FACTORS INFLUENCING THE SUSTAINABILITY OF UNIVERSAL HEALTH COVERAGE IN VULNERABLE LIVELIHOODS IN KENYA: A CASE OF WAJIR COUNTY

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DECLARATION

This project is my original work and has not been presented for the award of a degree in this University or any other institution of higher learning for examination.

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DEDICATION

I dedicate this research study to my loving parents for always being with me throughout my academic journey. I also dedicate to my family for their constant encouragement and for being patient enough to see me go through my academic struggle in an effort to realize my long cherished academic dream.

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LIST OF ABBREVIATIONS

GDP	:	Gross Domestic Product
GGHE	:	General Government Health Expenditure
GHS	:	Global Health Security
HSA	:	Health Systems Assessment
ICT	:	information and communication technology
IMF	:	International Monetary Fund
KHPF	:	Kenya Health Policy Framework
LICs	:	Low Income Countries
LMICs	:	Low and Middle-Income Countries
MDG	:	Millennium Development Goal
MOH	:	Ministry Of Health
NCDs	:	Non-Communicable Diseases
NCDs	:	Non-Communicable Diseases
NGOs	:	Non Governmental Organizations
NHSSP	:	National Health Sector Strategic Plan
OOP	:	Out-Of-Pocket
PFM	:	Public Financial Management
RDT	:	Resource dependence theory
SGDs	:	Sustainable Development Goals
TB	:	Tuberculosis
UHC	:	Universal Health Care
UNICEF	:	United Nations International Children's Emergency Fund
WHO	:	World Health Organization

ABSTRACT

The aim of the study was to investigate the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County. The specific objectives were to assess the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya, to establish the influence of stakeholder engagement on sustainability of universal health coverage in vulnerable livelihoods in Kenya, and to determine the influence of monitoring and evaluation on sustainability of universal health coverage in vulnerable livelihoods in Kenya. The study used descriptive research design. This method of research was preferred because the researcher is able to collect data to answer questions concerning the status of the subject of study. The target population was beneficiary households, universal health care workers, and local leaders in Wajir County. The target population of beneficiaries estimated at 677. This study adopted the stratified sampling technique. Stratified sampling is a probability sampling technique wherein the researcher divides the entire population into different subgroups or strata, then randomly selects the final subjects proportionally from the different strata. From the possible target population of 677, stratified random sampling was employed to select a total of 204 sample population. A questionnaire was used to collect primary data. The questionnaire comprised of questions, which sought to answer questions related to the objectives of this study. The data for the study was analyzed both qualitatively and quantitatively. The data collected was keyed in and analyzed with the aid of SPSS. The Quantitative data generated was subjected to the descriptive statistics feature in SPSS to generate mean, and standard deviation which was presented using tables, frequencies and percentages, while Qualitative data consist of words and observations, not numbers. The study established that resource mobilization influence sustainability of Universal Health Coverage. The study found that stakeholder engagement influence sustainability of Universal Health Coverage. The study also established that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. The study established that monitoring and evaluation influence sustainability of Universal Health Coverage. The study also found that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. The study concluded that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage. The study also concluded that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. The study concluded that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. The study recommended that Kenya's state department for health and the county governments should focus on investments in Universal health care through mobilization of resources to improve county health centre readiness scores so as to achieve equitable access to skilled delivery services across the country. The government should involve every stakeholder in the health sector through training and provision of education on Universal Health Care.

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

Health care is viewed by some as a fundamental right but by others as a tradable commodity. In the course of just over a century, universal health care (UHC) has gone from being an aspiration to a reality in most industrialized countries, but not yet all. Yet for many, especially in the developing world, it remains no more than a dream (Kruk et al., 2016). For those who have it, never before has it been so insecure. Throughout most of recorded history, the concept of UHC was essentially meaningless because health care had so little to offer. To the extent that care was provided, it was delivered largely by laypeople with no formal training. What care was effective consisted largely of basic first aid or, in some cases, herbal remedies whose efficacy had been established by long experience (Chan et al., 2017). Most of what passed for health care was ineffective, or worse, hazardous and unpleasant, such as cupping, bleeding, purges, and similar remedies, so that the treatment was often worse than the disease.

Moving towards UHC can help tackle endemic challenges for health and wellbeing across all societies. This is dependent on the level of universality and engagement within those societies, particularly for marginalized groups. Potential for progress is evident in the case of addressing neglected tropical diseases, which could substantially alleviate poverty and expand productivity of the vast number of people affected by them overwhelmingly in poorer settings (Bangert et al., 2017). UHC can also improve maternal and child health, key to the long-run socioeconomic potential of countries and established goals for health such as Millennium Development Goal (MDG) 4 and MDG 5 (Bain and Ebuenyi, 2017).

While global maternal mortality ratios decreased across all countries by 44% between 1990 and 2015, many states and sub-national regions were left behind in the wake of aggregate progress, leaving an inequity gap (Lieberman, 2016). The rising burden of non-communicable diseases (NCDs) globally also threatens gains in maternal health, with the stresses caused by chronic disease expected to increase as causal factors for maternal mortality. Addressing such critical

health and wellbeing issues is further constrained by the estimated 12.5 million deaths that are linked annually to diseases associated with environmental hazards. UHC is being championed as a pro-poor pathway for development that explicitly engages the most vulnerable in society. Health and wellbeing framed as human rights further strengthen domestic accountability for moving towards UHC (Gostin and Friedman, 2017).

According to UNICEF, (2013) involvement by individuals, communities and distinct groups in universal health care should be followed as a foundation for positive programs and services to uphold and improve their health. Government agencies in Australia nationwide and at state level have upheld a concern in people participation since it has some perceived benefits. Rural health service development people participation has remained to result in more reachable, significant, and suitable services. Moreover, it is often implied that people participation will result in greater community fulfillment with health services, and certainly improved health results, however, proof to support this statement is inadequate, (Tallon-Baudry, 2012).

In Rwanda universal health care remains an important challenge, with millions of households struggling with high percentage of Out-Of-Pocket (OOP) in total household expenditure for health services. Rwanda was recognized as one of the nine countries in Africa and Asia making significant progress to make universal healthcare systems possible. This is due to the ability of the ministry of health in Rwanda to ensure majority of the people are enrolled in the programme and thus improving their health status. According to Hsiao (2013) until September 2012 the universal health care built on Community-Based Health Insurance had been observed nowhere in the world; the model of Rwanda UHC would be therefore the first of the kind.

In Kenya, though access to quality healthcare is a constitutional right, the scarcity of quality public and private health facilities, as well as the high cost of care has limited people participation in accessing health care (Ayeni, 2015). This therefore means that universal health coverage remains little more than words on paper for much of the population. The World Bank estimates that only a fifth of Kenyans are the only ones who have enrolled in the universal health care by having any sort of medical cover, which means that as many as 35 million Kenyans are vulnerable to the financial devastation occasioned by a medical emergency. This therefore

indicates that very few people in the country have the capacity to participate in the scheme as many of the households do not have the financial capability to participate (Ekman, 2014).

In Kenya various factors have been found to impede the sustainability of the universal health care among the vulnerable livelihoods especially in Wajir County. First, majority of Kenyans cannot afford the high cost of treatment and medication. The rising cost of doctor consultations, medical procedures and drugs has pushed healthcare beyond the reach of millions of Kenyans. Research shows that 32 per cent of Kenyans' household health budget is financed out-of-pocket. Second, there is lack o f a clear legal framework as to how the costs of treatment and drugs are computed. Third, public health facilities are under-funded. Government spending on healthcare is approximately six per cent of GDP. This is low compared, for instance, to education or infrastructure. State funding for the health sector needs up-scaling.

In addition there is lack of appropriate monitoring and evaluation to ensure UHC is implemented appropriately. The stakeholders involved have not been up to task and this has affected the sustainability of the health coverage significantly. Wajir County has been struggling on the part towards adopting universal health coverage from the devastating effects of the violence in the county that has seen many livelihood projects and activities reduced to nothing. As the recovery process continues, one hopes that wise moods including universal health coverage is embraced. Universal health coverage is a cheaper option. It will be desirable that this study establishes the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya.

1.2. Statement of the Problem

Despite universal health coverage being important to the wellbeing of the vulnerable groups in the society, it has not been well embraced in Kenya. Various factors have existed as a barrier to its sustainability (Ekman, 2014). With health now a devolved function, inadequate funding of counties has imposed financial constraints on the public health system. Throw in recurrent strikes by health personnel and one begins to fathom the enormity of the crisis facing Kenya's health system. Inadequate funding compromises quality and availability of health services. Dilapidated public health facilities force many Kenyans to resort to private health facilities which are often expensive. In addition, most public hospitals suffer chronic lack of drugs forcing patients to

purchase these from private pharmacies (Ayeni, 2015).The rising prevalence of non-communicable diseases like cancer has further strained the health system and impoverished many families.

Few studies have been conducted on the sustainability of the universal health coverage with it being a new concept in the health sector. Wamai (2013) studied the health system in Kenya, analyzing the situation people participation in health insurance in Kenya and concluded that health cost remains the greatest barrier for people participation in universal health care. Deloitte (2011) studied the reciprocal relationship between poverty and participation in health initiatives in Kenya and concluded that 46% of Kenyans live on less than a dollar per day, and these high poverty levels among the population limit their participation in universal health care scheme. This has created a knowledge gap that needs to be filled. It is for this reason that the current study will investigate the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County.

1.3. Purpose of the Study

The purpose of the study was to investigate the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County

1.4. Objectives of the Study

The study was guided by the following objectives:

i. To assess the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya

ii. To establish the influence of stakeholder engagement on sustainability of universal health coverage in vulnerable livelihoods in Kenya

iii. To determine the influence of monitoring and evaluation on sustainability of universal health coverage in vulnerable livelihoods in Kenya

1.5. Research Questions

The study answered the following research questions:

i. What is the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya?

ii. What is the influence of stakeholder engagement on sustainability of universal health coverage in vulnerable livelihoods in Kenya?

iii. What is the influence of monitoring and evaluation on sustainability of universal health coverage in vulnerable livelihoods in Kenya?

1.6. Significance of the Study

The study may be expected to determine the challenges facing the implementation universal health coverage to realize sustainability. The study would benefit the Board of Directors and practitioners in the health sector who closely deal with issues of sustainability of universal health coverage. The government would have a better understanding of the factors influencing universal health coverage sustainability and therefore come up with intervention strategies that may see the provision and expansion of medical services through attraction of more medical service providers to the county. Under the country's new decentralization strategy, counties are responsible for delivering health services and implementation of health programs. In addition, Wajir County would use this research in designing better structures that may ensure sustainability to guarantee better provision of Universal Health Coverage in all health facilities in the County. To the general academia, this would go a long way in building a body of knowledge on health and medical services. Various stakeholders can use the study to facilitate further research in private and other public health sectors in Kenya.

1.7. Delimitations of the Study

The study focused on the resource mobilization, stakeholder engagement, and monitoring and evaluation. The respondents were beneficiary households, universal health care workers, and local leaders in Wajir County who were sampled and supplied with questionnaires with the aim of getting their views regarding the subject matter of the study.

1.8. Limitations of the Study

Time may be a limitation in that the researcher may not be in a position to adequately address all issue in relation to the study and thus worked within the allocated time. The research period was

considerably short but this was solved by allocation of more time for data collection. The respondents may not fully answer the questions in the questionnaire satisfactorily due their level of literacy and this may affected the analysis of data. To avoid this researcher explained the importance of the research to the respondents and why they should fill in the questionnaires. Another limitation which may be encountered was the lack of adequate resources in terms of money to carry out the study satisfactorily. The researcher w addressed this limitation by carrying out the research with the available finance.

1.9. Basic Assumptions of the Study

This study was based on the following assumptions: The study was conducted under the assumption that the respondents were available and also that they give honest responses. This study assumed that respondents had a good understanding of the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County.

1.10. Definition of Key Terms

This section presents the definition of key terms that have been applicable in the current study:

Monitoring and Evaluation: refers to the process that helps improve performance and achieve results. Its goal is to improve current and future management of outputs, outcomes and impact. It is mainly used to assess the performance of projects, institutions and programs set up by governments, international organizations and NGOs. It establishes links between the past, present and future actions.

Resource Mobilization: refers to all activities involved in securing new and additional resources for the universal health coverage

Stakeholder Engagement: refers to the practice of interacting with, and influencing health project stakeholders to the overall benefit of the universal health care project and its advocates. The successful completion of universal health care project usually depends on how the stakeholders view it.

Sustainability: refers to the capacity of a health based project to continuously meet the demands of the community through delivery of health services.

1.11. Organization of the Study

The study was organized in five chapters. Chapter one is introduction featuring background to the study, statement of the problem, purpose of the study and objectives that guided the study. In this chapter, research questions, significance of the study, limitations and delimitations of the study are also included. Moreover, it also presents basic assumptions of the study, definitions of significant terms used in the study. Chapter two captures literature review done on the basis of key study variables. Also outlined in the chapter are theoretical framework, conceptual framework, research gaps and summary of the literature review. Chapter three captures research methodology are used, outlining introduction, research design, target population, sample size and sample selection. Besides, it also presents data collection instruments, piloting, validity of the instruments and instruments' reliability. In addition, it also outlines the procedures used for data collection, and methods that are used for data analysis. Chapter four covers analysis of the data collected from the field. Data will be analyzed using means, standard deviation and other info graphics in representing the analyzed data. The analyzed data was presented in tables. Further the chapter had interpretation of the findings in write up to explain the tables. Chapter five describes the summaries of findings with regard to the objectives of the study. Main findings will be discussed at length with linkages to existing knowledge. The chapter finally provided a conclusion of the study and suggest possible recommendation of the study problem.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

Chapter two provides the literature review of the study. It accounts for the previous research and what has been found out in the area of study. This chapter mainly focuses on the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya. The themes discussed in this chapter include sustainability of universal health coverage, resource mobilization on sustainability of universal health coverage, stakeholder engagement on sustainability of universal health coverage, and monitoring and evaluation on sustainability of universal health coverage. In addition the chapter presents the theoretical framework, conceptual framework, knowledge gap, and summary.

2.2. Sustainability of Universal Health Coverage

Sustainability as health promotion capacity refers to the extent to which a community has local access to the knowledge, skills and resources needed to conduct effective health promotion programs (Jackson, 2014). Sustainability thus appears to be a multidimensional concept of the continuation process whose reality remains elusive. The sustainability of health care systems, particularly those supporting universal health care, is a matter of current discussion among policymakers and scholars. Public financing is essential for countries to make sustainable progress towards universal health coverage (UHC). These funds need to be used efficiently and directed to priority populations and services to ensure equitable access to quality health services and financial protection for all.

Recognizing this, WHO has been implementing the jointly agreed upon Collaborative Agenda on Fiscal Space, Public Financial Management (PFM) and Health Financing since the end of 2014. As the global community continues to scale up HIV/AIDS, TB, and malaria interventions, it is vital to understand the state of the health systems in which these services are being delivered. Good health systems should be able to deliver effective and quality health care services to the needy in a cost effective way. To address the health challenges facing the health sector, the

health ministry's has, in recent years, been implementing health sector reforms with health system strengthening as a top health reform agenda.

The National Health Sector Strategic Plan (NHSSP II) underscores the importance of health system strengthening with major efforts directed at institutional strengthening, organizational development, improving the availability of human resources for health, health financing, service delivery and information, medical commodity availability, and improved donor coordination (World Vision, 2014). As the ministries continue to strengthen the health system, a thorough understanding of its unique strengths and weaknesses becomes paramount. The Health Systems Assessment (HSA) process allows countries to systematically assess their national health system and provides policymakers with information on how to strengthen the health system. The HSA approach, therefore, provides a comprehensive assessment of key health systems functions, organized around the six WHO building blocks: governance, health financing, health service delivery, human resources, medicines and medical product management, and health information systems (World Vision, 2014).

The link between spending and health outcomes has been as controversial as the relationship between health care and economic growth. This issue is of particular relevance in the debate over consolidated universalist health systems, in which achieving further health gains appears to require unaffordable new investments (Bain and Ebuenyi, 2017). In the past, the literature has provided inconclusive results regarding the contribution of health care expenditure to health outcomes. The case of the United States has often been proposed as the clearest example of a health care system that, if compared with other Organization for Economic Cooperation and Development countries, displays "more-than-expected spending with less-than-expected life expectancy (World Vision, 2014).

More recently, however, evidence of a positive relationship between spending and health outcomes has begun to emerge in studies that compare either health care systems at the macro level or local health authorities/organizations and their processes of care at more meso- and micro levels. Macro-level studies have shown that total health care costs or investments in human capital for health (Jackson, 2014) contribute to reducing overall and infant mortality and, more rarely, to increasing life expectancy. Several methodological challenges, however, remain

in this type of analyses, given the difficulty in isolating the impact of spending from all other determinants and the potential endogeneity of several of the explanatory variables utilized in the studies.

This literature draws attention to the fact that UHC or health care spending per se is not economically unsustainable but rather the part that is poorly allocated and wasted without producing health. Dealing with economic sustainability means devising better ways to assess what are critical, defining priorities in the allocation of resources and, simply, getting the most out of health care systems (Chan et al., 2017). In principle, this is not very different from what has been done in other sectors that, when facing issues of long-term sustainability, have not revised their core principles but rather have redesigned their work processes to be more efficient and effective.

Some prominent scholars have proposed that a more explicit analysis of health care costs might be a critical step in the understanding of how costs are generated and in solving the efficiency issue. We suggest that the production of evidence on the economic sustainability of health care, particularly UHC, is a much wider research enterprise that entails an analysis of the processes, competences, and organizational models that make a difference for health (Bain and Ebuenyi, 2017). Researchers in health management and economics might be in a privileged position to work with both policymakers and managers in the analysis of data and information, including information on costs, with the explicit aim of supporting priority-setting decisions. These decisions have the potential to be based on justifiable and reasonable arguments about why some things are prioritized and others are not, grounded in the reality of health care organizations and systems (Jackson, 2014).

2.3. Resource Mobilization on Sustainability of Universal Health Coverage

According to Kruk et al., (2016), achieving Universal health coverage is a key objective for advancing the Sustainable Development Goals (SGDs), however a big challenge in achieving this is how best to afford good health services for the whole population. Funding public services will always be a matter of prioritizing limited resources. Continuing the theme of the previous discussion on Global Health Security (GHS), estimates of the cost of delivering even basic health protection services are significantly more than many countries are able to afford (Chan et al.,

2017). UHC is about more than just health protection, with issues such as the rising costs of Non-Communicable Diseases (NCDs) putting an ever increasing burden on national health budgets.

Lieberman, (2016) stated that resource mobilization systems for health care financing are fundamentally national by definition. Domestic fiscal resources can be enhanced and in many cases in both advanced and emerging world are very substantially enhanced by international and regional funding. However, it is paramount that sustainable health care financing systems are to rely first and foremost on domestic revenue collection (Bain and Ebuenyi, 2017). Efficient health care system is about pooling risks by definition; every universal health care system is insurance system. In turn, the very nature of insurance implies resource allocation from those in good health towards sick. Therefore, domestic political compact is needed to set up modalities of how the insurance premiums are paid to what extent resource transfers will take place between healthy and sick, but also between generations and between higher and lower income strata in society.

Ayeni, (2015) argued that the key to health care financing is its political and fiscal sustainability that, in turn, requires that certain time consistent ground rules as per revenue sources are in place. Health care prioritization is concerned not only with absolute amounts of health care spending, but predictability of revenues that are safeguarded to the largest extent possible from yearly negotiations on general state budget (Roseland, 2015). The ground rules for health care financing should establish whether the bulk of UHC costs are credited to some tax or, as the case may be, directly to insured persons, or these costs are internalized so as they are covered by general budget revenues (Bain and Ebuenyi, 2017). Most systems combine these two approaches, albeit using very different weights. Sustained financing models can be (technically) developed under both systems or by combination thereof.

The starting point for health care sustainable prioritization and sufficient revenue mobilization would in any case be the needs assessment. Nevertheless, transfers from general budget should be determined by using concrete and time consistent budget rule (Ayeni, 2015). Finally, two essential points are to be made: first, that total amount of health care spending is determined via an iterative (political) process that would result in eventual agreement on how much society as a

whole is willing to spend on health and second, that while technically the use of any particular financing model can be regarded as fiscally neutral, the ultimate choice between insurance-based (either public or private) and budget-based approach may have, in turn, impact on the delivery side (Chan et al., 2017).

According to Chan et al., (2017), between US$ 70 and US$ 90 billion in additional health spending annually is needed in order to ensure that a set of key health services identified in the SDGs as important stepping stones towards UHC are universally available. That means that, at current levels of health spending, LICs and LMICs will need to increase health expenditures by a third (Bain and Ebuenyi, 2017). These are a significant amount of resources but there has been some progress towards increasing resources for health. Between 1995 and 2013, global health spending increased, driven by economic growth. Indeed, total health expenditure grew more rapidly than GDP, with average spending as a share of GDP increasing from 4.9 to 6.4 per cent over the same period.

However, although very positive, this does not paint the full picture. A closer look reveals that although General Government Health Expenditure (GGHE) increased during this period, the majority of this increase came from high income countries (Bain and Ebuenyi, 2017). Countries would also need to ensure that catastrophic and impoverishing out-of-pocket payments (OOPPs) are kept to a minimum. OOPPs can be large and unpredictable, and can often be the triggers that push a family into poverty. Because of this, they act as a very real barrier to health services and economic success for the poorest members of society (Chan et al., 2017). To remove these barriers, it is recommended that governments commit to ensure that OOPPs represent at least less than 20 per cent of the total health expenditure and there are no OOPPs for priority health services or for the poorest families. Currently, however, LICs and LMICs are only halfway towards this target, with OOPPs accounting for an average 43 per cent and 34 per cent respectively of total health expenditures.

Most LICs and LMICs, even with the economic downturn, have considerable scope to raise revenue through increases in tax collection efforts and government charges. For example, the International Monetary Fund (IMF) estimates a potential of up to 4 percentage of GDP in additional tax revenues for LICs. Developing countries can improve tax collection through more

efficient tax administration, and broadening the tax base (Bain and Ebuenyi, 2017). This is not easy and can take time but is do-able. In addition, there is scope within developing countries to increase tax revenues by reforming tax policy. For example, indirect taxes like VAT are still low in some countries, and this offers an opportunity for increase (Roseland, 2015). Similarly, tackling tax avoidance and evasion, and tax incentives for companies, such as those related to natural resources can raise additional revenues in LICs and LMICs. Governments could also greatly benefit from plugging leakages in revenues resulting from corruption and the illicit flow of funds.

2.4. Stakeholder Engagement on Sustainability of Universal Health Coverage

World Bank, (2013) stated that sustainability of universal health coverage should engage stakeholders from all sectors of society. Health and wellbeing depends on socioeconomic, geographic, demographic and political determinants. This requires integrating risk-mitigating strategies into long-term inter-sectoral development planning to improve management of shocks and stresses, while supporting broader favourable outcomes for health, resilience and sustainable development overall (Murray, 2013). Domestic government-led financing offers the clearest foundation to efforts towards universal health coverage, strengthened by political engagement and effective governance. Adaptive support mechanisms and financial instruments, potentially backed by international funding mechanisms, can offer incentives for preparedness and effective response to the impacts of shocks and stresses.

Nturibi, (2014) stated that universal health coverage ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship has continued to dominate in health care. This continues to attract the attention of many stakeholders including governments (Turner, 2013). This is because it embodies three related objectives namely equity in access to health services-those who need the services should get them, not only those who can pay for them; that the quality of health services is good enough to improve the health of those receiving services; and finally financial risk protection which aims at ensuring that the cost of using care does not put people at risk of financial hardship (Stephens, 2015).

Universal coverage brings the hope of better health and protection from poverty for hundreds of millions of people - especially those in the most vulnerable situations. Universal coverage is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda as stipulated in the Alma-Ata declaration of 1978. Four key elements are identified by World Health Organization (WHO) necessary towards the realization of universal coverage (World Bank, 2013). One, a strong, efficient, well-run health system; two, a system for financing health services; three, access to essential medicines and technologies; and finally a sufficient capacity of well-trained, motivated health workers.

In Kenya, with support of various stakeholders, the government of Kenya has over the years since independence in 1963 initiated policy reforms and strategies earmarked towards universal health coverage. Some of these are outlined in various policy documents including Kenya Health Policy Framework (1994–2010), Health Sector Strategic Plans, Vision 2030, the Constitution 2010, and finally, the Health Bill of 2015. Notably, the government recognized a high quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation (Tallon-Baudry, 2012). Further the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. These initiatives can be argued are aimed towards universal health coverage for the populace in the country. In the draft Health Bill of 2015, the government has declared access to reproductive health and emergency medical treatment as a right by all persons.

Universal Health Coverage (UHC) implies that all people, without discrimination, have access, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines. UHC is crucial to increase healthy life expectancy, to reduce poverty, to promote equity, and to achieve sustainable development all together (Tallon-Baudry, 2012). UHC also presents an opportunity to improve the performance of the health system and service delivery outputs. UHC requires resilient and responsive health systems to provide comprehensive primary health-care services, with extensive geographical coverage, including in remote and rural areas, and an adequate number and equitable distribution of skilful and committed health workforce. Mechanisms to

pool risks among the population on the basis of equity and solidarity can bring sustainable resources for strengthening health systems with the view to ensure universal access to essential health services and proven life-saving interventions (World Bank, 2013).

Functioning health systems is an essential platform for UHC achievement; it requires adequate number and equitable distribution of skilful and committed health workforce and all stakeholders; effective disease surveillance systems for timely responses to infectious diseases and ensure national, regional and global health security; health information which guides evidence-informed policy decisions; availability and affordability of essential health technologies for which Sciences, Technology and Innovation, including ICT, plays a vital role.

In several countries, information and communication technology (ICT) by various stakeholders is used to enhance health literacy, provide health information, support diseases surveillance, improve care and strengthen monitoring and evaluation. Prioritized and coordinated research and innovation by various stakeholders is essential for development of new interventions, such as vaccines, medicines and diagnostic devices, while strengthen research institutions and systems in low and middle-income countries are recommended (World Bank, 2013). Adoption of new health technologies, often expensive and out of reach by the poor, requires improved country capacities to conduct health intervention and technology assessment to guide procurement and management of technologies; this ensures value for money and long term financial sustainability

2.5. Monitoring and Evaluation on Sustainability of Universal Health Coverage

The steps towards adopting effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. According to Kusek & Rist (2012) a readiness assessment is the foundation and first step of a monitoring and evaluation system for sustainability of universal health coverage. Available literature accumulated in the last decade is mainly from monitoring and evaluation readiness assessment conducted by the World Bank, specifically in developing countries (Mackay, 2013). The aim of the studies was to assess the countries according to key factors that are critical prior to building an monitoring and evaluation system for sustainability of universal health coverage. The identified key factors from these studies included presence of regulatory frameworks, leadership, monitoring and evaluation structures and systems, and capacity building.

Previous studies have revealed that there are common factors across countries that hinder effective implementation of monitoring and evaluation systems for sustainability of universal health coverage. Such factors include: the need for high level leadership to drive the monitoring and evaluation reform; inadequate monitoring and evaluation capacity, particularly human resource and technical skills; insufficient monitoring and evaluation training; inadequate monitoring and evaluation systems; lack of monitoring and evaluation framework in some countries and poor utilization of performance information (Olivera & Velasco, 2014). In Africa, studies have attributed poor infrastructure, fragmented monitoring and evaluation systems, lack of a culture of monitoring and evaluation, lack of ownership and political will, impact on the monitoring and evaluation systems as the major challenges for organizations and governments failing to adopt comprehensive monitoring and evaluation systems (Hange, 2012).

Although there are limitation to adopting monitoring and evaluation systems for sustainability of universal health coverage, useful lessons can be derived that are critical in implementing a monitoring and evaluation system. There is need for political will with highest commitment and national champions. Enjela & Jam (2015), Kusek & Rist (2012), and mackay, (2013) have argued that there is need for champions at the highest level, as strong political leadership and incentives are essential for sustainability of monitoring and evaluation system for sustainability of universal health coverage.

Some degree of centralization in a monitoring and evaluation system is necessary. They have proposed that it is crucial to build a monitoring and evaluation system for sustainability of universal health coverage in phased approach, develop simplified monitoring and evaluation systems with clear goals, objectives, and standardized measurable indicators (Hange, 2012).. The above scholars also suggest that the systems should produce reliable and credible performance information.

In the MOH however, monitoring and evaluation systems for sustainability of universal health coverage are yet to be developed. Instead, there are reporting frameworks that incorporate indicators, outcomes and outputs to measure programs and projects implemented by the ministry (Olivera & Velasco, 2014). This is not adequate since it leaves out important aspects of monitoring and evaluation unaddressed. Thus, conducting a readiness assessment is crucial to

inform the ministry on its current status if they were to adopt and institutionalize monitoring and evaluation systems.

MacKay, (2013) stated that to reach UHC, governments need a clear understanding of the population's demographic profile, socioeconomic development, and health priorities. Monitoring the performance of the health system is critical. It informs policy and planning to provide the right mix of quality services and to support appropriate financing strategies. By regular monitoring of key UHC performance indicators, governments can adjust health services to ensure progress toward UHC. Insufficient evidence has been gathered at the national level on the extent to which countries have been monitoring UHC to date. The discussion at the country level so far has focused on the financial dimension of UHC, neglecting the dimensions of service quality and equitable access (MacKay, 2013). The benefits of robust M&E go beyond understanding and tracking progress. Once that mechanism is in place, countries become better positioned to harness innovative financing to increase the sustainability of health care financing and scale up successful pilot initiatives. Sound M&E is also a foundation for better collaboration with the private sector and for better-quality health service delivery.

The framework and the indicator list for monitoring and evaluation of UHC are designed to be flexible and adaptable to the country context and health sector development programs, and to be readily implemented with direct linkages to existing country health information systems and indicator reporting systems (Olivera & Velasco, 2014). They also have the capacity to include additional indicators as country UHC M&E requirements evolve and national reporting systems improve. This is a significant step forward because there are no readily available country publications or assessments on UHC (Hange, 2012). The proposed M&E framework empowers both governments and development partners. It enables them to track progress; identify reform efficiencies and improvements in other key dimensions such as equity, quality, resilience, and people centeredness; monitor health systems performance; develop health sector programs supported by development partners with clear performance targets; and improve coordination at all levels.

2.6. Theoretical Framework

This section presents the theories applicable in the study. The study will utilize the resource dependency theory and stakeholder theory.

2.6.1. Resource Dependency Theory

Resource dependence theory (RDT) is the study of how the external resources of organizations affect the behavior of the organization. RDT is based upon how the external resources of organizations affect the behavior of the organization. The theory is based upon the following tenets: organizations are dependent on resources, these resources ultimately originate from the environment of organizations, the environment to a considerable extent contains other organizations, the resources one organization needs are thus often in the hand of the organizations, resources are a basis of power, legally independent organizations can therefore be dependent on each other (Pfeffer and Salancik, 1978).

In as much as organizations are inter-dependent, the theory of Resource Dependence needs a closer examination. Its very weakness lies in its very assertions of dependence. With changing trends of financial uncertainties, there is need to lean towards other theories of uncertainties. According to this theory, organizations depend on resources for their survival; therefore, for any organization to achieve sustainability, resources are indispensable. For community based projects to achieve sustainability, resources are important. These resources will come in the form of human resource therefore the need to involve all the stakeholders in the project for sustainability. Other resources include land and finances.

This theory will be applicable in the study as it will inform the researcher on how resources are used to implement and ensure sustainability of UHC. The resource dependence theory will be used to explain how resources of health ministry affect sustainability of the universal health coverage project. The sustainability of universal health coverage project is affected by the resources of the health ministry. These resources come in the form of both financial and human resource therefore the need to involve all the stakeholders in the project for sustainability, other resources of land and finances.

2.6.2. Stakeholder Theory

Stakeholder theory came from four major academic fields: economics, politics, sociology, and ethics. It was highly influenced by many concepts that were raised in the planning department of the Lockheed Company. These ideas were developed from the research done by Igor Ansoff and Robert Steward in this company. Muchlinski (2011) viewed the stakeholder theory from different perspectives. There is the Normative Stakeholder theory, which contains theories of how managers or stakeholders ought to act and view the method of reasoning of organization on some moral guideline (Koschmann, 2008). The other point of view is the unmistakable partner hypothesis that is worried with how administrators and partners act and how they see their duties and activities.

The aim here is to know how supervisors manage partners and how they remain for their interests. The partnership is viewed as an accumulation of interests, at some point aggressive and different times helpful. Instrumental stakeholder theory majors on the hierarchical consequences of considering partners in administration by analyzing the relations between the act of partner administration and the achievement of different corporate administration targets. It concentrates on how administrators ought to do in the event that they need work for their own great. In some writing their own particular intrigue is acknowledged as the interests of the association, which is to get the most out of benefit or to boost shareholder esteem.

This demonstrates if supervisors treat partners in accordance with the partner idea the projects was more fruitful over the long haul (Freeman, Harrison, Wicks, Parmar, and DeColle, 2010). Freeman defines stakeholders as those groups who are fundamental to the survival of the organization (Bailur, 2016). There is concern for mapping the stakeholders, provision of comprehensive list of the specific groups associated with each category of stakeholders, and an equivalent list of interests. How does each stakeholder affect us? What are their interests? Who are our current and potential stakeholders? How do we affect every stakeholder? How do we measure these variables and their impact and how do we maintain score with our stakeholders?

Freeman, Harrison, Wicks, Parmar and De Colle, (2014) incorporates in this list of stakeholders employees, stockholders, suppliers, and the organizations local community. This list, though similar to list given by stakeholder theorists, is not uncontroversial. The stakeholder concept

itself has its critics. Those critics imply that the stakeholder approach is not capable of guiding essential enhancements in corporate government in that numerous lines of accountability inferred by acknowledging a multiplicity of stakeholders, minimizes efficiency and that the idea of stakeholders as ethically important undermines the morally significant relations between community and stakeholders.

This theory will be applicable in this study in that it will help the researcher to identify the role stakeholder play in ensuring the sustainability of the universal health care in Kenya. UHC is being championed as a pro-poor pathway for development that explicitly engages the most vulnerable in society. The stakeholders have a function to play and the theory has explained their role. Health and wellbeing framed as human rights further strengthen domestic accountability for moving towards UHC. To achieve UHC, stakeholders policies must work to strengthen health systems through forward-looking horizontal interventions, rather than dedicating resources to vertical interventions for specific concerns such as an epidemic that undermine health services and investments elsewhere.

2.7. Conceptual Framework

A conceptual framework is a diagrammatical research tool intended to assist the researcher to develop awareness and understanding of the situation under scrutiny and to communicate this (Roberts, 2011). The conceptual framework shows the relationship between the dependent variable and the independent variable. An independent variable is one that is presumed to affect or determine a dependent variable (Van der Waldt, 2008). It can be changed as required, and its values do not represent a problem requiring explanation in an analysis, but are taken simply as given. The conceptual framework for this study will be researcher based framework depicted in figure 2.1. In the framework the researcher intends to determine how resource mobilization, stakeholder engagement, and monitoring and evaluation influence sustainability of Universal Health Coverage.

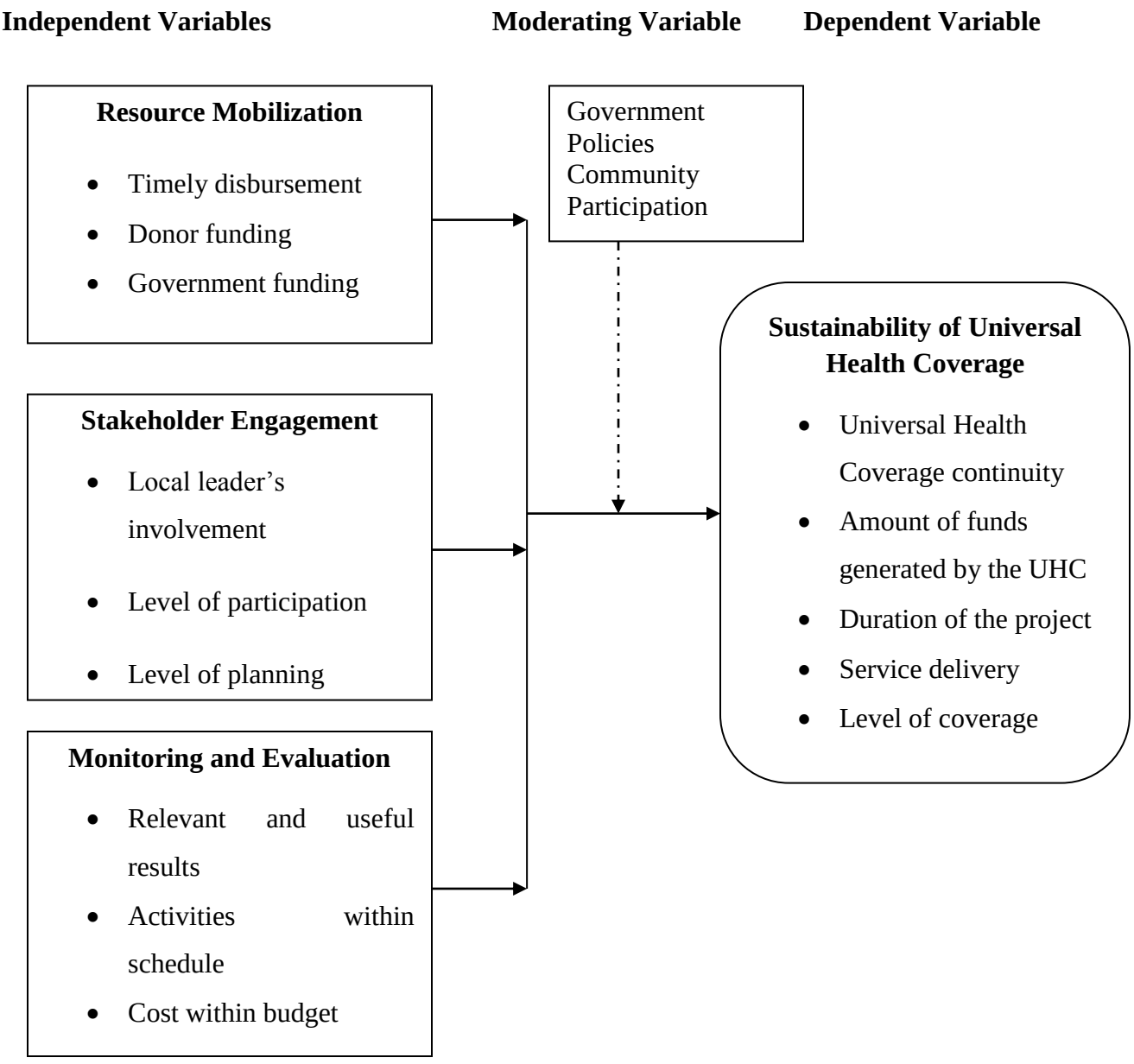

Figure 2.1: The Conceptual Framework

2.8. Knowledge Gaps

The literature reviewed shows that there is a lot of studies on the factors assumed to affect the sustainability of Universal Health Coverage. However, there was less emphasis on factors influencing sustainability of Universal Health Coverage. The literature of health projects is available and is associated mostly with NHIF and financing of health projects which are part of UHC. The study will however limit its investigation towards Universal Health Coverage and the factors influencing sustainability of Universal Health Coverage. The study will also focuses on internal factors influencing sustainability of Universal Health Coverage overlooking such factors as environmental factors effects on sustainability of Universal Health Coverage which has been a popular subject of research.

Author	Title	Findings	Gaps
Kruk et al., (2016)	achieving Universal health coverage	The study established that achieving Universal health coverage is a key objective for advancing the Sustainable Development Goals (SGDs), however a big challenge in achieving this is how best to afford good health services for the whole population. Funding public services will always be a matter of prioritizing limited resources	The study concentrated on achieving sustainable universal health coverage but was not specific on the factors that influence sustainability thus creating a knowledge gap
Nturibi, (2014)	universal health coverage	The study found that universal health coverage ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that	The study did not have specific timeline thus creating a knowledge gap

		the use of these services does not expose the user to financial hardship has continued to dominate in health care	
Kusek & Rist (2012)	effective monitoring and evaluation systems for sustainability of universal health coverage	A readiness assessment is the foundation and first step of a monitoring and evaluation system for sustainability of universal health coverage.	The study was not specific on universal health coverage thus creating a knowledge gap
Mackay, (2013).	factors that hinder effective implementation of monitoring and evaluation systems for sustainability of universal health coverage	The study found the factors to include inadequate monitoring and evaluation capacity, particularly human resource and technical skills; insufficient monitoring and evaluation training; inadequate monitoring and evaluation systems; lack of monitoring and evaluation framework in some countries and poor utilization of performance information	The study did not have a specific timeline thus creating a knowledge gap

2.9. Summary of Literature Review

The chapter reviews existing literature on the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya. The concept of sustainability of universal health coverage has also been explained. Two theories, namely; resource dependence and Stakeholder Theories, under which the study is based, have been discussed. The chapter also

presents a conceptual framework reflecting the relationship between independent and dependent variables. Lastly, the research gap has been presented.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter presents the research design, the target population, the sampling design, the sample, data collection instruments, techniques and the data analysis techniques that was used in the study.

3.2 Research Design

The study used descriptive research design. This method of research is preferred because the researcher is able to collect data to answer questions concerning the status of the subject of study. Descriptive research determines and reports the way things are done and also helps a researcher to describe a phenomenon in terms of attitude, values and characteristics (Mugenda and Mugenda, 1999). According to Orodho (2003), descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals. This method is appropriate for the study in that it will help in portraying the accuracy of peoples profile events and situations. A descriptive research design also allowed for in-depth analysis of variables and elements of the population to be studied and as well as collection of large amounts of data in a highly economical way. It enabled generation of factual information about the study. This is so because the descriptive design relies much on secondary data which helps in developing the case basing on facts, sustained by statistics and descriptive interpretations from archival materials and data.

3.3. Target Population

Population refers to all people or items (unit of analysis) with the characteristics that one wishes to study. The unit of analysis may be a person, group, organization, country, object, or any other entity that you wish to draw scientific inferences about (Bhattacherjee, 2012). The target population were the beneficiary households, universal health care workers, and local leaders in Wajir County. The target population of beneficiaries estimated at 677. The table 3.1 shows the target population that will be utilized in the current study

Table 3.2.Target Population

Strata	Frequency	Percentage
Beneficiary Households	551	81.3%
universal health care	29	4.3%
workers	97	14.4%
local leaders		
Total	**677**	**100**

3.4. Sample Size

A sample is a smaller group or sub-group obtained from the accessible population (Mugenda and Mugenda, 1999). This study adopted the stratified sampling technique. Stratified sampling is a probability sampling technique wherein the researcher divides the entire population into different subgroups or strata, then randomly selects the final subjects proportionally from the different strata. The reason for the choice of the sampling method is because it will enable the researcher to representatively sample even the smallest and most inaccessible subgroups in the population. This allowed the researcher to sample the rare extremes of the given population. In addition, the study used the following formula proposed by Using Yamane (1973) to determine the sample size;

Using Yamane (1973) formulae

$$n = N/ (1+N^*) (e)^2$$

Where

n = sample size

N = the population size

e = the acceptable sampling error (7%) at 93% confidence level

Thus;

$n = 677/ (1+677) (0.07)^2$

n = 204

Therefore the sample population size (n) was 204 respondents. The sample zsieze is shown in table 3.2.

Table 3.3: Sample Size

Strata	Frequency	Percentage	Sample size
Beneficiary Households	551	81.3%	166
Universal Health Care Workers	29	4.3%	9
local leaders	97	14.4%	29
Total	**677**	**100**	**204**

3.5. Sampling Procedure

Sampling is the process of selecting the people who will participate in a study. This process should be representative of the whole population. Sampling is hence the procedure, process or technique of choosing a sub-group from a population to participate in the study (Ogula, 2005). This study adopted the stratified sampling technique. From the possible target population of 677, stratified random sampling was employed to select a total of 204 sample population.

3.6. Data Collection Methods

A questionnaire was used to collect primary data. The questionnaire comprised of questions, which sought to answer questions related to the objectives of this study. The questions entailed both closed-ended questions to enhance uniformity and open ended to ensure maximum data collection and generation of qualitative and quantitative data. The questionnaire was divided into two sections, the background information section and the research questions section. Furthermore, the research questions section was divided to sections according to the research objectives.

3.7. Research Instruments

A questionnaire was used to collect primary data. The questions were both closed-ended to enhance uniformity and open ended to ensure maximum data collection and generation of qualitative and quantitative data. The questionnaire was divided into four sections, the background information section and other three sections based on research objectives.

3.8. Data Analysis

The data for the study was analyzed both qualitatively and quantitatively. The data collected was keyed in and analyzed with the aid of SPSS. The Quantitative data generated was subjected to the descriptive statistics feature in SPSS to generate mean, and standard deviation which was presented using tables, frequencies and percentages.

3.9. Pilot Study

Piloting helps the researcher to generate an understanding of the concept of the people being interviewed. In conducting the pilot study, the researcher was interested in establishing whether the respondents had the same understanding of the questions and thus would offer the information required. Mugenda and Mugenda (2003) posit that "even the most carefully constructed instrument cannot guarantee to obtain one hundred percent reliability". Piloting is important as it helps in determining the reliability of the instrument. In this research, 20 respondents were chosen to contribute and were not be included in the sample chosen for the study. Test-retest reliability is obtained by administering the same test repeatedly over a period of time and still produces the same results. During piloting the researcher administered the questionnaire to a different set of respondents who are not part of the groups of sampled respondents, but similar in characteristics to those sampled for the study. The piloting process also played the important role of checking the respondents for their suitability, clarity, relevance of information and appropriateness of the language used.

3. 10. Validity of the Instruments

Validity is the degree to which an instrument measures what it purports to measure (Mugenda and Mugenda, 2003). It is the accuracy and meaningfulness of inferences, which are based on the research results. In this regard, experts in the field of projects achieved the content validity through an evaluation of the content. The instruments were given to two groups of experts, one group was requested to assess what concept the instrument was trying to measure and the other group was asked to determine whether the set of items accurately represents the concept under study.

3.11. Reliability of the Instruments

Reliability refers to the consistency of data arising from the use of a particular research method. A test measures what it is measuring to the degree. Mugenda (2003), states that reliability is the measure of the degree to which a research instrument yields the same result after repeated trials over a period. In this regard, test-retest was employed to check on reliability. This involved administering the same instruments twice to the same group of subjects, but after some time. Hence, to determine stability, a measure or test was repeated on the subject at a future date. Results were compared and correlated with the initial test to give a measure of stability. Responses obtained during the piloting were used to calculate the reliability coefficient from a correlation matrix. The reliability of the instrument was estimated using Cronbach's Alpha Coefficient which is a measure of internal coefficient.

3.12. Operationalization of variables

Operationalization is the process of strictly defining variables into measurable factors. The process defines fuzzy concepts and allows them to be measured, empirically and quantitatively. The operational definitions of variables for the current study were as shown in the table 3.3.

Table 3.4. Operational definition of variables

Objective	Type of Variable	Indicator(s)	Measurement scale	Method of Data Collection tools	Method of Data Analysis
To assess the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya	Independent variable	Timely disbursement Donor funding Government funding	Nominal Ordinal	Questionnaire	Descriptive statistics.
To establish the influence of stakeholder engagement on sustainability of universal health coverage in vulnerable livelihoods in Kenya	Independent variable	Local leader's involvement Level of participation Decision making	Ordinal Nominal	Questionnaire	Descriptive statistics.

To determine the influence of monitoring and evaluation on sustainability of universal health coverage in vulnerable livelihoods in Kenya	Independent variable	Relevant and useful results Activities within schedule Cost within budget	Nominal Ordinal	Questionnaire	Descriptive statistics

3.13. Ethical Considerations

The researcher assured the respondents that the data was confidential and was used for academic purposes only and no disclosure of the names. In addition participation in the study was voluntary and no respondent was compelled to participate in. the interview with the respondents commenced through an introduction from the researcher to the respondents. The researcher was true to his/her word and aimed at collecting the truthful information only

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the data that was found on factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County. The research was conducted on a sample of 204 respondents to which questionnaires were administered. The chapter introduces with analysis of respondents' personal information, and then looks into the analysis of themes: resource mobilization, stakeholder engagement, and monitoring and evaluation. Findings from open-ended questions were presented in prose.

4.2 Questionnaire Return Rate

This part analyzes information on the questionnaires that were returned from the field. Findings on filled in questionnaires and unreturned questionnaires are presented in Table 4.1.

Table 4.1: Response Rate

Response	**Frequency**	**Percentage**
Filled in questionnaires	175	85.8
Un returned questionnaires	29	14.2
Total Response Rate	**204**	**100**

Out of the sampled population, 175 questionnaires were returned duly filled in making a response rate of 85.8%. The response rate was representative and was adequately used to answer the research questions. According to Mugenda (2003) that a response rate above 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent.

4.3. Demographic characteristics of the respondents

The respondents' personal information included gender, age, level of education, the period of time the respondent has known universal health coverage.

4.3.1. Distribution of Respondents by Gender

The respondents were requested to indicate their gender. Accordingly, the findings are as presented in the Table 4.2.

Table 4.2: Distribution of Respondents by Gender

	Frequency	**Percentage (%)**
Male	90	51.4%
Female	85	48.6 %
Total	**175**	**100.0**%

From the findings, majority (90) of the respondents were male and 85 of the respondents were female. This implies that even though most of the responses emanated from males there was gender balance. The gender information was significant for the current study in that it helped the researcher to indentify the gender which was actively involved in the formulation of the UHC.

4.3.2. Distribution of Respondents by Age

The study sought to establish the age of the respondents and the findings are as shown in Table 4.3

Table 4.3: Distribution of Respondents by Age

	Frequency	**Percentage (%)**
24 years and below	10	**5.7%**
25-29 years	23	**13.1%**
30-34 years	49	**28.0%**
35-39 years	56	**32.0%**
40-44 years	18	**10.3%**
45-49 years	12	**6.9%**
Above 50 years	7	**4.0%**
Total	**175**	100**%**

According to the findings, 56 of the respondents were between 35-39 years, 49 were 30-34 years, 23 were 25-29 years, 18 were 40-44 years, 12 were 45-49 years, 10 were below 24 yrs and 7 respondents were above 50 years old. This depicts that most of the respondents were aged enough and thus could offer high quality information because of their experience. The age information was significant for the current study as it helped the researcher to indentify the age group which was actively involved in the universal coverage. It also helped the researcher to identify the age group which highly benefited from the Universal Health Coverage.

4.3.3. Distribution of participants by Level of Education

The respondents were requested to indicate their level of education. The findings on analysis of respondents level of education has been presented on Table 4.4

Table 4.4: Distribution of participants by Level of Education

	Frequency	**Percentage (%)**
Secondary	30	17.1%
Certificate/Diploma	66	37.7%
Graduate	56	32.0%
Post Graduate	25	14.3%
Total	**175**	100%

From the findings, most (66) of the respondents had certificate/diploma level of education, 56 were graduates, 30 had secondary education while 25 were postgraduate. This implies that respondents were well knowledgeable and hence higher chances of getting reliable data. This was significant as the researcher could identify whether the information provided was true to the word and whether the respondents actually understood what was involved in universal health coverage.

4.3.4. Duration of knowing Universal Health Coverage

The study also sought to establish how long respondents had known universal health coverage. The findings are as shown in Table 4.5.

Table 4.5: Duration of working in project work

	Frequency	Percentage
Less than a year	31	17.7%
between 1-3 years	57	32.6%
between 4-6 years	73	41.7%
over 4 years	14	8.0%
Total	**175**	**100%**

Based on the findings, 73 of the respondents had were aware of universal health coverage for a duration between 4-6 years, 57 of the respondents were aware of it between 1-3 years, 31 of the respondents knew it for less than a year, while 14 of the respondents knew about universal health coverage for a duration of over 4 years. This illustrates that the most of the respondents were aware of the UHC and therefore had accumulated a lot of knowledge and skills over time. The information was significant to the study as the researcher would determine the interest in universal coverage by the time an individual has participate in the universal health coverage project.

4.4. Resource Mobilization

This section presents findings on resource mobilization which are presented in the subsequent section.

4.4.1. Influence of Resource Mobilization on Sustainability of UHC

The respondents were requested to indicate whether resource mobilization influence sustainability of Universal Health Coverage. The findings are show in table 4.6

Table 4.6: Influence of Resource Mobilization on Sustainability of UHC

	Frequency	Percentage (%)
Yes	125	71.4%
No	50	28.6%
Total	**175**	100%

From the majority (125) of the respondents indicated that resource mobilization influence sustainability of Universal Health Coverage while 50 were of contrary opinion. This depicts that resource mobilization influence sustainability of Universal Health Coverage.

4.4.2. Extent of Resource Mobilization influence on sustainability of UHC

The respondents were requested to indicate the extent to which they agree with statements on resource mobilization influence on sustainability of Universal Health Coverage. The responses were placed on a five likert scale where 1=strongly disagree, 2-disagree, 3-moderate, 4=agree, while 5=strongly agree. The findings are shown in the table 4.7

Table 4.7: Extent of Community Participation influence on sustainability of UHC

Statements	Mean	Std Dev.
Sustainability of universal health coverage should engage stakeholders from all sectors of society	3.61	0.1569
Various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage	3.99	0.2378
The government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance	3.78	0.1872
The public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system	3.57	0.1920
Sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers	3.70	0.1389

From the findings the respondents agreed that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage (mean=3.99), followed by the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance (mean=3.78), sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers (mean=3.70), sustainability of universal health coverage should engage stakeholders from all sectors of society (mean=3.61), and that the public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system (mean=3.57). This depicts that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage.

4.5. Stakeholder Engagement

This section presents findings on stakeholder engagement and sustainability of UHC which are presented in the subsequent section.

4.5.1. Influence of Stakeholder Engagement on Sustainability of UHC

The respondents were requested to indicate whether stakeholder engagement influence sustainability of Universal Health Coverage. The findings are show in table 4.8

Table 4.8: Influence of Stakeholder Engagement on Sustainability of UHC

	Frequency	**Percentage (%)**
Yes	112	64.0%
No	63	36.0%
Total	**175**	100%

From the majority (112) of the respondents indicated that stakeholder engagement influence sustainability of Universal Health Coverage while 63 were of contrary opinion. This depicts that stakeholder engagement influence sustainability of Universal Health Coverage.

4.5.2. Extent of Stakeholder Engagement influence on sustainability of UHC

The respondents were requested to indicate the extent to which they agree with statements on stakeholder engagement influence on sustainability of Universal Health Coverage. The responses were placed on a five likert scale where 1=strongly disagree, 2-disagree, 3-moderate, 4=agree, while 5=strongly agree. The findings are shown in the table 4.9

Table 4.9: Extent of Stakeholder Engagement influence on sustainability of UHC

Statements	Mean	Std Dev.
Sustainability of universal health coverage should engage stakeholders from all sectors of society	3.65	0.1834
Various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage	4.04	0.1324
The government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance	4.12	0.2081
The public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system	3.80	0.2189
Sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers	3.57	0.1894

From the findings the respondents strongly agreed that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance (mean=4.12), followed by various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage (mean=4.04), the public and private health practitioners have collaborated to ensure successful and sustainable universal

health coverage system (mean=3.80), sustainability of universal health coverage should engage stakeholders from all sectors of society (mean=3.65), and that sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers (mean=3.57). This depicts that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance.

4.6. Monitoring and Evaluation

This section presents findings on monitoring and evaluation and sustainability of UHC which are presented in the subsequent section.

4.6.1. Influence of Monitoring and Evaluation on Sustainability of UHC

The respondents were requested to indicate whether monitoring and evaluation influence sustainability of Universal Health Coverage. The findings are show in table 4.10

Table 4.50: Influence of Monitoring and Evaluation on Sustainability of UHC

	Frequency	**Percentage (%)**
Yes	130	74.3%
No	45	25.7%
Total	**175**	100%

From the majority (130) of the respondents indicated that monitoring and evaluation influence sustainability of Universal Health Coverage while 45 were of contrary opinion. This depicts that monitoring and evaluation influence sustainability of Universal Health Coverage.

4.6.2. Extent of Monitoring and Evaluation influence on sustainability of UHC

The respondents were requested to indicate the extent to which they agree with statements on monitoring and evaluation influence on sustainability of Universal Health Coverage. The responses were placed on a five likert scale where 1=strongly disagree, 2-disagree, 3-moderate, 4=agree, while 5=strongly agree. The findings are shown in the table 4.11

Table 4.11: Extent of Monitoring and Evaluation influence on sustainability of UHC

Statements	Mean	Std Dev.
Effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline	3.82	0.8901
High level leadership to drive the monitoring and evaluation reform hinder sustainability of universal health coverage	3.68	0.7723
There is need for political will with highest commitment and national champions in implementing a sustainable universal health coverage	3.58	0.9240
Some degree of centralization in a monitoring and evaluation system is necessary for sustainable universal health coverage	3.52	0.8245
For sustainability of universal health coverage, phased approach, simplified monitoring and evaluation systems with clear goals, objectives, and standardized measurable indicators should be adopted	3.79	0.8112

From the findings the respondents strongly agreed that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline (mean=3.82), followed by for sustainability of universal health coverage, phased approach, simplified monitoring and evaluation systems with clear goals, objectives, and standardized measurable indicators should be adopted (mean=3.79), high level leadership to drive the monitoring and evaluation reform hinder sustainability of universal health coverage (mean=3.68), there is need for political will with highest commitment and national champions in implementing a sustainable universal health coverage (mean=3.58), and that some degree of centralization in a monitoring and evaluation system is necessary for sustainable

universal health coverage (mean=3.52). This depicts that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline.

4.7. Discussion of Findings

The study established that resource mobilization influence sustainability of Universal Health Coverage. The study also found that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage. The findings contradict a study by Bain and Ebuenyi, (2017) who stated that efficient health care system is about pooling risks by definition; every universal health care system is insurance system. In turn, the very nature of insurance implies resource allocation from those in good health towards sick. Therefore, domestic political compact is needed to set up modalities of how the insurance premiums are paid to what extent resource transfers will take place between healthy and sick, but also between generations and between higher and lower income strata in society.

The study found that stakeholder engagement influence sustainability of Universal Health Coverage. The study also established that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. In Kenya, with support of various stakeholders, the government of Kenya has over the years since independence in 1963 initiated policy reforms and strategies earmarked towards universal health coverage. Some of these are outlined in various policy documents including Kenya Health Policy Framework (KHPF 1994–2010), Health Sector Strategic Plans, Vision 2030, the Constitution 2010, and finally, the Health Bill of 2015. Notably, the government recognized a high quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation (Tallon-Baudry, 2012).

The study established that monitoring and evaluation influence sustainability of Universal Health Coverage. The study also found that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. According to Kusek & Rist (2012) a readiness assessment is the foundation and first

step of a monitoring and evaluation system for sustainability of universal health coverage. Available literature accumulated in the last decade is mainly from monitoring and evaluation readiness assessment conducted by the World Bank, specifically in developing countries (Mackay, 2013). The aim of the studies was to assess the countries according to key factors that are critical prior to building an monitoring and evaluation system for sustainability of universal health coverage. The identified key factors from these studies included presence of regulatory frameworks, leadership, monitoring and evaluation structures and systems, and capacity building.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presented summary, discussion, conclusion and recommendations on the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County.

5.2. Summary of findings

This section presented the summary of the findings and they are discussed in subsequent headings:

5.2.1. Resource Mobilization

The study established that resource mobilization influence sustainability of Universal Health Coverage. The study also found that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage. The government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance

5.2.2. Stakeholder Engagement

The study found that stakeholder engagement influence sustainability of Universal Health Coverage. The study also established that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. Various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage, the public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system

5.2.3. Monitoring and Evaluation

The study established that monitoring and evaluation influence sustainability of Universal Health Coverage. The study also found that effective monitoring and evaluation systems for

sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. Sustainability of universal health coverage, phased approach, simplified monitoring and evaluation systems with clear goals, objectives, and standardized measurable indicators should be adopted

5.3. Conclusion of the Study

This section presented the conclusion of the study as shown in the subsequent headings:

5.3.1. Resource Mobilization

The study concluded that resource mobilization influence sustainability of Universal Health Coverage. The study also concluded that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage. The findings contradict a study by Bain and Ebuenyi, (2017) who stated that efficient health care system is about pooling risks by definition; every universal health care system is insurance system. In turn, the very nature of insurance implies resource allocation from those in good health towards sick. Therefore, domestic political compact is needed to set up modalities of how the insurance premiums are paid to what extent resource transfers will take place between healthy and sick, but also between generations and between higher and lower income strata in society.

5.3.2. Stakeholder Engagement

The study concluded that stakeholder engagement influence sustainability of Universal Health Coverage. The study also concluded that the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. In Kenya, with support of various stakeholders, the government of Kenya has over the years since independence in 1963 initiated policy reforms and strategies earmarked towards universal health coverage. Some of these are outlined in various policy documents including Kenya Health Policy Framework (KHPF 1994–2010), Health Sector Strategic Plans, Vision 2030, the Constitution 2010, and finally, the Health Bill of 2015. Notably, the government recognized a high quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation (Tallon-Baudry, 2012).

5.3.3. Monitoring and Evaluation

The study concluded that monitoring and evaluation influence sustainability of Universal Health Coverage. The study also concluded that effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline. According to Kusek & Rist (2012) a readiness assessment is the foundation and first step of a monitoring and evaluation system for sustainability of universal health coverage. Available literature accumulated in the last decade is mainly from monitoring and evaluation readiness assessment conducted by the World Bank, specifically in developing countries (Mackay, 2013). The aim of the studies was to assess the countries according to key factors that are critical prior to building an monitoring and evaluation system for sustainability of universal health coverage. The identified key factors from these studies included presence of regulatory frameworks, leadership, monitoring and evaluation structures and systems, and capacity building.

5.4. Recommendations

Based on the study findings the following recommendations were made:

1. Kenya's state department for health and the county governments should focus on investments in Universal health care through mobilization of resources to improve county health centre readiness scores so as to achieve equitable access to skilled delivery services across the country.

2. The government should involve every stakeholder in the health sector through training and provision of education on Universal Health Care. The strengthening of policies to ensure improvements in the proportions of people enrolling on civic education for UHC.

3. This study recommends that a study should be conducted further to find ways of minimizing the influence current nomadic livelihood on Universal Health Care utilization

4. The study recommends that the government should ensure that the monitoring and evaluation processes are geared to ensure the Universal health coverage process is implemented in the right manner and with the right strategies

5.5. Suggestions for Further Studies

Opportunity for further research in the subject matter exists thus: it would be interesting to compare the findings with lower units of analysis such as the sub-county. The population of the study would be much bigger; a second study is suggested to come up with a standard acceptable utilization levels. This will provide a standard upon which such studies can be replicated.

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APPENDICES

APPENDIX I: INTRODUCTORY LETTER

UNIVERSITY OF NAIROBI
OPEN, DISTANCE AND e-LEARNING CAMPUS
SCHOOL OF OPEN AND DISTANCE LEARNING
DEPARTMENT OF OPEN LEARNING
NAIROBI LEARNING CAMPUS

Your Ref:
Our Ref:
Telephone: 318262 Ext. 120

Main Campus
Gandhi Wing, Ground Floor
P.O. Box 30197
NAIROBI

REF: UON/ODeL/NLC/28/405

1st August, 2018

TO WHOM IT MAY CONCERN

RE: ABDULLAHI SHEIKH ABDIRAHMAN- REG NO: L50/5544/2017

This is to confirm that the above named is a student at the University of Nairobi, Open Distance and e-Learning Campus, School of Open and Distance Learning , Department of Open Learning pursuing Masters of Art in Project Planning and Management.

He is proceeding for research entitled **"Factors Influencing the Sustainability of Universal Health Coverage in Vulnerable Livelihoods in Kenya: A Case Study of Wajir County"**

Any assistance given to him will be highly appreciated.

08 AUG 2018

CAREN AWILLY
CENTRE ORGANIZER
NAIROBI LEARNING CENTRE

APPENDIX II: QUESTIONNAIRE

Dear respondent. The researcher is a student of Project Planning and Management at University of Nairobi and the research is for academic purpose only and will be treated with outmost confidentiality. The research seeks to investigate the factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County. Kindly provide correct and useful data and fill appropriately as logically guided. (This questionnaire has been provided as a word document that can be filled out in soft copy and returned via e-mail; or printed, filled out and mailed).

Section 1: General Information

1. Gender of the respondent

   a) Male ( ) b) Female ( )

2. Indicate by ticking your age bracket

   a) 24 yrs and below [ ] b) 25-29 [ ]

   c) 30-34 [ ] d) 35-39 [ ]

   e) 40-44 [ ] f) 45-49 [ ]

   g) 50 and above [ ]

3. Kindly indicate your highest level of educational qualification (tick)

   a) Secondary education [ ] c) Certificate or diploma [ ]

   d) Graduate [ ] e) Postgraduate [ ]

4. How long have you known universal health coverage?

   a) Less than 1 Year [ ] b) 1-3 Years [ ]

   c) 4-6 Years [ ] d) 7 Years and above [ ]

SECTION B: RESOURCE MOBILIZATION

5. Does resource mobilization influence sustainability of Universal Health Coverage?

Yes ( ) No ( )

6. Using a scale of 1-5, where 1= strongly disagree; 2=disagree; 3=Neutral; 4=agree; 5=strongly agree; Please indicate the extent to which you agree with the following statement on resource mobilization influence sustainability of Universal Health Coverage.

Statements	**S.A**	**D**	**N.S**	**A**	**S.A**
Sustainable health care financing systems are to rely first and foremost on domestic revenue collection					
Efficient health care system is about pooling risks by definition; every universal health care system is insurance system					
Key to health care financing is its political and fiscal sustainability that, requires that certain time consistent ground rules as per revenue sources are in place					
Health care prioritization is concerned not only with absolute amounts of health care spending, but predictability of revenues that are safeguarded					
Domestic political compact is needed to set up modalities of how the insurance premiums are paid to what extent resource transfers will take place between healthy and sick					

SECTION C: STAKEHOLDER ENGAGEMENT

7. Does stakeholder engagement affect the sustainability of Universal Health Coverage?

Yes ( ) No ( )

8. Using a scale of 1-5, where 1= strongly disagree; 2=disagree; 3=Neutral; 4=agree; 5=strongly agree; Please indicate the extent to which you agree with the following statement on stakeholder engagement and sustainability of Universal Health Coverage.

Statement	**S.A**	**D**	**N.S**	**A**	**S.A**
Sustainability of universal health coverage should engage stakeholders from all sectors of society					
Various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage					
The government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance					
The public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system					
Sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers					

SECTION D: MONITORING AND EVALUATION

9. Does monitoring and evaluation influence sustainability of Universal Health Coverage?

Yes ( ) No ( )

10. Using a scale of 1-5, where 1= strongly disagree; 2=disagree; 3=Neutral; 4=agree; 5=strongly agree; Please indicate the extent to which you agree with the following statement on monitoring and evaluation and sustainability of Universal Health Coverage.

Statement	S.A	D	N.S	A	S.A
Effective monitoring and evaluation systems for sustainability of universal health coverage begin by conducting a readiness assessment to set the baseline					
High level leadership to drive the monitoring and evaluation reform hinder sustainability of universal health coverage					
There is need for political will with highest commitment and national champions in implementing a sustainable universal health coverage					
Some degree of centralization in a monitoring and evaluation system is necessary for sustainable universal health coverage					
For sustainability of universal health coverage, phased approach, simplified monitoring and evaluation systems with clear goals, objectives, and standardized measurable indicators should be adopted					

THE END

THANK YOU

APPENDIX III: RESEARCH PERMIT

THIS IS TO CERTIFY THAT:
MR. ABDULLAHI SHEIKH ABDIRAHMAN
of UNIVERSITY OF NAIROBI, 596-70200
WAJIR,has been permitted to conduct
research in *Wajir County*

on the topic: *FACTORS INFLUENCING THE SUSTAINABILITY OF UNIVERSAL HEALTH COVERAGE IN VULNERABLE LIVELIHOODS IN KENYA: A CASE STUDY OF WAJIR COUNTY*

for the period ending:
14th August,2019

.....
Applicant's Signature

Permit No : NACOSTI/P/18/96550/24695
Date Of Issue : 14th August,2018
Fee Recieved :Ksh 1000

.....
Director General
National Commission for Science, Technology & Innovation

CONDITIONS

1. The License is valid for the proposed research, research site specified period.
2. Both the Licence and any rights thereunder are non-transferable.
3. Upon request of the Commission, the Licensee shall submit a progress report.
4. The Licensee shall report to the County Director of Education and County Governor in the area of research before commencement of the research.
5. Excavation, filming and collection of specimens are subject to further permissions from relevant Government agencies.
6. This Licence does not give authority to transfer research materials.
7. The Licensee shall submit two (2) hard copies and upload a soft copy of their final report.
8. The Commission reserves the right to modify the conditions of this Licence including its cancellation without prior notice.

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No.A 20027

CONDITIONS: see back page

APPENDIX IV: RESEARCH AUTHORIZATION

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/18/96550/24695** Date: **14th August, 2018**

Abdullahi Sheikh Abdirahman
University of Nairobi
P.O Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: A case study of Wajir County,"*** I am pleased to inform you that you have been authorized to undertake research in **Wajir County** for the period ending **14th August, 2019.**

You are advised to report to **the County Commissioner and the County Director of Education, Wajir County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Wajir County.

The County Director of Education
Wajir County.

National Commission for Science, Technology and Innovation is ISO9001: 2008 Certified

APPENDIX V: LETTER OF AUTHORITY TO CARRY OUT RESEARCH

Telegrams. "046-21029
When replying please quote
Fax.....
Telephone: 0722384134
EDW/RESARCH/VOL1 (60)

COUNTY DIRECTOR OF EDUCATION,
Wajir County
P.O Box 31,
Wajir

DATE:20TH AUGUEST 2018

REPUBLIC OF KE NYA
MINISTRY OF EDUCATION
State Department of Basic Education

RE: AUTHORITY TO CARRY OUT RESEARCH

Following your authorization by National commission for Science, technology and innovation to undertake research on factors influencing the sustainability of universal health care coverage in vulnerable livelihoods in Kenya: A case study of Wajir county. I hereby allow you to carry out your research in Wajir county for the period ending 14th August, 2019.

Please co-operate with them.

COUNTY DIRECTOR OF EDUCATION
WAJIR COUNTY
P. O. Box 31 - 70200,
WAJIR.

HUSSEIN OSMAN ADAN

FOR: COUNTY DIRECTOR OF EDCATION

WAJIR

APPENDIX VI: LETTER OF WAJIR COUNTY COMMISSIONER

THE PRESIDENCY

MINISTRY OF INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT

Telegraphic Address: "County"
Email: ccwajircounty@yahoo.com
When replying please quote

Ref No: F.50 VOL I (131)

The County Commissioner
Private Bag
Wajir

20th August, 2018

Adbullahi Sheikh Abdirahman,
University of Nairobi
P.O. Box 30197– 00100,
Nairobi.

RE: RESEARCH AUTHORIZATION.

Reference is made to a letter Ref. NACOSTI/P/18/96550/24695 from the Director – General/CEO, National Commission for Science Technology and Innovation dated 14th August, 2018 on the above subject matter.

You are hereby authorized to undertake your research ***for factors influencing the sustainability of Universal Health coverage in vulnerable live hoods in Kenya*** in the eight Sub-Counties in Wajir County for the period ending14th August, 2019.

Liaise with the relevant Deputy County Commissioners (DCC's) for any necessary assistance.

Andrew M. Mathiu
For: County Commissioner
Wajir County

CC.

All Deputy County Commissioners
Wajir County.