then when we ask we are told the money is not being sent from the national government to fund the universal healthcare.” (Clinical Officer, OPD)

As a result of these delays and inconsistencies, providers reported that the general condition of the hospital infrastructure deteriorated and operations would be interrupted from time to time due to inadequate resources and the available resources were overstretched.

“The hospital really deteriorated. If you had seen this hospital when people were paying and during UHC, the hospital really went done during the UHC. Even the structures, even the benches used to be very nice.” (Clinical Officer, OPD)

“After the free thing, everything was depleted and due to delay in resource allocation. I can’t remember after how long we had nothing in the lab so it looks like the planning was not done well.” (Laboratory technician.)

It was reported that there were frequent breakdowns of machines whose repairs and maintenance could not be done on time due to lack of funds. Patients would then be referred to other facilities, most of them private, where they ended up paying for the same services that were supposed to be free in the public facilities. In addition to machines breaking down, basic commodities were reported to have ran out of stock due to increased demand for services from the overwhelming rise in patient visits. As a result, providers would be forced to ask the patients to buy supplies such as drugs and gloves. This meant that patients ended up incurring out-of-pocket expenditure, a challenge that the pilot was intended to address in the first place.

“The x-ray machine broke down and no one cared about repairing it. We also ran out of supplies at some point. It became so dire that at one point we even lacked the basics like gloves, so we would tell patients to go and buy gloves outside the hospital. In some instances, we had to continue with treatment without the much needed x-rays which compromised healthcare quality.” (Dental Health worker)

“Sometimes I would see a patient but there are no supplies like drugs or lab reagents forcing patients to go to private facilities for tests and drugs. Patients would suffer paying for these services. That was discouraging.” (Medical Officer, Inpatient)

Commodities stock outs were also attributed to delays and inconsistent supply from Kenya Medical Supplies Agency (KEMSA). The agency was supposed to get funding directly from the national government to supply the hospitals. However, it was not clear whether the delays were due to a lack of funding or institutional incompetency.

Due to these challenges, respondents reported being discouraged, having low levels of motivation and job satisfaction.

“There was lack of job satisfaction whereby you are here with the patient, the drug has been prescribed and it is not available in pharmacy so the patient has to avail it and they don't have the funds.” (Nurse 2 Maternity)

Some providers reported that one of the reasons why funding could be inadequate was that some funds meant for healthcare, were being channeled to other county functions hence reducing the amount available for healthcare. Some also felt that the reimbursements should have been sent directly to the facilities and structures be put in place to ensure the funds are not misappropriated.

“They have to put good structures to ensure that the funds are not embezzled or being diverted. Some counties do not prioritize healthcare as it should be so they divert money or funds which are meant for healthcare to other needs like roads.” (Dental Health Professional)

Even though the removal of user fee was beneficial to the patients, providers raised concerns about the long-term sustainability of the pilot citing the government's inability to reimburse adequately and on time and felt that the government was not adequately prepared to offer free services.

“I think for me free things are not the best. People misuse free things. So I think they should have put up a system whereby people pay something for the services.” (Clinical Officer 1, OPD)

“I wouldn’t encourage for a free service. Maybe they put up minimal payment or maybe waive for some patients and then subsidize cost for everybody but free can’t work.” (Laboratory Tech.)

“There should be a minimum payment of say 200/= so that they only come here when there is need and leave the free service to the dispensaries and health centers.” (Nurse 1, Maternity)

According to (Guyo & Vilcu, 2020) as at 2012, user fees contributed to 70% of the revenues, without which hospital operations would be paralyzed if reimbursements are not commensurate and timely. The providers felt that if user fees had been retained but subsidized equitably, the hospital would have been able to meet its daily needs such as carrying out minor repairs, paying support staff and buying basic commodities such as gloves. However, due to the aforementioned delays, providers reported that daily operations had been compromised.

“When services are free and reimbursements are not regular it means that there will be no cash at hand to get something needed urgently, eventually affecting service for sure.” (Radiology staff)

“The cleaners used to be paid from Facility Improvement Fund (FIF) so removal of user fee affected cleaning services due to delayed salary payments.” (Nurse 2, Theatre)

4.4.1.2 Human Resources for Health

Respondents across all departments reported an increase in workload during the piloting of the UHC program. These high numbers of patients were attributed to services being free and also to an influx of patients to the hospital from the neighboring counties of Kitui, Nairobi, Makueni and Kajiado where the UHC pilot had not been implemented. Providers would work from morning until evening, sometimes even without taking meal breaks.

“There were overwhelming numbers of patients. For example, previously we would do tooth extractions for around 100 patients daily, but this number suddenly rose to approximately 300 patients daily.” (Dental Health worker)

“We had a lot of patients. It was crazy, a lot of work. We had long queues. We worked for long hours sometimes without breaks.” (Pharmacy staff)

“The main challenge was workload because no one wanted to be seen in the lower level health facilities, they all wanted to come to Level 5 because everything is free.” (Clinical Officer 1, OPD)

While some additional staff were employed during the pilot phase, it was reported that they were still not enough and the staffing needs of all departments were not considered resulting in increased workloads for staff across all departments.

“The main challenges where I was, labor ward, patients were so many with 2 nurses in every shift and we needed 5 nurses in every shift, so it was a big mess.” (Nurse 1, Maternity)

“There are a few staff who were employed under UHC, but they were very few, they could not meet the needs of the staff ratio.” (Nurse 1, OPD)

4.4.1.2.1 Quality of Services

The WHO recommended provider to patient ratios could not be achieved. This was reported to have had a negative effect on quality of services albeit slightly according to the providers. For instance, it was reported that midwives would only take a brief history and examine only the affected systems because there was no time for full assessment. It was also a challenge for the midwives to properly monitor labor of each mother due to the high numbers. Mothers in labor would wait on the benches for beds to be available. Clinicians would also be forced to rely on clinical diagnosis instead of medical diagnosis when it was not possible to do radiological or laboratory tests. It was also reported that clinicians would barely do thorough examinations since they were more focused on clearing the queue. The compromise on quality was further compounded by inadequate and inconsistent supplies and lack of proper maintenance of equipment.

“People began working to clear the queue without looking at the quality of test results that is being reported. There are systems in the lab where one has to review and countercheck results. You would find one or two staff don’t even report, they simply do the test and release.” (Laboratory Tech.)

“All the beds were occupied and sharing was not allowed and you could not send them away. So you would find a mother with cervical dilation of about 6-7 centimeters is just on the bench. Monitoring all mothers in labor was also tricky with the few number of midwives.” (Nurse 1, Theatre)

“Long queues especially in OPD wore out staff. The first batch gets good services but the remaining may end up having quick service.” (Radiology staff)

4.4.1.2.2 Health Workers' Morale and Job Satisfaction

As a consequence of the increase in workload arising from increased utilization, providers reported having burnouts, low morale and job dissatisfaction which were compounded by the shortage of basic commodities at the hospital.

“The administrators did not compensate us as we expected because we thought with the increased numbers maybe they are going to promote people, motivate them. We realized we were just suffering; the work has increased but the conditions are still the same or become worse. It was demoralizing.” (Dental Health worker)

Respondents also reported other human resource challenges like lack of compensation for working overtime, delays in salary payment and unfavorable employment terms specifically being hired on short term contracts and delayed promotions.

“Sometimes getting salaries is a problem. Secondly doctors are being employed on contract instead of permanent, so they are not motivated because they would want to go to school faster, but when they are on contract there is no study leave. Thirdly there is delay in promoting consultants after qualifying making them feel unappreciated.” (Medical Officer, Inpatient)

However, the providers intimated that despite all the mentioned challenges, they still kept going because of their commitment to serve and to care for the patients and ease their suffering.

“You can't just look at a patient who is waiting for service. You know this is a call. You have to work. I don't think we were motivated per se; it is your duty.” (Laboratory Tech.)

“It was just to work. Like at the end of the day you specialized in healthcare because you are compassionate, you want to help people, so those were the things that would keep me going.” (Pharmacy staff)

4.4.2 Sensitization and Uptake of Healthcare Services by Patients

Health providers reported widespread misuse of health services by patients because the services were free. Some of them noted that the conditions patients presented with could have been managed at home or with a simple over the counter medication or better still at lower level facilities. Patients also demanded for services like laboratory tests, some of which were deemed unnecessary by clinicians. It was reported that some even became violent and could not listen to reason. This resulted in overcrowding, work overload for healthcare workers and depletion of the limited supplies that could have helped those that really needed the services.

“Someone would request for an X-ray, ultrasound or CT scan for some random pain or minor ailments that could even be treated in the dispensary or health centers.” (Clinical Officer 1, OPD)

“Like for labor ward we would have like 10-15 ambulances bringing mothers even those who were not in labor but just had minor complaints. Such complaints did not warrant referral to our facility and would have been managed in lower level facilities.” (Nurse 1, Maternity)

“So many patients came even those who weren’t really sick and just had a headache, they just come for the free drugs.” (Pharmacist)

The providers attributed the misuse of services to a number of factors including free services, Lack of proper sensitization and education of users, weak referral system and ineffective service provision at lower level facilities. On free services, the providers reported that when user fee was still in place, only legitimate cases would come to the hospital. They felt that having users pay a subsidized amount would have created some form of responsibility and curb misuse.

“I think for me free things are not the best. People misuse free things. So I think they should have put up a system whereby people pay something for the services.” (Clinical Officer 1, OPD)

When discussing sensitization and education of users, providers reported that patients were very entitled and demanded for these services even when deemed unnecessary by clinicians. Some patients were overly aggressive to the extent of getting violent if their unreasonable demands were not being met. Providers were of the view that health education to the users at the community level on what their obligations were and when to seeking these services, would have been helped in preventing such incidences.

“I feel health education could have been helpful because there are some things that can be treated at home or lower level facilities.” (Clinical Officer 2, OPD)

Providers also reported that the existing referral system was weak and ineffective and that service provision at lower level facilities was ineffective. According to the providers, patients were by-passing the low level facilities to come to Machakos Level 5 hospital even for conditions that could be managed at lower levels. The referral system was clearly non-existent. There was the belief among patients that they level 5 facilities were better equipped, had a wide range of services and that the healthcare workers were better skilled.

“A lot of people used to skip the lower level (health facilities) back home to come to Level 5 because services are free.” (Clinical Officer 1, OPD)

4.4.3 Planning and Stakeholder Involvement

The providers felt that planning was not adequately done. This included costing for a range of services which would inform resource allocation. There seems to have been a disparity between resources that were allocated for UHC and the need. First the human resources were overstretched and supplies ran out from time to time. The pilot was reported to have been concluded prematurely due to inadequate funding.

“I think they should do proper costing of services per patient for all points of care in order to estimate the amount of funds needed.” (Nurse 3, OPD)

“They didn’t have the real picture of what is happening on the ground. They should come to the ground, take the real analysis and talk to the stakeholders. This was not done.” (Nurse, Surgical Ward)

Providers also reported that they were not involved in the decision to pilot the UHC program. They felt that the pilot was imposed on them and without consultation or involvement. Some of the challenges they faced, they felt would have been mitigated if only their input had been sought before the program was implemented.

“It’s just like any other person hearing from the TV but we were never consulted.” (Clinical Officer, Theatre)

“Am not aware if frontline workers were involved but I think maybe it came from up there. You know sometimes things are imposed.” (Nurse, surgical Ward)

“We were just told its UHC everything is free; you just give everything for free so there was not even a proper take through of what is going to happen in the hospital. I think one thing we lack as a country is a system of communication. The way we channel communication from bottom-up and up-bottom is really poor. We don’t communicate properly.” (Pharmacist)

4.4.4 Support for NHIF as a Driver for Financing Healthcare

Most of the providers overwhelmingly were supportive of the idea of making NHIF the driver of healthcare financing. They felt that increasing contributions to NHIF would increase the pool of funds available to finance health services. NHIF was also supported as a way of ensuring efficient use of services by users. However, they mentioned that some reforms needed to be made to make NHIF more effective such as ease of access to services and equitable NHIF contributions.

“I think NHIF would work if they ensure contributions are equitable, that is, those who are paid higher contribute more and then if it is pooled up it supports people with lower income.” (Laboratory Tech.)

“People misuse free things. NHIF is a very good mode of paying because you know you have to pay monthly for you to come to the hospital, someone will not misuse it.” (Clinical officer 1, OPD)

4.4.5 Support for Universal Health Coverage

Despite the challenges faced during the UHC pilot and its premature end, health providers supported the idea of scaling UHC in the whole country after addressing the gaps identified. The main reason for this was that many people especially the needy were able to access healthcare services when it was available without the burden of catastrophic expenditure.

“People were able to access treatment. Even the old grandmother in the kijiji would come to the hospital unlike today where people come to the hospital when their condition has worsened due to lack of funds.” (Nurse 2, OPD)

Diagnosis for chronic illnesses such as cancer and diabetes were made early and treatment started early leading to better outcomes. Obstetric complications were reduced or managed promptly because expectant mothers were able to access healthcare early.

“Diagnosis for cancer was done faster and the decision to management, either managing in our facility or to refer to either KNH, was faster compared to now hence delay of care because of finances.” (Medical Officer, Inpatient)

“An expectant mother with previous scar would call, come to the hospital early enough, be attended to and go home. Ruptured uterus cases were not heard. Patients laboring and being attended to by traditional birth attendants (TBAs) was history because they only

needed to call an ambulance and they would be brought to the hospital.” (Nurse 1, Maternity)

4.4.6 Role of Private Institutions

It was mentioned that private institutions play a big role in providing healthcare hence should be included in the decision to implement UHC as a form of public private partnership.

“The private sector should also be consulted because they play a role. Most people don't go to private facilities because of expenses. The government can control pricing for example they can say consultation fee for this service should not go beyond here.” (Radiology staff)



CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter consists of discussion of the findings in relation to the study objectives, conclusion drawn and recommendations of the study.

5.2 Discussion

In December 2018, Kenyan President Uhuru Kenyatta announced the launch of a universal health coverage (UHC) plan. The first pilot phase dubbed Afya Care was to cover four strategically located Kenyan counties, that is, Kisumu, Nyeri, Isiolo and Machakos. Following review of the pilot, the plan was to be scaled up to the rest of the country with the aim of reaching 100 percent coverage by 2022. Under the pilot programme, user fees were discontinued at secondary public hospitals and in return, the selected counties were to receive commodities and reimbursements from the national government. Households were expected to be registered in order to access the services.(Nzwili, 2018).

This study set out to explore the perceptions and perspectives of frontline healthcare workers in one of the pilot counties, Machakos, on how the UHC pilot was implemented. This was important because it is common to observe a gap between what was planned and what actually occurs in policy implementation. (Buse et al., 2012b). Moreover, these perspectives could inform scaling of UHC in the country.

Frontline health workers are key in implementation of directives. Michael Lipsky in his Street Level Bureaucracy theory, describes the workers as street level bureaucrats, that is, public servants who have discretion over dispensation of government benefits, in this case free health services, and through whom citizens obtain such services. (Lipsky, 2010). Lipsky further posits that these bureaucrats can exercise discretion and make modifications when implementing these policies due to challenges they face such as growing demand for services, vague expectations and lack of enough resources to achieve set objectives. (Lipsky, 2010). In the Machakos pilot case, frontline health workers

understood and interpreted the UHC directive in varied ways. They reported unclear instructions from management and as a result, there were inconsistencies in service provision.

The specific objectives that were explored included frontline health workers' perspective on policy fidelity, effects of UHC policy on service provision and barriers to and facilitators of UHC pilot implementation.

5.2.1 Policy fidelity from the perspectives of frontline health workers

the UHC pilot program was intended to give Kenyans who were registered for the pilot, access to quality health care services without suffering from financial hardship hence user fee was removed (Ministry of Health, 2020). The pilot was intended to run for one year starting December 13, 2018 (MOH, 2020). Our findings show that the pilot program managed to reach a wide coverage of Machakos County's population that were registered hence a many people benefited from free services. Free services however became unsustainable therefore the facility reverted back to charging user fee, which was what the program was aiming to get rid of in the first place.

5.2.2 Effects of UHC pilot on health services provision

As mentioned earlier, user fee was removed during the UHC pilot program. The effects of removal of user fee have been well documented in literature. Our study shows there was marked increase in outpatient service utilization and secondly, loss of revenue. This meant that the facility was not able to cope with the increasing demands for services leading to compromised quality of services and negative user consequences such as out of pocket expenditure for services referred outside the facility. Similar experiences on removal of user fees have been reported in South Africa, Nigeria and Burundi. (Wilkinson et al., 2001) (Ridde & Diarra, 2009), (Nimpagaritse & Bertone, 2011). Health policy scholars have cautioned against abrupt removal of fees for service delivery (Gilson & McIntyre, 2005) since increased utilization of services have been found to be unsustainable following removal of fees (McPake et al., 2013).

The study found that there were inadequate human resources to provide services for the influx of patients resulting in increased workload and burn-outs. This is in keeping with

review done in Isiolo (Guyo & Vilcu, 2020) and other studies done in countries such as Nepal and Zambia (McPake et al., 2013). With increased patient services the quality of care provided was compromised for instance, midwives had to take a brief history in order to clear the queue. There was also misuse of services by users leading to unnecessary workload for the health workers. As a results of increased workload without proper incentives, the providers reported dissatisfaction, low morale, burnout and reduced motivation to work. This phenomenon was also reported in a similar study in Kenya by (Lang'at & Mwanri, 2015) and in Burundi by (Nimpagaritse & Bertone, 2011). Pyone et al, (2016) also reported that increased uptake of free maternity services in Kenya led to increased workload of healthcare workers contributing to weak free maternity policy implementation, among other factors.

However, the findings also show that health seeking behavior of the target population improved evidenced by the increased uptake of health services. Chronic illnesses such as cancer, renal diseases and diabetes were diagnosed early enough and proper treatment given which led to better outcomes. On maternal health, cases of delivery at home were unheard of since mothers were able to access services by calling an ambulance.

5.2.3 Barriers and facilitators of the UHC pilot implementation

The analysis identified funding, supply side challenges, poor planning and inadequate stakeholder involvement as some of the barriers in the implementation of the pilot.

In Kenya, the main sources of revenue for counties for healthcare expenditure include allocation from national government, local revenue from generated from user fees and health insurance reimbursements and conditional grants from donors (Tsofa et al., 2017). The counties are also free to decide if facilities can retain and spend their own source revenue according to The Public Finance Management Act. During the UHC pilot, an agreement was reached between the national and the 4 county governments to remove user fees in level 4 and 5 facilities. The lost revenue from user fee was to be reimbursed by the national government in collaboration with development partners through conditional grants (Vilcu et al., 2020).

Our findings show that the reimbursements were inadequate and inconsistent resulting in funding challenges during the implementation of the UHC pilot in Machakos County. This is in keeping with similar findings in Isiolo County (Guyo & Vîlcu, 2020) where the UHC program was piloted as well, and on free maternal healthcare program implemented in Kenya (Tama et al., 2017), (Pyone et al., 2017). In addition to inadequate funding, other supply side challenges included inconsistent supply of commodities by KEMSA and inadequate human resource for health.

Analysis indicates that planning was poorly done. This was evidenced by challenges discussed above leading to the pilot ending prematurely. It seems that the pilot was rushed since it was a political pronouncement and leaders felt they were obligated to roll it out. A similar scenario was also observed during implementation of free maternity policy in Kenya. (Tama et al., 2017) as well as in Burkina Faso and Nepal. (Ridde & Diarra, 2009);(Witter et al., 2007).

Data also shows that providers were not involved in the decision to pilot the UHC neither was their welfare looked into despite the work overload and inadequate supplies to offer services. A top-down approach to policy implementation was adopted for the UHC pilot program. This approach, though commonly used, can have many challenges when it comes to implementation. A more participatory approach involving people on the ground would have been more useful given that there could be a sharp difference between the information available on the ground and centrally. The frontline health workers have more detailed information on what happens on the ground hence could have guided the implementation of the program. (Nimpagaritse & Bertone, 2011). Participation in designing the benefit package was also necessary to ensure equity. Beneficiaries needed to be informed of their entitlements and also their obligations to curb misuse that was experienced.

5.3 Conclusion

The program managed to achieve its objective of increasing access to care for the target population without suffering catastrophic expenditure in the initial stages when funding was available. This was evidenced by increased uptake of health services free of charge. Due to increased access, patients benefited from early diagnosis and management of

diseases and conditions which would have otherwise resulted in complications and morbidities.

However, the program was marred by various challenges. First, there was inadequate, inconsistent and delayed funding that could only allow partial implementation of the program and eventually rendered free services unsustainable. Secondly, inadequate human resources that lead to compromise in quality of services and dissatisfaction of staff. Lastly, lack of proper involvement of relevant stakeholders especially the frontline health workers and users which could have provided more beneficial baseline data to guide in implementation. The role of the private sector cannot be ignored given that they contribute a significant percentage in provision of healthcare services.

Going forward, the highlighted issues need to be addressed as the government is in the process of scaling UHC countrywide.

5.4 Recommendations

Based on the findings, to ensure successful implementation of UHC, the following are recommended. First, the Kenyan government should increase budgetary allocation and intensify efforts in mobilizing funding for healthcare considering declining donor funding. There should be clear structures in place to ensure efficient and effective allocation of the available funds to maximize health outcomes. Second, local county departments should provide adequate human resources for health workers who have the right and attitude to provide quality services as well as have a retention strategy. Third, there is a need for strengthening lower level facilities and improving referral systems to curb overcrowding at higher level facilities and misuse of services. Lastly, MOH should engage all key stakeholders when planning and collaborating with the private sector to make sure services still remain affordable.

5.5 Study limitations

The study only focused on the views of the frontline workers without the input of management which could have shed more light on some of the challenges highlighted. The study also did not include any statistical data to substantiate the views of the frontline workers hence a generalization cannot be made.

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APPENDICES

APPENDIX I: INTERVIEW GUIDE

Study Title: Healthcare workers' perceptions towards implementation of UHC Pilot in Machakos Level 5 Hospital

Respondent details

Name	
Gender	
Age	
Qualification/Cadre	
Department	

Respondent profile

1. How long have you worked in this facility?

Policy fidelity

1. In your understanding what is UHC and what does it aim to achieve?
2. Why do you think Machakos county was selected for the pilot?
3. Are you aware if frontline health workers were involved in the decision to pilot UHC? If yes, how and which cadres?
4. What was the pilot aiming to achieve? In your opinion was the objective met after the pilot?

Do you think the UHC pilot had an impact on health outcomes in the county? Could you provide some examples?

5. Who in your opinion are the key structures/people or systems that are in place or need to be put in place to make these UHC interventions work at their best and to become part of routine services?

Effects of the pilot on service provision

1. During the pilot the services were offered for free to those that were registered for UHC. What are your views on removal of user fee?
2. Was there any change in how you give care to your patients when UHC pilot was introduced?
3. What are your thoughts on quality of services provided during the pilot?
4. How available were supplies needed to give services?
5. Have your patients approached you to discuss UHC? What issues did they raise?
6. Has anything changed in the facility since the pilot?
7. What was the impact of the pilot generally?

Barriers and facilitators to UHC provision

1. what do you think are some of the factors that influenced the implementation of UHC pilot?
2. In your view did the UHC pilot succeed or fail and why?
3. What do you think should be done differently?

Way forward

1. UHC was piloted in 4 counties only, what do you think about scaling it up to all 47 counties?
 - a. What would be the challenges?
 - b. What components of the pilot should be adopted and strengthened?
 - c. What should be done differently and how?
2. Do you have anything else you would like add?

Many thanks for your time – Do you have any questions for us?

APPENDIX II: PARTICIPANT INFORMATION SHEET AND CONSENT

Title of Project: Healthcare workers’ perceptions towards implementation of UHC Pilot in Machakos County

Strathmore Business School – Institute of Healthcare Management.	Winnie Abuto
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Who is carrying out this study and what is this study about?

This study is being carried out by Winnie Abuto, a masters student at Strathmore University’s Institute of Healthcare Management.

All research at Strathmore has to be approved by the university’s ethics board and NACOSTI before it begins. They must agree that the research is important, relevant and follows agreed research guidelines.

In this research we want to learn more about your views about the UHC pilot specifically on fidelity to policy, effects of UHC on service provision and implementation barriers.

We are carrying out in-depth interviews with doctors, clinical officers, pharmacist/pharmaceutical technologists, laboratory technicians and nurses at Machakos Level 5 Hospital who were working during the pilot phase.

The study is being conducted by independent researchers – we are not part of MoH, County Government or regulatory Boards and Councils. We are not here to assess your performance but to hear your views and opinions.

Why should you talk to me, and what does it involve?

You have been selected to participate due to your role as a frontline health worker during the pilot. If you do not wish to answer any of the questions you may say so and I will move on to the next question. Only the note taker and myself will be present unless you would like someone else there.

Are there any disadvantages or benefits to me of taking part?

- The discussions should take approximately 30 minutes to one hour, but this will be highly dependent on how much you will have to say.
- There are no individual benefits to taking part. However, in talking to us, you will provide us with useful information that will be shared with national and county managers to help improve service provision.

Who will have access to the information I give?

- We will not share individual information about you or other participants with anyone beyond a few people who are closely concerned with the research. All of our documents/ recordings are stored securely in locked cabinets and on password-protected computers.
- We will share summaries of research findings with other researchers and health policy makers through reports, presentations at meetings and publishing papers in scientific journals.
- Any future research using information from this study must be approved by an expert committee to make sure that the interests of participants and their communities are protected.
- If you agree, we will record the discussions. The voice recordings will be used to write up the information that you give but we will remove any information from these records that could identify you in person. This includes removing your name and any other personal or professional information that might identify you. Audio recordings will be destroyed after transcription and data analysis.

What will happen if I refuse to participate?

All participation in research is voluntary. You are free to decide if you want to take part or not. Even after agreeing, you can still change your mind at any time without any consequences, or choose to not answer specific questions if you are uncomfortable.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact me using the contacts below:

Winnie Abuto 0712679117, winnie.abuto@strathmore.edu

If you want to ask someone independent anything about this research, please contact:

The secretary, Strathmore University – Institution Review Board – P.O Box 59857 – 00200, Nairobi, Kenya. Tel: +254 703 034 375. Email: ethicsreview@strathmore.edu

In order to protect your privacy, signatures will not be collected. By participating in the study it implies you have given your consent.

To be filled in by interviewer

I certify that this participant (name of participant) from (Machakos Level 5 Hospital) has been informed about the study, and has had the opportunity to ask questions which have been answered satisfactorily. He / She apparently understood the nature and the purpose of the study and consents voluntarily to participate in this study. He / she understands that he / she has the right to withdraw from the study at any time.

They agree to the following (tick where appropriate):

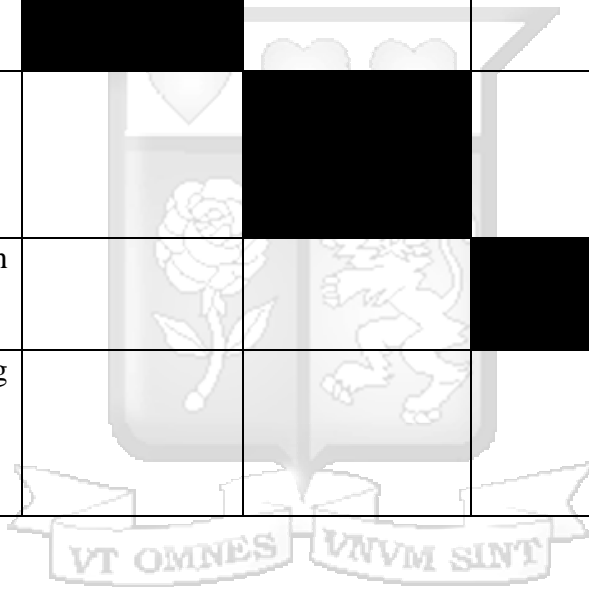
- Agree to be interviewed
- Agree for the interview to be recorded
- Agree for their quotes to be used anonymously in publications or reports released on the study

Researcher’s signature: _____ Date: _____

Researcher’s name: _____ Time: _____

APPENDIX III: GANTT CHART

Timeline/ Activity	January- March 2022	April- September 2022	October- December 2022	January- May 2023
Choice of research topic, development and presenting concept note				
Proposal development and presenting				
Data collection and analysis				
Report writing and presentation				



APPENDIX IV: BUDGET ESTIMATES

Item	Activity	Quantity	Unit Price (Ksh)	Total Amount
Proposal	Printing	30 pages	20	600
	Photocopying	4 copies	300	1200
	Binding	4 copies	200	800
	Miscellaneous	-	-	2000
Project	Travelling cost	-	-	20000
	Research assistant stipend	1	20000	20000
	Audio recorder	2	2000	4000
	Data Collection	-	-	20000
	Data analysis	-	-	20000
Final document	Printing	100 pages	20	2000
	Photocopying	5 copies	500	2500
	Binding	5 copies	200	1000
			Subtotal	94,100
			10% Contingency	9410
				103,510

APPENDIX V: RESEARCH INTRODUCTION LETTER

Ole Sengale Rd, Maceraka Estate,
P.O. Box 59857 00200, Nairobi, Kenya,
Cell: +254 703 414/6/7, Twitter: @S95Kenya
Email: info@sbs.ac.ke or visit www.sbs.strathmore.edu



13th June 2022

To whom it may concern,

RE: FACILITATION OF RESEARCH – WINNIE ADHIAMBO ABUTO

This is to introduce Winnie Adhiambo Abuto who is a Master of Business Management in Healthcare Management (MBA-HCM) Student at Strathmore University Business School, admission number MBA-HCM 120390/20. As part of our MBA-HCM Programme, Winnie is expected to do applied research and undertake a project. This is in partial fulfilment of the requirements of the MBA-HCM course. To this effect, Winnie would like to request for appropriate data from your organization.

Winnie is undertaking a research paper on “**HEALTH WORKERS’ PERCEPTION TOWARDS IMPLEMENTATION OF UHC PILOT AT MACHAKOS LEVEL 5 HOSPITAL, MACHAKOS, KENYA.**” The information obtained shall be treated confidentially and shall be used for academic purposes only.

Our MBA-HCM Programme 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 sincerely,

A handwritten signature in black ink, appearing to read "Caroline Tiara".

Caroline Tiara.
Manager – Graduate Programs.
Strathmore University Business School.



APPENDIX VI: ETHICAL APPROVAL



1st August 2022

Ms Abuto, Winnie
winnie.abuto@strathmore.edu

Dear Ms Abuto,

RE: Healthcare workers' perceptions towards implementation of UHC Pilot in Machakos Level 5 Hospital


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-IERC1395/22**. The approval period is **1st August 2022 to 31st July 2023**.

This approval is subject to compliance with the following requirements:

- i. Only approved documents including (Informed consents, study instruments, 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 affected 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 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 expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days upon completion of the study to SU-ISERC.

Prior to 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: Prof Fred Were,
Chairperson; SU-ISERC



APPENDIX VIII: MACHAKOS AUTHORIZATION LETTER

REPUBLIC OF KENYA



GOVERNMENT OF MACHAKOS COUNTY
DEPARTMENT OF HEALTH AND EMERGENCY SERVICES
Office of the County Director of Medical Services

Telephone: +254-44-20575
Fax: 254-44-20655

Machakos Highway
P.O. Box 2574-90100
Machakos, Kenya

19/10/2022

Ref No. MKS/DHES/RSCH/VOLI/251

Dear Ms Winnie Abuto,

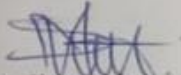
RE: LETTER OF AUTHORIZATION FOR CONDUCTING PROPOSED RESEARCH

The Department of Health and Emergency Services, Machakos County is keen to collaborate in your study titled, *"Health workers' perceptions towards implementation of Universal Health Coverage pilot at Machakos level 5 hospital, Machakos, Kenya."*

Note is taken of the letter of Ethical clearance from SU-ISERC, REF: SU-IERC1395/22. for the approval period **1st August 2022 to 31st July 2023** as well as the Research License from the National Commission for Science, Technology & Innovation number NACOSTI/P/22/19453 for the period ending **21st August 2023**.

You are hereby authorized to proceed with the research in Machakos County and urged to share the findings with the Department of Health and Emergency Services; Machakos County, through this Email: research.dhes@gmail.com

Sincerely,



Dr. Sharon Mweni
County Director Medical Services & Research.
Machakos County

Cc:
County Executive Committee Member – Health
Chief Officer – Medical Services
Chief Officer – Public health & Community Outreach