

Towards Universal Health Coverage: An assessment of the Healthcare System in Kenya Between 2017 -2020

Ruth A. Owino

Department of Mass Communication - Kabarak University,
P. O Box Private Bag 20157, Kenya

rowino@kabarak.ac.ke

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ABSTRACT

This study explored the universal health coverage (UHC) process in Kenya through the lens of its potential to progressively realize the constitutional promise of the right to the highest attainable standard of healthcare. The health sector in Kenya has experienced tremendous changes since the introduction of the Big Four Agenda. In 2018, the government piloted a universal health coverage program in four counties, where there was abolition of all fees, more than 200 community health units were launched, and 7700 community health volunteers with over 700 health workers recruited (MOH, 2020). The government in its efforts to achieve the Big Four Agenda is in the process of scaling up universal health coverage, reforming the national hospital insurance fund and establishing a mandatory health coverage scheme. This study sought to examine the framing of UHC within the context of the Big Four agenda; assess the healthcare system between 2017–2020 and; investigate the challenges faced in the implementation of UHC in Kenya. The researcher utilized document analysis to collect the relevant data using a coding schedule. A purposive search was conducted to identify key policy and relevant documents for this study. Eighteen documents were sampled for data analysis and interpretation. The findings reveal that Kenya's healthcare facilities index stands at 59%, with a density of 2.2 per 10,000 population, the workforce density is at 15.6/10,000. Several strategies and programs such as Afya Care, abolished maternity fees for mothers delivering at public facilities, and expansion of the National Health Insurance Fund (NHIF), have been initiated to drive the UHC agenda. The Ministry of Health's (MoH) budget also continues to rise, in 2018/19 the MoH received its largest allocation. The findings indicate there is commitment towards UHC though with minimal financial support; cases of dysfunctional healthcare system; medicine stock outs, inadequate medical supplies and healthworkers, dilapidated health infrastructure, and governance concerns at NHIF. In lieu of these, this study recommends the increase of sustainable healthcare financing; support to enhance devolution of healthcare, engagement of various stakeholders in the enactment of UHC; investment in health infrastructure, training of medical workers; and revamping NHIF into a full-fledged health insurance scheme.

Key words: Universal Health Coverage, Health Equity, Healthcare System, Big Four Agenda

I. INTRODUCTION

The right to health is a fundamental human right, that every human is entitled to the highest attainable standard of health conducive to living a life in dignity (UN Doc. No. E/C. 12/2000/4, 2000, No. 14). According to the Committee on Economic, Social and Cultural Rights (General Comment No. 14), the universal right to accessible, affordable, and acceptable healthcare is a fundamental right. The right to health imposes legal obligations on state parties requiring that health care be both comprehensive and progressive in accordance with World Health Organization (WHO) seven principles (UN Doc. No. E/C.12/2000/4, 2000). These includes the principle of progressive realization, which requires each state

to employ the maximum available resources to advance the right to health for all. The second principle is the non-discrimination that requires the availability, accessibility, and quality of health care suitable for all. Third, the principle of cost-effectiveness requires that states make choices about the health care provided by allocating resources so that they benefit the larger population.

The fourth principle is the participatory decision-making that requires states to develop a national public health strategy and plan of action through an inclusive, participatory, and transparent process. Fifth principle is on the process of developing the national strategy and plan of action that requires special attention be paid to the needs of those made vulnerable or marginalized. The sixth principle is on the provision of essential drugs, as defined under the WHO Action Programme on Essential Drugs, for equitable distribution to all health facilities. The seventh principle is shared responsibility, enshrined in Article 2(1) of ICESCR, that commits parties to take steps in achieving progressively the full realization of the rights to healthcare (UN Doc. No. E/C12/2000/4, 2000).

In Kenya, the government initiated several policy reforms and strategies towards achieving UHC. Some of these policies include Health Act No. 21 of 2017; Health Policy of 2013 -2030, Planning, Budgeting and Performance Review Process Guide for Health Sector (2019); Policy Brief on Pathways to Optimal Health Infrastructure; NHIF Strategic Plan 2018-2022; Vision 2030, Constitution of Kenya 2010, and the Health Bill of 2015. With the support of key global players including WHO, World Bank and United Nations, Kenya has made significant progress in its efforts to the realisation of UHC (UN Resolution on Universal Health Coverage, 2014; WHO, 2015). Universal Health Coverage has increasingly been embraced at a global level as a priority in the post-2015 development agenda (UN Resolution on Universal Health Coverage, 2018). Health is acknowledged as essential for human welfare and sustained economic and social development (WHO, 2018). When people have poor health or lack health services, they are more often than not vulnerable to poverty. It is therefore important to ensure there is equity, access to health services for healthy and productive populace, while at the same time, safeguarding them from financial risks (UN Resolution on UHC, 2018).

II. STATEMENT OF THE PROBLEM

According to WHO (2019), millions across the globe still lack access to basic health care services; and the costs associated with utilizing health services places an immense financial burden on many. Global statistics indicate that every year, nearly 150 million people experience catastrophic health expenditure due to out-of-pocket payments hence forcing them to forego their basic needs (O'Donnell & Wagstaff, 2012). The Global Burden of Disease ranks Kenya at index 55 percent (WHO, 2018). The absence and inadequacy to quality and affordable services continue to compromise patient's safety, child and maternal health, and overall health service delivery (Wangia & Kandie, 2020). Article 43 (1) (a) of the Constitution stipulates that every person has the right to the highest attainable standard of

health. UHC is also one the key pillars under the “Big Four” agenda that has seen government launch UHC pilot programme in Nyeri, Kisumu, Machakos and Isiolo Counties. These counties were selected as pilot sites based on the prevalence of unique health needs among their populations. Nyeri County was selected due to the high burden of non-communicable diseases; Kisumu due to the high prevalence of infectious diseases like Malaria; Machakos due to high prevalence of injuries associated with road traffic accidents; and Isiolo due to the concerning cases of maternal mortalities.

However, only Isiolo and Machakos counties piloted the UHC project to conclusion. In Kisumu, the project was a non-start from the beginning, in Nyeri the project was terminated due to financial constraints. The failure to effectively transition the pilot into a fully functional national project presented further crisis of private health providers to cash in and increase the cost of healthcare. The attainment of equity and access to healthcare remains elusive due to the inequities that exist within the healthcare system including regional disparities, poverty, education, gender and age. The country’s average inpatient bed intensity is at 13.3 beds per 10,000 population which is below the WHO target of 25 beds per 10,000 population. Worse still, only 19 percent of Kenyans have a health insurance cover (NHIF, 2020), meaning most Kenyans access healthcare through out-of-pocket payments, or avoid healthcare services unless they are in advanced stages of the disease. There is need to address these inequities by assessing the healthcare interventions and policies. It is against this backdrop that this study examined the framing of UHC within the context of the Big Four agenda; assessed the healthcare system in Kenya between 2017 - 2020; and, Investigated the challenges faced in the implementation of UHC.

III. OBJECTIVES OF THE STUDY

The following were the objectives of this study:

- Examine the framing of UHC within the context of Big Four agenda (2017 -2020)
- Assess the healthcare system in Kenya between 2017 -2020
- Investigate the challenges faced in the implementation of UHC in Kenya

IV. LITERATURE REVIEW

Overview of the health system in Kenya

The provision of the health services in Kenya are under four main sectors: public, private, faith-based and non-governmental organizations (NGOs) (MOH, 2016). While the private and faith-based institutions are a mix of profit and not-for-profit agencies, the public sector operates the largest share of healthcare facilities in the country, and is the major health service provider in the rural areas. As such, access to health services by the majority of Kenyans is largely influenced by the functionality of the public health sector. The public health sector is characterized by inadequate and mismanagement of funds, inefficiencies, shortage of health workers, inadequately equipped facilities, dilapidated infrastructure, medicine stock outs; hence limiting the availability and quality of health services

(Wangia & Kandie, 2020). Service delivery is compromised due to staff shortages, and healthcare workers who prefer working in urban than rural areas (KMPDU, 2018). The inability to retain key specialized health workers in the public service has had a negative impact on the healthcare system. In many cases, the specialized doctors have either opted to join private practice or resigned to pursue further studies (Luomo et al., 2010). This has resulted to patients receiving services from less qualified personnel or seek alternative services from private facilities which are relatively expensive, thereby negating the financial risk protection (KMPDU, 2018).

Kenya is a signatory to the 2030 Agenda for Sustainable Development Goals (SDGs), and has committed to put in place the appropriate measures and investments to ensure healthy lives and promote well-being for all. The attainment of SDG 3 and that of UHC is underpinned on the financial risk protection, access to quality essential healthcare services, and access to safe healthcare. Laying a firm foundation for UHC in Kenya is the Big Four Agenda, whose one of the pillars is accelerating implementation of the UHC agenda, by improving the access, affordability and quality of healthcare. Towards achieving UHC, the government introduced different programmes including free maternity services; abolition of user fees in primary health facilities; waived user fees for maternity delivery services (Free maternity services); launch of UHC pilot programmes in four counties; EDU Afya (medical insurance for all public secondary school students), and health insurance as a subsidized programmes for the elderly, poor and persons with severe disability (MoH, 2018). A critical focus on use of community health workers in service delivery was introduced, with a community strategy implemented across the country. The health insurance programme requires employers to contribute and is also open to voluntary contributions from citizens in the informal sector (Barasa, Rogo, Mwaura and Chuma (2018). The health services were also devolved to the 47 newly formed counties.

There has been an increase in the number of health facilities providing Kenya Essential Package for Health (KEPH) services from 41 percent (2013) to 55 percent (2016) and to 57 percent (2018). However, with this increase in demand for services, the quality and access to healthcare services is still a challenge especially in rural areas and marginalised communities. There are still substantial differences within the country, with an increased per capita outpatient utilisation rate from 1.8 in 2012/2013 to 2.2 in 2018 (Kenya Harmonised Health Facility Assessment, 2018). The number of admissions per year also indicates a decline, from 38 per 1,000 population in 2013 to 35 per 1,000 population in 2018, with an average length of stay (ALOS) of 7.8 days (Kenya House Health Expenditure and Utilisation Survey, 2018). There has been an increase in facilities that provide high level, specialised care in the counties. The national community health strategy has been revised and updated. The country has also developed a national referral strategy that provides clear guidelines on referral processes (MoH, 2019). While the country's health budget allocation is on the increase,

achievement of the 15 percent set by the Abuja Declaration which is bound to accelerate Kenya's journey towards UHC still requires a significant amount of funds (MoH, 2018).

National Health Insurance Fund (NHIF)

The National Hospital Insurance Fund (NHIF) is a state corporation whose primary mandate is to secure Kenyans from financial risk occasioned by the high cost of healthcare services (NHIF, 2018). According to its 2018–2022 Strategic Plan, it should do this by pooling funds for affordable, accessible, sustainable and quality health insurance. The expansion of the health insurance in Kenya is much viable through NHIF, that should not only focus their effort on formal sector employees but also include the informal sector (Health Financing Strategy (KHFS) 2016-2030). NHIF however continues to face governance challenges and negative media coverage, that has created perception of a politicised institution who wholly relies on contributions from members. According to NHIF strategic Plan 2018 - 2022, the management and board is accountable to the government and not directly to its members. The Fund deals with mandatory contributions from the public, which have been on the increase for the last five years. In the past, media coverage of NHIF has been tainted by corruption allegations (The Standard Newspaper, 2020; Business Daily, 2021).

In 2018, NHIF lost more than Kshs. 10 billion in false medical claims (Standard Newspaper, 2020). Auditors had flagged the figure as fraudulent and said it was part of approximately Kshs. 50 billion that was to be paid to NHIF by the Treasury as capitation premiums for medical cover for civil servants, Kenya Police Service, National Youth Service, and Kenya Prisons Service since 2013 (Business Daily, July -2021). In late 2019, NHIF was linked to corruption in county governments where healthcare providers falsely billed the Fund for non-existent surgical procedures. In early 2020, the Fund drew up rules requiring individuals who voluntarily join the scheme to wait for three months before accessing benefits, contrary to the NHIF Act, a decision that could hamper their access to healthcare under UHC. Making NHIF an effective social insurance fund will increase the insurance coverage, strengthen the financing of primary care, increase domestic spending for essential programmes, improve the efficiency of budget allocation while engaging the private sector to enhance supply and choice of healthcare (NHIF Performance Report: Strides Towards Universal Health Coverage for all Kenyans, 2019).

According to NHIF Performance Report (2019) the financial sustainability of NHIF is dependent on sufficient revenues, expenditures, assets and liability management. Payment of out-of-pocket expenditures for health services has become a major barrier to access, it is currently estimated at about 40 percent of total health expenditure (Barasa, Rogo, Mwaura & Chuma, 2018). The current healthcare system in Kenya is a mixed model comprised of nine different models including: one, general tax financing where there are 'free' services in public health facilities; two, NHIF scheme where the fund collects revenue, pools funds and purchases care on behalf of its members (MOH, 2018).

The third model is the private health insurance (voluntary) provided through the medical insurance providers that are currently regulated by the Insurance Regulatory Authority (IRA); four, employer self-funded schemes that are financed by annual budgets and are either managed in-house or through third party administrators (TPA); the fifth is the community based health-financing (CBHF) schemes that finance the low-income earners, and often finance other needs outside healthcare (Bultman, 2014). The sixth model is the out of pocket (OOP) health spending which are very high, and are a major financial barrier to accessing healthcare services; seven, donors and non-governmental organisations (NGOs) who have contributed significantly to healthcare financing and provision of services such as PEPFAR at \$607 million, Global Fund for HIV/Aids, TB and malaria at \$378 million and the World Bank who has so far contributed over \$100 million (Barasa, Rogo, Mwaura & Chuma, 2018).

The eight model is the Health Sector Services Fund (HSSF) which is a form of supply side financing to Level Two and Three health facilities (mainly in the public sector). It is aimed at improving service availability and quality, particularly for low-income earners and the poor. The ninth model is the output-based approach reproductive health voucher (OBA) which targets the poor, who buy vouchers at a token price and redeem them within a specific provider for certain health services. The current vouchers cover maternal health, family planning and gender-based violence (Barasa, Nguhiu, McIntyre & Di, 2019).

Universal healthcare and the big four agenda

In 2008, the government launched Vision 2030 that is anchored on economic, political and social pillars. The healthcare services are one of the priorities under social pillar, it recognizes that for the country to realize its set objectives, high quality of life is necessary (GoK, 2008). The Medium-Term Expenditure Framework (MTEF) affirmed government's commitment to the provision of equitable and affordable healthcare at the highest affordable standard (MTEF, 2010). This was to be realized through the provision of health infrastructure including equipment, stronger service delivery, risk pooling finance mechanisms, and effective social solidarity through health insurance (NHIF, 2015). The government further committed to social health protection for all Kenyans through social health insurance and tax financing for financial protection of the poor and vulnerable groups (Health Financing Strategy, 2013). The required legal framework for a comprehensive and people driven health care delivery is within the Constitution (2010). The Constitution specifically introduced a devolved system of governance, to enhance utilization and geographical access to quality care for all. There have however been near collapse of healthcare delivery due to the continuous strike by health workers, citing poor health infrastructure, delays in salary, lack of schemes, and political interference. All these issues necessitated the need to relook at the health care service delivery in Kenya.

In December 2017, President Kenyatta declared UHC as the third pillar of the five-year social and economic development strategy under part of the Vision 2030 (Presidential Delivery Unit, 2017).

Earlier in 2017, the President had signed the Health Bill (2015) into law, providing legal backing for the health sector and the rollout of the UHC Pilot. It also prioritised investment in public health infrastructure through provision of equipment, improvement of health service delivery, adoption of risk pooling financing systems and making aid more effective (GoK, 2018). The target of UHC is to reduce medical out-of-pocket expenses by 54 percent and ensure that essential medical services in public health institutions are subsidized. The government piloted the Afya Care -Wema wa Mkenya programme in Kisumu, Nyeri, Machakos and Isiolo counties (GoK, 2018). The government allocated Ksh. 3.1 billion to delivery of primary healthcare, restructured NHIF and Kenya Medical Supplies Authority (KEMSA) so as to end the persistent shortage of essential medicine and other critical supplies.

V. METHODOLOGY

Qualitative document analysis was used to analyze the framing of UHC within the context of the Big Four Agenda. The analysis was done using relevant documents such as policies, articles, legislations, guidelines, reports, briefs and monitoring tools. The documents were accessed using two methods. Desktop searches were conducted to identify and access key UHC relevant resources to answer the objectives of this study. Data responding to the challenges faced in the implementation of UHC was collected from routine data by the World Health Organization (WHO), Ministry of Health (MoH), United Nations (UN), National Health Insurance Fund (NHIF), Presidential Delivery Unit (PDU), and Kenya Medical and Practitioners Dentist Board (KMPDU). The data was supplemented by a review of donor reports and surveys conducted on UHC in Kenya. The abstract and summaries of the identified articles and reports published were reviewed to determine the relevance of the documents. Desktop searches on key phrases like “UHC in Kenya,” “UHC and the Big Four agenda” and “Healthcare financing strategy” “Financing UHC” “Implementation progress of UHC” “NHIF reforms” were done using google scholar. Second, the Ministry of Health, and PDU were contacted in person by the researchers from August, 2021–October, 2021 to validate the relevant documents.

Documents were based on three criteria after having been carefully screened. First documents comprehensively focused on UHC in Kenya. Second, documents with an agenda on UHC in terms of accessibility, quality and affordable healthcare. Third, documents as listed by official of ministry of health were identified and analysed. The documents were published from 2017 to 2020 because they set the foundation for drafting the current healthcare systems and policies under the UHC guidelines. The documents were categorized into two main areas: the first was based on scale on whether they were local, national or global; the second was based on the purpose in terms legislation, policy, guidelines, monitoring tool, plans or briefs. Table I (appendix I) shows the list of relevant documents included in this study. First, the documents were categorized based on scale, national or global. Second, based on the purpose of the document; legislation, policy, guidelines, monitoring tool, plans or briefs. In total, 19 documents were included, fourteen (15) national level, four (4) global and (1) local level. A coding

frame was developed based on the Accessibility, Quality, and Affordability of UHC. The frame was guided by the heuristic framework and policy triangle as guided by Walt et al (2008). See table II (appendix II) for coded frames. The themes were developed and data analyzed using key phrases like UHC, Big Four agenda, Healthcare infrastructure, Financing UHC, Healthcare Policy Implementation, and NHIF reforms.

V. FINDINGS AND DISCUSSION

The analysis and discussions were guided by the three objectives of this study; Examine the framing of UHC in the context of the Big Four agenda; Assess the healthcare system in Kenya between 2017 - 2020; and, Investigate the challenges faced in the implementation of UHC in Kenya

Examine the Framing of UHC in the context of the Big Four agenda between 2017 -2020

This research explored the framing of UHC based on the three main categories: Equity in access, Quality Health Services, and, financial risk protection.

Equity in access

Access to health care service is improving though there are still substantial differences within the country. The study found out that there is an increased per capita outpatient utilization rate (Service Availability and Readiness Assessment Report, 2018); and an increase in inpatient admission rate (MOH, 2018). There has been an increase in “staff and equipment services, expansion of maternity wings and facilities that provide high level specialized care at the counties” (Wangia & Kandie, n.d, p. 2). The national community health strategy has been revised and updated to ensure there is nation-wide hospital access (Health Sector Monitoring & Evaluation Unit, 2018). There is also a national referral strategy for referral processes and guidelines, abolished user fees at primary level facilities and maternity services; increased grants for improved access to quality primary healthcare (PHC), reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services (MoH, 2019). The study found out that government offers support on operation and maintenance costs for primary health care facilities (United Nations Development Assistance Framework 2018-2022); introduced slum upgrading project in effort to accessing healthcare services (MoH, 2018). The project has so far established several mobile clinics in 12 major towns, and a number of policy guidelines have also been developed to ensure the provision of quality accessible healthcare services.

Quality health services

The findings of this study reveal that the government adopted the Kenya Quality Model for Health (KQMH), which led to regulation, accreditation and level playing ground for quality healthcare services (Kenya Quality Model for Health, 2014). According to a policy brief titled ‘Pathways to Optimal Health Infrastructure’ (2018) several modalities of quality assurance were introduced including accreditation

of public health facilities, the use of ISO and Safe Care in private health facilities, regular inspections of health facilities, and regulation by professional bodies and government agencies in enforcing compliance to minimum statutory requirements. This study found out that there has been enhanced citizen accountability through community involvement in planning, budgeting and accountability (Planning, Budgeting and Performance Review Process Guide for Health Sector, 2019).

Financial risk protection

According to WHO report on financing health systems, many countries are faced with the three fundamental questions of “Where and how they can find the financial resources they need; How can they protect people from financial burden of health; and, How can they make optimum use of resources” (WHO, 2019, Para. 9). In order to achieve UHC, the study found out that the NHIF performance report dubbed ‘Strides towards universal health coverage for all Kenyans’ (2019), recommend adequate provisions for health resources to cushion people from financial risk. The report states that “financing healthcare system enables people to use all types of health services without incurring financial distress. The United Nations Development Assistance Framework 2018-2022 report that the health system in Kenya continues to face key challenges including “High levels of poverty; preventable infectious diseases and non-communicable diseases are of high burden to the county; Inadequate funding; Inefficient allocation and use of scarce resources” (p. 48). The Third Medium Term Plan 2018-2022 further identifies other challenges as “high out-of-pocket expenditure; dilapidated infrastructure; shortage and poor distribution of health workers; poor management of health facilities; dysfunctional referral systems leading to wastage of resources; and, high dependence on donors” (p. 72).

The Health Financing Strategy (2010) also reports that most of the healthcare expenditure in Kenya is used for curative services in urban health facilities. The research found out that the obligation to pay directly for services at the moment of need is a challenge for many who seek treatment in Kenya, and can result in severe financial distress. The NHIF Strategic Plan (2018) suggests ways in which government can raise funds to increase the efficiency of revenue collection which in turn will improve healthcare services; re-prioritising government budgets to 15 percent; provide innovative financing as alternative ways of raising funds for health budget.

Assess the healthcare system in Kenya between 2017 -2020

According to Kenya Harmonized Health Facilities Assessment (2018), the “national health facilities density in Kenya is 2.2 per 10,000 population, slightly surpassing the WHO target of 2 per 10,000” (p. 19). The report notes that 14 counties have health facilities density below the WHO target of 2 per 10,000 population. The assessment report further reveals that “the national healthcare workforce density is estimated at 15.6/10,000 compared with the WHO target of 23 per 10,000” (p. 22). The report states that “only four counties that have achieved well above WHO target, are: Tharaka Nithi (33.8), Nyeri

(31.0), Uasin Gishu (28.2) and Nairobi (26.3)” (p. 23). This means that majority of the counties are understaffed and struggle to provide quality health care. Kenya’s health facilities index of 59 percent, translating to nearly 6 in 10 facilities are prepared to provide health services (KHHFA, 2018). The report on Primary Health Care on the Road to Universal Health Coverage (2019) indicate that there is a tendency of high concentration of facilities in the western part of Kenya, central region, Nairobi, Mombasa and south coast, leaving behind the other parts of the county with poor or inadequate facilities.

The policy brief titled Pathways to Optimal Health Infrastructure in Kenya (2018) highlights the infrastructural gap and inadequate healthcare workers as major challenge. It further indicates that:

Between 2014 and 2018, the overall number of medical clinics (Level 2) grew from 2,575 to 3,646. Majority of them were privately-owned medical clinics. In 2014, private medical clinics accounted for 94.25 percent of the overall clinics compared with 94.26 percent in 2018. Health centres increased by 3.1 percent to 1,806 in 2018 and most of them were publicly-owned. On the other hand, Level 4 and 5 hospitals grew from 668 in 2014 to 771 in 2018 (p. 26).

The researcher found out that most facilities scored below average (47 percent) in having routine and systematic processes in place for checking the quality of data used for reports. The brief also revealed that just 10 percent of health facilities have developed policy guidelines for checking the quality of data utilised in official reports. The number of health facilities with a “routine process for performance review grounded on data on facilities, outcomes, or patient feedback is at 34 percent. Only 15 percent of health facilities have evidence of using patient survey data, while just 14 percent have evidence of use of mortality data” (p. 29). The results also indicate that government introduced the Linda Mama Programme which is a health insurance cover for expectant mothers, Health Insurance Subsidy Programme (HISP), and, EduAfy which is a free and comprehensive health cover for all public secondary school students. The removal of user fees has led to increased utilization of health facilities, this move has led to congestion in some public health facilities.

Investigate the challenges faced in the implementation of UHC in Kenya

According to Government Third Medium Term Plan (2018-22), the provision of UHC is part of the Kenya’s efforts to attain the highest standard of the desired status of health. UHC lowers the healthcare cost and eliminates administrative costs by reducing the need to deal with private insurance firms (Community Health System Report, 2018/2019). However, the study found out that the implementation of UHC is faced with myriad challenges. The Third Medium Term Plan (2018-2022) reveal such challenges as Inadequate emergency services for delivery and under-utilization of existing antenatal services; Inadequate capacity for emergency and disaster preparedness; Inadequate skills and competences of health workers; Inadequate funding; Low Insurance coverage; expensive health services; skewed distribution of available infrastructure with a strong bias towards the urban areas; Weak multi-sectoral coordination of programmes and projects; Poor surveillance systems for NCDs (p. 75). The Community Health System Report (2018/2019) also highlighted the factors hindering the

realisation of UHC. They include: poor coordination in the devolution of healthcare workers; lack of decentralised trade unions to engage and agree on comprehensive bargaining agreements (CBAs) with government; weak regulation and coordination; lack of adherence to set standards and regulations; existence of multiple fragmented health insurance pools; and, leakages in the flow of healthcare funds.

The findings further indicate that poor service delivery in maternal and child health nutrition, exacerbated by inadequate emergency services for delivery, under-utilisation of antenatal services, inadequate skills and competencies of health workers, are major challenges in the realization of UHC. Even with the introduction of Linda Mama programme, there has been continued fees charge at primary healthcare facilities despite the abolition. This undermines the government's efforts of reducing the financial burden. The other challenge is the lack of policy to support the initiative in sustaining the programme especially in the event of political regime change. There is skewed distribution of healthcare workers which has been caused by lack of supporting infrastructure and opportunities for healthcare workers (WHO, 2018). The majority of these workers have opted for urban areas and in private hospitals. The Economic Survey report (2019) indicates that the number of health personnel increased from 165,333 in 2017 to 175,681 in 2018 (GOK, 2019). The report further shows that registered nurses accounted for the highest proportion of personnel at 29.9 percent, with enrolled nurses at 13.3 per cent in 2018. The proportion of registered personnel per 100,000 population increased to 368 in 2018 from 355 in 2017. Despite these improvements, there is need to enhance human resources gaps, by training community health nurses, specialized health workers, capacity building of public health officers and recruitment of additional health workers (WHO, 2017; Third Third Medium Term Plan, 2018 -2022).

Further, the Harmonised Health Facility Assessment report (GOK, 2018) reveal that the number of health facilities have grown especially in urban areas. The researcher found out that the clinics rose by 18.6 per cent to 3,646 in 2018, out of which 94.2 percent were private clinics. The private hospitals increased by 22.3 percent to 4,327 in 2018. Faith-based organisations (FBOs) and non-governmental organisations (NGOs) accounted for 11.5 per cent of the total health facilities. This points to the extent to which people are likely to suffer financial risk, considering that those seeking services from most private clinics will have to pay out-of-pocket (Pathways to Optimal Health Infrastructure, 2018).

VI. CONCLUSION

Kenya has been on the forefront in accelerating the realization of UHC. Kenya's strong economic growth has enabled significant reforms that have driven social development, while making progress in the health sector. The findings of this study indicate that Kenya's facilities index stands at 59%, with a density of 2.2 per 10,000 population, and the workforce density is at 15.6/10,000. Four counties including Tharaka Nithi (33.8), Nyeri (31.0), Uasin Gishu (28.2) and Nairobi (26.3) have achieved well above the WHO target. Several strategies and programs such as Afya Care and expansion of NHIF,

have been initiated to drive the UHC agenda. The Ministry of Health's budget also continues to rise, in 2018/19 the health sector received its largest allocation of 7 percent. This positive progress coupled with the country's growing productive population, skilled workforce, and strong infrastructure provides a solid foundation in achieving UHC. Now more than ever, the country has an opportunity to accelerate progress towards equitable access to healthcare. Despite significant strides made towards the SDGs and extensive political will, several gaps remain. The enactment and implementation of important policy decisions and inevitable trade-offs, extending coverage to individuals not previously covered, expanding and reducing the direct cost of healthcare. Kenya is faced with a series of difficult choices but, significantly, the legitimacy of these choices can be pegged onto the robustness of accountability and participation mechanisms that facilitate the process of decision-making.

VII. RECOMMENDATIONS

The road to UHC has been bumpy thereby contributing towards health inequity. Whereas the devolved healthcare has accelerated the healthcare service delivery, and brought much more positive gains, it is important that there is constructive stakeholder engagement between the national and county government on how to effectively deliver health services. There is need to ensure initiatives and policy coherence between the two governments, such that the policies speak to each other, for more collaboration and coordination. This study recommends that both the national and county government provide the appropriate support and initiative to increase recruitment and retention of health workers; and increase supplies, equipments and infrastructures to health facilities especially in the rural areas. Long term strategies be undertaken to address the human development and management constraints within the counties, so as to improve efficiency of health service delivery. Further, there is need to engage the private sector in complementing government initiatives such that there is public-private partnerships, finalise and adopt the UHC policy to guide in the implementation, efficiency in allocation and utilization of funds; support devolution of healthcare; and speed up the process of reviewing the NHIF Act. The study recommends that county governments prioritize healthcare, and seek to address the health inequities within the counties.

Conflict of Interest

The author declares that there is no conflict of interest regarding the publication of this paper. The author certifies that the submission is original work and is not under review in any other publication.

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APPENDICES

Table I: Document analysis

Document Title	Author	Scale	Type	Year	No. of pages
1. The Health Act No. 21 of 2017	Republic of Kenya	National	Act	2017	72 pages
2. Kenya Health Policy (2013 -2030)	Ministry of Health	National	Legislation	2013-2020	87 pages
3. Laws of Kenya, The Constitution of Kenya	National Council for Law Reporting	National	National	2010	194 pages
4. Planning, Budgeting and Performance Review Process Guide for Health Sector (Simple Guide to MTEF for Health Sector)	Ministry of Health	Local	Guide	2019	41 pages
5. Kenya Health Financing System Assessment	Ministry of Health	National	Act	Report	181 pages
6. Kenya Health Sector Strategic Plan	Ministry of Health	National	Stratetegic Plan	2018	152 pages
7. The Big Four Agenda	Presidential Delivery Unit	National	Policy Brief	2017	
8. National Infection Prevention and Control Guidelines for Health Care Services in Kenya	Ministry of Public Health Ministry of Medical services	National	Guideline	2010	210 pages
9. Implementation of the Agenda 2030 for Sustainable Development in Kenya	UN Sustainable Development	International	Report	2017	76 pages
10. Health Sector Monitoring and Evaluation Framework (2014-2018)	Ministry of Health	National	Report	Undated	124 pages
11. Accelerating attainment of Universal Health Coverage: The Kenya Health Sector Strategic and Investment Plan 2014 - 2018. Ministry of Health.	Ministry of Health	National	Strategic plan	2015	152 pages
12. Policy Brief: Pathways to Optimal Health Infrastructure in Kenya	Ministry of Health	National	Policy	2018	4 pages
13. Harmonized Health Facility Assessment	Ministry of Health	National	Report	2018	46 pages
14. NHIF Strategic Plan 2018-2022	National Hospital Insurance Fund	National	Strategi Plan	2018	52 pages
15. NHIF Performance Report: Strides Towards Universal Health Coverage for all Kenyans	National hospital Insurance Fund	National	Report	2019	22 pages
16. Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report	WHO	International	Report	2019	12 pages
17. Third Medium Term Plan 2018-2022	National Treasury	National	Policy	2018	272 pages
18. United Nations Development Assistance Framework 2018-2022	UN	International	Brief	2018	82 pages
19. Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya	Health Sector Monitoring & Evaluation Unit, Ministry of Health	National	Policy Brief	Undated	2 pages

Table II: Code Frames

Content/Topic	Context/Field	Actor/Participant	Process
Equity in access (17)	UHC Facilitation in the primary healthcare, Healthcare policymaking, Primary healthcare Infrastructure, Community healthcare services, Reproductive Healthcare	Policy makers, Government representatives, Decision makers, Stakeholders, Government Agencies, Donors and Key Actors	Policy Developed, Negotiated, Communicated, and Implemented
Quality health services (15)	UHC Facilitation in the primary healthcare, Community healthcare services, Reproductive healthcare services, Maternal newborn and child health, Healthcare workforce development and retention,	Policy makers, Government representatives, Decision makers, Stakeholders, Donors and Key Actors, Government Agencies	Policy Developed, Negotiated, Communicated, and Implemented
Financial risk protection (17)	Implementation of the out-of-pocket payments, Health policy implementation, Healthcare workforce development and retention, Financing public healthcare system, medical insurance coverage, Healthcare infrastructure	Policy makers, Bureaucrat, Key Informants, Donors, Government Representatives, Government Agencies, Decision makers, Key Actors, Stakeholders	Policy Developed, Negotiated, Communicated, and Implemented
Healthcare system in Kenya (19)	Multisectoral action in non-communicable disease, UHC Facilitation in the primary healthcare, Healthcare policymaking, Primary healthcare Infrastructure, Community healthcare services, Reproductive Healthcare, Maternal newborn and child health, Healthcare workforce development and retention, Implementation of the out-of-pocket payments, Policy implementation, Healthcare workforce development and retention, Financing public healthcare system, Medical insurance coverage, Healthcare infrastructure	Policy makers, Bureaucrat, Key Informants, Donors, Government Representatives, Government Agencies, Decision makers, Key Actors, Stakeholders	Policy Developed, Negotiated, Communicated, Implemented, and Evaluated
Challenges faced in the implementation of UHC (12)	Multisectoral action in non-communicable disease, UHC Facilitation in the primary healthcare, Healthcare policymaking, Primary healthcare Infrastructure, Community healthcare services, Reproductive Healthcare, Maternal newborn and child health, Healthcare workforce development and retention, Implementation of the out-of-pocket payments, Policy implementation, Healthcare workforce development and retention, Financing public healthcare system, Medical insurance coverage, Healthcare infrastructure	Policy makers, Bureaucrat, Key Informants, Donors, Government Representatives, Government Agencies, Decision makers, Key Actors, Stakeholders, National and County governments	Policy Communicated, Implemented, and Evaluated