UNIVERSITY OF NAIROBI

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

EFFECTS OF PARTICIPATION IN PLANNING AND UTILIZATION OF UNIVERSAL HEALTH CARE SCHEME: THE CASE OF MAKUENI COUNTY, KENYA

CANDY MUMBUA NDETI

C50/84598/2016

A PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN SOCIOLOGY (RURAL SOCIOLOGY AND COMMUNITY DEVELOPMENT), IN THE UNIVERSITY OF NAIROBI

2019

DECLARATION

This research project has never been submitted for the award of a degree in this University or in any other institution of higher learning.

Signature…………………………………   **Date: …………………………………**

CANDY MUMBUA NDETI

No: C50/84598/2016

This research paper has been submitted for examination with my approval as the University Supervisor.

Signature…………………………………   **Date: …………………………………**

PROF PRESTON CHITERE

SUPERVISOR

DEDICATION

This research is dedicated to my cherishing parents Dr. Titus Ndeti and Ruth Ndeti and sister Lucy Ndeti for their consistent support throughout my scholarly adventure. They were with me and encouraged me in my journey to achieve my dreams.

ACKNOWLEDGEMENTS

An exceptional gratitude to my supervisor Professor Chitere for his direction, understanding and consolation in the composition and development of this research. His significant assistance and broadmindedness through this adventure has been essential in enhancing my capacity to accomplish this task.

Further to my schoolmates and companions without whose intrigue and support, I could not have delivered this research paper. I therefore wish to express gratitude towards them for the support towards this research by providing their time, assistance and sharing their encounters and their experiences with me.

Lastly, I am grateful to my family for providing me with overwhelming support, motivation and affection that I greatly needed. I also thank them for continually believing and trusting me consistently all through the year.

TABLE OF CONTENTS

DECLARATION .... **ii**

DEDICATION .... **iii**

ACKNOWLEDGEMENTS .... **iv**

TABLE OF CONTENTS .... **v**

LIST OF FIGURES .... **viii**

LIST OF TABLES .... **ix**

LIST OF ABBREVIATIONS .... **x**

ABSTRACT .... **xi**

CHAPTER ONE: INTRODUCTION **1**

1.1. Background of the Study 1

1.2. Statement of the Problem 4

1.3. Research Questions 6

1.4. Objectives of the Study 6

1.5. Justification of the Research 7

1.6. Scope and Limitations 7

1.7. Definition of Key Concepts 8

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK **9**

2.1. Introduction 9

2.2 The Universal Health Care Scheme 9

2.3. Effectiveness of the Universal Healthcare Scheme 11

2.4. Perception of the Universal Health Care Scheme 12

2.5 Level of Participation in the Universal Health Care Scheme 13

2.6. Utilization of the Universal Health Care 15

2.7. The Demographics of the Universal Health Care Scheme Participants 16

2.8. Government Policies on Universal Health Care 17

2.9. Theoretical Framework 19

2.10. Conceptual Framework 23

2.11. Summary of Literature Review 24

CHAPTER THREE: RESEARCH METHODOLOGY 26

3.1 Introduction 26

3.2. Research Site 26

3.3 Research Design 26

3.4 Unit of Analysis and Unit of Observation 27

3.5 Target Population 27

3.6 Sample Size and Sampling Procedure 28

3.7 Data Collection Methods and Tools 29

3.8 Ethical Considerations 30

3.9 Data analysis 30

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION ... 31

4.1. Introduction 31

4.2. Health Care Scheme in Makueni 31

4.3. Effectiveness of Universal Health Care 32

4.4. Perceptions of the respondents on the Universal Health Care 35

4.5. Level of Participation in the UHCS 36

4.6. Use of Universal Health Care 39

4.6. Profiles of the Household Participating in UHC 42

4.7. Conclusion 45

CHAPTER FIVE 47

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS 47

5.1. Summary of findings 47

5.2. Conclusions of the Study 48

5.3. Recommendations 49

REFERENCES 51

Appendices 55

Appendix 1: The questionnaire 55

Appendix 2: Key Informant Interview Schedule 63

Appendix 3: The Letter from Ministry of Health 65

Appendix 4: The Research Permit from County Government of Makueni 66

Appendix 5: The Letter from Mukuyuni Health Center 67

Appendix 6: Nacosti Letter 68

LIST OF FIGURES

Figure 2.1. Conceptual Framework 23

Figure 4.2: Benefits from the County UHCS 32

Figure 4.3. Requirement for Payment of the Hospitalization Services 34

Figure 4.4. Respondents Attendance of Meetings for Planning for UHC 36

Figure 4.5: Other Family Members Participation in the Health Committee 38

Figure 4.6: Relationship with Community Members 39

Figure 4.7. Respondents Joining of the UHC in the County 40

Figure 4.8. Ways of Joining UHC 41

Figure 4.9: Distribution of Respondents by Gender 42

Figure 4.10 Number of Children and Dependents Reported by the Respondents 45

LIST OF TABLES

Table 4.1 Duration of UHC Benefit 33

Table 4.2 The Respondents Opinion of UHC in the County 35

Table 4.3 Member of a Health Committee 37

Table 4.4 The distribution of Respondents by Age 43

Table 4.5 The Distribution of Respondents by their Level of Education 43

Table 4.6 The Marital Status of the Respondents 44

LIST OF ABBREVIATIONS

CBHI: Community Based Health Insurance

KI: Key Informant

KHPF: Kenya Health Policy Framework

LMICs: Low and Middle-Income Countries

NGOs: Non-governmental organizations

NHIF: National Hospital Insurance Fund

UHCS: Universal Health Care Scheme

ABSTRACT

The purpose of this study was to assess the effects of participation in planning on the viability of the Universal Health Care (UHC) in Makueni County. The objectives of the study were to examine the effectiveness of the UHC in Makueni County, establish peoples' perceptions towards the UHC scheme, determine the level of the participation in the planning of the UHC scheme in Makueni County and establish the use of UHC by the residents of Makueni County. The study applied descriptive research design. The unit of observation was the UHC scheme in Makueni County while the unit of analysis was Makueni referral hospital. The target respondents were 85 adult citizens in the county who comprised the outpatients, UHC scheme employees of the community, health staff and also the community leaders within Makueni County. Multistage sampling was applied to select the study sample of Makueni referral Hospital and two sub county emergency clinics. Quantitative data was collected using a questionnaire while qualitative data was collected using an interview guide. Data analysis was through frequency tables and percentages and presentation was through bar graphs, charts and tables. Qualitative data was presented through prose. The study found that (82%) of the respondents did not participate by attending the meetings. More (nearly 70%) of them, however, attended meetings of village health committees. Similarly, more (49%) of other family members had not equally participated in meetings of health committees. The study also found that a majority (71%) had joined the scheme as individuals in 2014 when it was started. The joining fee at that time was Ksh. 150 and rose to Ksh. 500 at the time of this study. All of those who had joined reported benefitting from the scheme, for example, those who had persistent illnesses they might not have afforded medication if it were not for UHC. The study concluded that the respondents did not participate in meetings held for planning and budgeting for the UHC at the county and sub-county levels. The respondents' perceptions of the scheme were rated as very good, good and poor. The study recommends that Ministry of Health in Kenya and County administrations should commit more resources in the universal healthcare by making sure that the required resources are mobilized to be able to enhance the county health facilities for equitable, quality and accessible healthcare services. The study also recommends that the county government should engage all the stakeholders by providing empowerment and training to enable them deliver the universal healthcare services. Lastly, the national government and county government should continually monitor and evaluate healthcare delivery activities to ensure that the provision of the Universal healthcare coverage processes are appropriately executed.

CHAPTER ONE: INTRODUCTION

1.1. Background of the Study

Universal Health Care (UHC) refers to the health care system which offers health coverage to all citizens in a particular country as well as financial coverage on health care to the citizens. This is done since healthcare services are regarded as basic needs for the public (Grossman, 2012). One of the goal with universal healthcare is to create a system of protection which provides equality of opportunity for people to enjoy the highest possible level of health. As part of Sustainable Development Goals, United Nations member states have agreed to work toward worldwide universal health coverage by 2030. Another goal of UHC is ensuring that people have access to the health care they need without suffering financial hardship. The third goal is that UHC aims at allowing countries to make the most of their strongest asset: human capital.

Agenda 21 of the World Health Organization (WHO) emphasizes that every citizen has a right to quality, safe and accessible healthcare services. General healthcare services are established with regard to the budgetary allocations required for provision of these services and the cooperation of the beneficiaries is fundamental (WHO, 1989). Further, the United Nations stipulates that inclusion of the people, communities and significant groups within the health care scheme should be considered as the mechanism through which governments and jurisdictions maintain and enhance the health care needs of their people (Ekman, 2014).

Within the context of Australia, across the nation and also at the state level, public organizations have maintained a deep concern in the healthcare provision for the masses since this has some apparent advantages. In its rural healthcare, public interest is the key to provision of safe, quality

and accessible services. Besides, it is regularly suggested that enhanced public involvement in the healthcare system will bring about more satisfaction within the healthcare system and unquestionably improved health care outcomes. However, there lacks evaluations of the effectiveness of the healthcare system to deliver the required results to the public (Tallon-Baudry, 2012).

For Rwanda, the concept of universal health care is one of the nation's main challenge, where majority of the people are unable to afford or cater for medical bills as the healthcare services have been expensive to most of them. The possibility of universal healthcare system becoming successful in Rwanda was identified as it is among nine nations in Asia and Africa that have made enormous progress over the years. This is because of the capacity of the Department of Health within Rwanda ensures that a great number of its residents are covered by the program. This has enabled the country to improve the health status of its people in totality. Therefore, Rwanda's approach to the UHC has been a success.

As for Kenya, apart from food, about 40% of the finances that people earn are used in paying for medical bills in most of the counties (Kutzin, 2013). In 2013, about a third of the country's total health expenditure was accounted by the direct payments made by citizens, while 36% was made up by the government, 20% by donors and 10% by employers (Carrin & Chris, 2015). Most Kenyans face difficulties in paying their medical bills and others go to media houses and social media to solicit for funds from people (Grossman, 2012). This has led to many Kenyans making appeals to the public to help them in clearing their medical bills. World Bank country director, Diarietou Gaye posited that more than one million people in Kenya are facing difficulties in dealing with medical bills due to being in the thrust of poverty (World Bank, 2013).

Makueni County launched the Universal Health Care (UHC) scheme in 2014. The county has since 2014 continued to ensure that its residents receive free health care services in all the public facilities, especially in the county the sub county hospitals. Members of the public are required to make an annual subscription of the Kenya shillings five hundred (Ksh500) only from each household, where all the children that are under 18 years are covered together with their parents. All the health care facilities at the dispensaries and health centres provide free healthcare services for all patients in Makueni County. Members of the public who are over 65 years are able to receive free treatment in all hospitals without any registration in the Makueni UHC plan.

In the past 50 years, there were colonial and national government built hospitals. The county has doubled these hospitals in the past five years. In 2019, there were 113 dispensaries and health centres that had been added, about 13 Level 4 hospitals which had employed more than 160 doctors whereas previously, only 38 doctors and 3 hospitals were in Makueni County (Makueni County, 2013). The largest budget item in Makueni today is health which is allocated KSh2.3 billion every year. The services that the Makueni hospital can offer include; admission of patients, surgical procedures, imaging of X-ray, testing in the Labs, dental check-ups and counselling services at no costs (Wamai, 2013).

Through the UHC plan by Makueni County, a large portion of Makueni residents have taken an interest in the universal healthcare program. However, the numbers that enrol are not encouraging. Therefore, it is significant for this investigation to assess what influences individuals' involvement and utilization of the universal healthcare plan within the County. The investigation therefore, attempted on building up on how the individuals took an interest in the

universal health care and the benefit they derived from the plan. Moreover, the study sought to examine what their perceptions were regarding the universal healthcare.

1.2. Statement of the Problem

The delivery of quality healthcare to all communities and people that does not expose them to financial hardship is what is termed as Universal Health Coverage. The United Nations in 2015 adopted the Sustainable Development Goals (SDGs) whose main objective was to guarantee that all the individuals gain accessibility to the health care services without being challenged by lack of funds to pay for health services. Kenya’s Vision 2030 also incorporates universal health coverage (Kanyiva, 2012). Organizations such as WHO and the World Bank have helped countries in realizing the importance of providing their citizens with Universal Health Coverage and the benefits that a country achieves.

The enrolment and renewals of health policies is determined greatly by individuals’ health status and their access to finances which influence them in deciding whether to enroll or renew. The individuals that are in good health are less likely to enroll and renew the health policies as compared to those that are mostly in poor health status as indicated by many studies (Omollo, 2012). The people who do not have chronic conditions were found not to have enrolled in a health policy while those that had reported chronic conditions and those that had been hospitalized had enrolled and frequently renewed their health insurance. The needs that people have on healthcare forces a high percentage of them to be enrolled or renew their health policies. Those with chronic health conditions are the most who seek health covers or policies. The immediate healthcare needs that those with poor health conditions require from time to time force them to enroll for the health plan.

More than 40% of Kenyans fail to take an interest in the universal healthcare on grounds that most people survive barely below the poverty line and hence cannot afford the plan. While the executive arm of the Kenyan government gives medical cover services through the National Hospital Insurance Fund (NHIF), this just entails the inpatient services to individual members and their dependents. In the past NHIF has had a plan to provide universal healthcare program to the Kenyan populace. This plan was rolled out in 2012 to all the government employees. However, the plan to enroll all Kenyans into the universal healthcare has been advocated for but it's financing and administration have yet to be implemented. This justifies this study to establish effectiveness and applicability of such a plan.

There are few studies conducted in Kenya regarding the effectiveness of the universal healthcare. This therefore warranted the carrying out of the present study regarding the public's participation in planning and the utilization of the universal healthcare within Makueni County. Some of the few studies conducted include that of Wamai (2013) who did a study on the healthcare framework in Kenya. The study established that healthcare costs in Kenya remain one of the most significant hindrance for individuals to access universal health care services. Hsiao (2013) investigated the association between poverty and participation of members of the public in the healthcare system in Kenya. The study revealed that about 46% of Kenyans are living on less than a dollar a day and therefore this high poverty level among the vast majority of the people limits their access to the universal healthcare services. These few studies have left a knowledge gap which should be filled. Therefore, it is against this background that the present research sought to establish the effects of the individuals' participation and utilization of the Universal healthcare scheme within Makueni County.

1.3. Research Questions

The study was therefore based on the following research question as enlisted below;

i. What is the effectiveness of the Universal Health Care Scheme implemented in Makueni County?
ii. How do the residents of Makueni perceive its Universal Health Care Scheme?
iii. What is the level of participation of the residents in planning of Universal Health Care Scheme in the County?
iv. What is the level of utilization of Universal Health Care by residents of Makueni?

1.4. Objectives of the Study

This section provides the general and specific objectives of the study.

1.4.1. General Objective

The overall aim of the research study was to ascertain the effects of the participation and involvement in planning on the effectiveness of the universal health care scheme which is implemented by the Makueni County Kenya.

1.4.2. Specific Objectives

The following are the specific objectives of the study:

i) To assess the effectiveness of Universal Health Care Scheme implemented by Makueni County.
ii) To establish people's perception of effectiveness of the Universal Health Care Scheme.

iii) To determine the level of participation of the residents in the planning of Universal Health Care Scheme.

iv) To assess the utilization of UHC by the residents of Makueni.

1.5. Justification of the Research

This study examines the effects of the residents' involvement in the universal health care scheme in Makueni County. Therefore, the study sought to establish the level of investment in the universal healthcare scheme, the viability of the plan, the residents' perceptions of the plan and the characteristics of those taking part in the program. Whereas studies have been done on health provision in Kenya, Universal health care has not been adequately covered. This has left a gap that should be filled. The present study sought to bridge this gap by examining the effects of residents' involvement in the universal healthcare within the Makueni County. The investigation will help the County and therefore the national governments generate lessons for building up the universal healthcare services in the entire country. The lessons will also provide knowledge for future research on universal healthcare.

1.6. Scope and Limitations

This study centers on the universal health coverage within the Makueni County by focusing on residents of the County who had enlisted and had been benefiting from the Universal health care. Makueni County has accepted the worldwide plea to give universal healthcare coverage to every one of its residents. The study concentrated on enrolled individuals who had gone to a couple of chosen health care facilities as outpatients, medical attendants, specialists and office managers.

Lack of enough financial resources, led the study to be restricted to the County referral and two Sub-County hospitals.

1.7. Definition of Key Concepts

The key terms emphasized in this current study are presented below;

Level of UHC coverage: This has been used to describe the extent of risk or the liability that is covered for an individual or the entity through the concept of the universal health coverage services within the County.

Perception of UHC: This has been used to refer to the way the concepts of universal healthcare has been regarded, understood and interpreted by the residents of the County.

Characteristics of the households: These are: age, gender, education, marital status and the number of dependents.

Universal Health Care: This is the healthcare program which is low cost and accessed by all residents of Makueni County.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Introduction

The current section dwells into the insights on the effects of the individuals' involvement on the effectiveness of the universal healthcare. It's based on the literature which has the particular importance or correlation to specific objectives used in this study. This chapter subsequently attempted to review the major theories which the study has been premised.

2.2 The Universal Health Care Scheme

The delivery of quality healthcare to the people to reduce their financial healthcare expenses is termed as Universal Health coverage. The United Nations in 2015 adopted the Sustainable Development Goals (SDGs) which its main goal was to guarantee that all the individuals have accessibility to the health care services without experiencing any financial hardships as the 2030 vision of universal health coverage. In 2016 Marie-Paule Kieny, who is the vice director general at World Health Organization (WHO), wrote that if world could be able to achieve delivery of healthcare services, then the other visions would be achieved as when individuals are healthy, they will work to the realization of all other visions for the better of the economy (WHO Report, 2015). It was established that about 150 million people in the world cannot afford to support themselves financially while another 100 million people cannot afford three basic meals in a day as they are below the poverty line as estimated by WHO.

In Kenya, apart from food, about 40% of the finances that people earn are used in paying for medical bills in most of the counties (Kutzin, 2013). In 2013, the country's total health expenditure was found to be accounted third by the direct payments made by citizens, while 36%

was made up by the government 20% by donors and 10% by employers (Carrin & Chris, 2015). Most of the Kenyans face difficulties in paying of the medical bills and others go to media houses and social media to bed for funds from people (Grossman, *et.a*l 2012). This has led to many Kenyans making appeals for people to help them in clearing of bills. It was rather recorded by the World Bank Country Director, Diarietou Gaye more than one million people in Kenyans are facing difficulties in dealing with medical bills due to being in the thrust for poverty (World Bank, 2013).

There are six levels of public healthcare facilities in Kenya that are hierarchically organized traditionally, where community health workers who are in the communities are the lowest in the hierarchy. The formal health system is connected to the community-based healthcare through the dispensaries and clinics that are in Level 2 (International Labour Organization, 2015). The primary healthcare units are made up of health centres maternity clinics and also the nursing home which are in Level 3. The sub county, county and the national referral hospitals are in Level 4, 5 and 6. The most visited levels are level 2 and 3 where they are then referred to level 4, 5 or 6 in cases where a specialist is needed or further consultations.

Despite all the challenges there have been wins in the sector. Some of these include; Counties such as Lamu and Mandera that have made history in that their hospitals can offer Caesarean section procedures to those in need, something that had never happened since independence (Carrin, 2012). The problems that have been faced include; the counties are forced to buy equipment that they felt that is not needed and that the resources they have are not enough, the Beyond Zero initiative which was started by First Lady's tend to be in shambles and patients are being turned away in many facilities due to them being abandoned. The Scheme's benefits and

the Universal Health Care Scheme are the two indicators that guide how effectively people participate.

2.3. Effectiveness of the Universal Healthcare Scheme

The concept of the health care has continued to be dominated by people suffering financial constraints to acquire these services which should not be the case in universal health coverage. The government and other stakeholders are attracted by these factors (Carrin, & Chris, 2015). There are three major goals that embody this fact. The first one should be to ensure that everyone who needs health care should get it despite any factor. Secondly, everybody should be given healthcare services whether they have finances or not and the third is that everyone who goes to receive healthcare should be able to improve the quality of their health. There should not be financial constraints faced by people when they intend to acquire healthcare and thus there should be a financial risk protection in all health centres.

Those people that are in vulnerable situations and the poor, are given hope by the Universal Healthcare where they are needed to participate so that they can acquire effective health care. Both the Alma-Ata declaration and WHO constitution that were started in 1978 and 1948 respectively were based on ensuring that health is a fundamental human right to every human being and that agenda was also stipulated later on (Carrin & Chris, 2015). There are four major elements that WHO identified as key in realising of the universal coverage.

They include; a health system that is strong, efficient and well run; a financing health service system; individuals should be able to access medicine and technologies that are essential to them and health workers that are well- trained and motivated. The universal health coverage in Kenya

has continued to be earmarked through initiating policy reforms by the government being supported by various stakeholders since independence in 1963. These policies have enabled Kenya to improve its health care in one way or another despite its challenges in providing effective health care services so that they can keep up with the global competition and become a prosperous nation.

Due to the devolved system of governance, Kenya has been capable of providing the effective health care services nearer to the individual residents as all the County Hospitals have been provided for funds to improve their services, buy the required equipment and employ skilled employees (Carrin & Chris, 2015). The population of the country is thus being provided for universal health coverage through these initiatives by the government. All the people in Kenya have been declared for accessibility to the reproductive health and the emergency medical treatments that are through the Health Bill of 2015 draft.

2.4. Perception of the Universal Health Care Scheme

There have been effective plans in Kenya for UHC compared to other countries. By 2030, Kenya has aimed at ensuring that it achieves its UHC as it is indicated in the country's Vision 2030 and in the constitution as per the Kenya health financing strategy. Through solidarity, responsibility, equity, and transparency, Kenya has built its health financing strategy through these factors (Carrin, & Chris, 2015). There are different mechanisms that have been put up to help in adding revenue to the health sector so that financial risk protection can be offered through the health financing strategy and policy debates that are key to Kenya.

There were different stakeholders that resisted the 2004 mandatory health insurance that tried to be introduced. Due to technical and political reasons that arose during that time, the bill was not signed by the President despite being passed in the parliament concerning social health insurance scheme bill. Back in the year 2007, another bill was also introduced so that the best approaches that involve health care can be searched and processed an initiative that is continuing until today. For the goals of UHC to be achieved and sustained, there is need for the National Health Insurance Scheme (NHIS) to have a program that is affordable and effective for all the citizens as per the discussion that are ongoing (Kirigia, 2010).

The NHIS designs tend to be discussed in this study and how people understand and their perceptions on health insurance in the communities. The NHIS critical issues, critical design features and premium payment levels are discussed in this study, where there is the desire and willingness to pay (WTP) or the capability to pay explicitly that have been elicited. UHC reforms are a great beneficiary to the communities. It is therefore advisable for communities to be trained on the advantages and benefits of UHC so that it can be well accepted and sustained.

2.5 Level of Participation in the Universal Health Care Scheme

Achievement of Universal Health Coverage (UHC) has continued to be done both in the Low and also the Middle-Income Countries (LMICs) through governments where efforts have increased in the past years. Without facing any hardships, UHC enables people to acquire good health services whenever they need it. The development of sustenance and reduction of poverty has been enhanced by UHC which is a major element in reduction of the social inequalities and also therefore enhancing the access to health care (Kutzin, 2013). Both or either of employer-based health insurance and government policies have been relied upon by most of the high

income countries so that the can progress towards achieving UHC. Lack of enough resources has made most of the LMIC, not to enable UHC due to lack of funds, a modest growth in the economy, public sector constrains and the government's capacity.

The delivery of quality healthcare is what is termed as Universal Health coverage by Holy Grail. The United Nations in 2015 adopted the Sustainable Development Goals (SDGs) which its main goal was to purpose that all the people must gain accessibility to the healthcare services without experiencing any financial hardships as the 2030 vision of universal health coverage. In 2016 Marie-Paule Kieny, wrote that if the world could therefore be able to achieve delivery of the health care services then all other visions would be achieved as when individuals are healthy, they will work to the realization of all other visions for the better of the economy (WHO Report, 2015). It was established that about 150 million people in the world cannot afford to support themselves financially while another 100 million people cannot afford three basic meals in a day as they are below the poverty line as estimated by WHO (Grossman, *et a*l 2012).

There are major variations in the achievement of UHC in how it is affected and covered despite the fact that the government has made efforts in improving financial protection and enhancing utilization through CBHI schemes (Musgrove, 2016). This shows that it's only under certain contexts and conditions that Community Based Health Insurance (CBHI) schemes are able to succeed. It's therefore necessary to ensure that the implementation and the sustainability of the UHC puts into consideration the factors that lead in its success and those that lead to its failure or slows its progress so that they can be eliminated. Thus, the CBHI schemes needs effective contexts and conditions to be identified before the process begins.

2.6. Utilization of the Universal Health Care

Majority of the health facilities in Kenya have made most citizens to have unmet health services bills due to the cash services offered. The people in the rural areas and peri-urban communities experience difficulties when it comes to enrolling and renewing of health policies. The factors that lead to these difficulties is in the health systems and individual levels as subscriptions are required and renewal processes (Nick, 2010). Most people are discouraged into enrolling into the scheme due to lack of employment, income levels that are low, lack of education and role of an individual in the family.

Healthcare vulnerability and roles of mother's lead most of the females to be involved in health policies. It was also found that most of the married people easily enroll and renew health policies. The single people are less likely to enroll and renew the health policies unlike those that are in the reproductive age who have a (95%) of enrolling (Kirigia, 2010). Financial factors are the major factors that influence people to either enroll or not enroll in the health policies. The health care policy participation is mostly influenced by people paying out of their pockets as most find it easier and effective to them thus leading to lack of renewal and enrolment.

The enrolment and renewals of health policies is also determined greatly by individuals' health status that influences them in making of the decision. The individuals that are in good health are therefore less likely to be enrolled and renew these health policies as compared to the ones that have a poor health status as most studies showed (Omollo, 2012). The people who do not have chronic conditions were found not to have enrolled in a health policy while those that had reported chronic conditions and maybe had been hospitalized had enrolled and frequently renewed their health insurance. The needs that people have on healthcare forced the highest

percentage of people to be enrolled renew the health policy which has increased in number of those that have chronic health conditions. The immediate health care needs that those with poor health conditions require from time to time force them to enroll for the health policies.

2.7. The Demographics of the Universal Health Care Scheme Participants

Most of health facilities within Kenya have made most citizens to have unmet health services bills due to the cash services offered. The people in the rural areas and peri-urban communities experience difficulties when it comes to enrolling and renewing of health policies. The factors that lead to these difficulties is in the health systems and individual levels as subscriptions are required and renewal processes (Nick, 2010). Most people are discouraged into enrolling into the scheme due to lack of employment, income levels that are low, lack of education and role of an individual in the family.

UHC is thus prevented by health systems and socio-demographic factors that affect many people and thus do not enroll or renew health policies in the society which is suggested by the study. On the other hand, most of the people who are enrolled in the scheme, majority are those that do not renew the scheme as effectively as it should be done (Carrin, 2012). Despite this, there is no study that has been done on how health policy active membership is influenced by households' socio-demographic factors.

Healthcare vulnerability and roles of mothers lead most of the females to be involved in health policies. It was also found that most of the married people easily enroll and renew health policies. The single people are less likely to enroll and renew the health policies unlike those that are in the reproductive age who have a (95%) of enrolling (Kirigia, 2010). Financial factors are

the major factors that influence people to either enroll or not enroll in the health policies. The health care policy participation is mostly influenced by people paying out of their pockets as most find it easier and effective to them thus leading to lack of renewal and enrolment.

The enrolment and renewals of health policies is also determined greatly by individuals' health status that influences them in making of the decision. The individuals that are in good health are therefore less possibly to be enrolled and renew health policies as related to the ones that have a poor health status as most studies showed (Omollo, 2012). The people who do not have chronic conditions were found not to have enrolled in a health policy while those that had reported chronic conditions and maybe had been hospitalized had enrolled and frequently renewed their health insurance. The needs that people have on healthcare forced the highest percentage of people to be enrolled renew the health policy which has increased in number of those that have chronic health conditions. The immediate health care needs that those with poor health conditions require from time to time force them to enroll for the health policies.

2.8. Government Policies on Universal Health Care

Many governments in various countries are already making progress towards UHC. The governments can take actions to move more rapidly towards it, or to maintain the gains they have already made (Carrin, & Chris, 2015). In some countries where health services have traditionally been accessible and affordable, governments are finding it increasingly difficult to respond to the ever-growing health needs of the populations and the increasing costs of health services.

Moving towards UHC requires strengthening health systems in all countries. Robust financing structures are key. When people have to pay most of the cost for health services out of their own

pockets, the poor are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness (Grossman, *et a*l 2012). Pooling funds from compulsory funding sources (such as mandatory insurance contributions) can spread the financial risks of illness across a population.

Improving health service coverage and health outcomes depends on the availability, accessibility, and capacity of health workers to deliver quality people-centred integrated care. Investments in quality primary health care will be the cornerstone for achieving UHC around the world (Kutzin, 2013). Investing in the primary health care workforce is the most cost-effective way to ensure access to essential health care will improve. Good governance, sound systems of procurement and supply of medicines and health technologies and well-functioning health information systems are other critical elements.

Universal Health Coverage is more than just eliminating the out-of-pocket expenditure; it is also about ensuring access to quality health care. This means that capacity in both structural and resource must be increased to handle the needs of the population (Kirigia, 2010). Additionally, there needs to be continuous awareness towards getting persons registered for the various health care programs and campaigns used to encourage registration prior to one getting sick. While expanding the NHIF cover is good, there is a need for the County Governments to work with the National Government to outline a plan that creates a seamless process and spectrum of cover at every level of care providing the necessary resources at any given time. There also needs to be lateral cooperation across counties and uniformity when designing various county health programs and schemes (within framework of the national plan).

2.9. Theoretical Framework

The current part is concerned with the theories that anchor the literatures under investigation & also the other framework for the proper confirmation and the proposals. These theories or the hypothesis to be investigated are health belief theories and also the stakeholder theories which are therefore considered to be much related to the current.

2.9.1 Health Belief Model

The individual's attitudes and beliefs are focused upon by the psychological theory in predicting and explaining their health behavior. The United States Public Health Service social psychologists were responsible in development of this theory in the 1950s. (Becker, 1984). These theories focus at the different aspect of the health care treatment with its main focus on the patient. Therefore, health conditions considered the susceptibility and the severity are the two parts contained in Perceived Threat. The perception of a person in that they might contract a certain condition is called Perceived susceptibility (Carpenter, 2010). When a person contracts a serious condition and they do not take the step of undertaking medication or treating it is termed as perceived severity where the possible consequences may arise. Threats that involve illness can be reduced through designing of effective strategies called perceived benefits. Lack of resources such as physical, psychological, and financial demands so that one can undertake health care, is called perceived barriers. The actions that people take without studying and are motivated by environmental factors are called cues to action (Glanz *et a*l. 2010).

Those people that are in vulnerable situations and the poor, are given hope by the Universal Healthcare where they are needed to participate so that they can acquire effective health care. Both the Alma-Ata declaration constitution that were started in 1978 and 1948 respectively were

based on ensuring that health is a fundamental human right to every human being and that agenda was also stipulated later on (Ayeni, 2015). There are four major elements identified as key in realising of the universal coverage. They include; a health system that is strong, efficient and well run; a financing health service system; individuals should be able to access medicine and technologies that are essential to them and health workers that are well- trained and motivated.

Performance can be improved through self-efficacy where an individual is expected to overcome challenges that influence behavior or performance and the patient is supposed to discuss the barriers that they face. Changes in lifestyle are influenced by cues to action (Kanyiva, 2012). Cues are; other family members' illnesses, media information and the symptoms that the individual experiences concurrently. An individual is supposed to make use of cues to find information on the unhealthy behavior practices they need to change so that they can adjust to the treatment and eventually improve their health. This hypothesis is more pertinent to the present investigation on the community involvement on the universal healthcare since huge numbers of general population has an opposite thought in regards to visiting different health care offices over the county because of their negative outcomes. The community customary doctors and mid wives has a very huge impact in general population's thought and their own decisions on what to action on.

The sexual risk behaviors that can lead to contracting HIV/ AIDS uses this model to educate individuals. The behaviors that are related to health are predicted and explained through influential variables called perceived barriers (Wamai, 2013). The perceived benefits and perceived susceptibility are other dimensions that are used by the theory, where the least

significant variable is the perceived severity. The model indicated that it is safe for an individual to either abstain from sexual behaviors or use a condom in case they need to engage in the activity.

The model was applicable to the study in that it helped the researcher to establish how UHC help in health promotion and disease prevention programs. It is used to explain and predict individual changes in health behaviors. It is one of the most widely used models for understanding health behaviors. Key elements of the Health Belief Model in relation to universal health coverage is its focus on individual beliefs about health conditions, which predict individual health-related behaviors. The model defines the key factors that influence health behaviors as an individual's perceived threat to sickness or disease (perceived susceptibility), belief of consequence (perceived severity), potential positive benefits of action (perceived benefits), perceived barriers to action, exposure to factors that prompt action (cues to action), and confidence in ability to succeed (self-efficacy).

2.9.2 Theory of Community Participation

The western ideology, development of the community and its influence, social work contributions to the community and radicalism in the community are the historical antecedents that help in participation of the community as suggested by Midgley (1986). There are two main areas are that are formed by literature on participation and participatory processes according to (Ross, 2000). They are political sciences and development theory. Financial factors are the major factors that influence people to either enroll or not enroll in the health policies. The health care policy participation is mostly influenced by people paying out of their pockets as most find it easier and effective to them thus leading to lack of renewal and enrolment (Lane 1995).

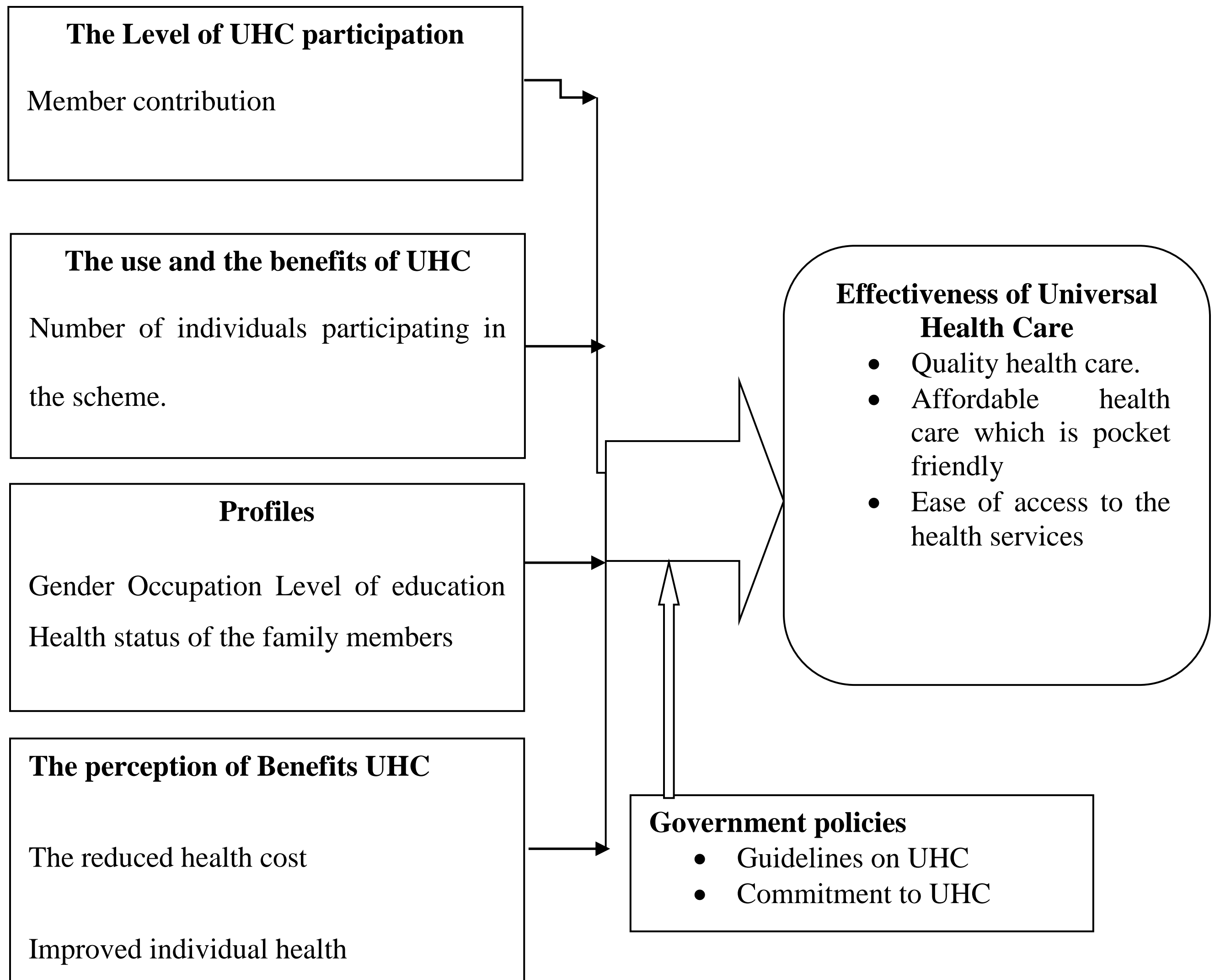
There are similarities in both the community development and participation theory where community participation theory was inspired by the 1950s and 1960s movement of developing the community as posited by (Midgley, 1986). Other countries have discredited community development as they consider it a colonialist overtone as identified by Moser (1987). Community development was however not discussed in the 1960s evolutionary trends which a good account provided by (Kelly, 2001).

In essential medicinal services it is the health care laborers in the health care centres and facilities who should do this network association and work with networks to choose and prepare community health care laborers and start network activity on medical problems. However the vast majority of them get small preparation on the techniques for working with networks. Network support can bring significant advantages yet there are additionally numerous difficulties in the usage of the network investment methodologies. In any case, these challenges can be survived and compelling network interest projects can be executed with appropriate preparations.

It is critical to therefore include the people from other offices, for example, horticulture, rural advancement and grown-up proficiency as the network may raise needs that can't be fulfilled by the healthcare administrations. Because the healthcare social and also the financial demands are altogether interconnected it is imperative to operate as a consolidated workforce. On the off chance that truly advancing network interest goals should be dictated by network themselves. Thus keep goals open-ended and when marketing the objectives don't be excessively timid on the expected results. The theory is pertinent for this present examination as network support ought to be viewed as the procedure over lime. It cannot be accomplished by means of incidental visits or holding gatherings.

2.10. Conceptual Framework

Figure 2.1. Conceptual Framework



Source (Author 2018)

Operational Definition

The Level of UHC participation: refers to the degree at which the people formulate, design, implement and contribute to the success of the universal health coverage

The use and the benefits of UHC: refers to the utilization and the advantages that are derived from the access to universal health coverage among people

Profiles: refers to the personal characteristics that include gender, age, level of education of the people utilizing the universal health coverage

The perception of Benefits UHC: refers to the way the concepts of universal healthcare have been regarded, understood and interpreted by the residents of the County in relation to have they have been of significance to the beneficiaries.

Government policies: refers to the rules or principle that better guides decisions on universal health care that results in positive outcomes that enhance the community.

Effectiveness of Universal Health Care: refers to the capability of universal health care of producing a desired result or the ability to produce desired output in relation to the provision of better health services

2.11. Summary of Literature Review

Therefore, under this section the literature review as above demonstrates the great deal of hesitations and also numerous issues as concerns the individuals' interest with regard to the universal healthcare services. It is recognized that there are numerous investigations that have been conducted on the issues of the individual's involvements bringing up reasons that explain why individuals don't take an interest completely in a given health care venture yet a prompt

consideration should be set up to comprehend this in the perspective of the development of the Universal Health Care issues all day every day. Obviously there is a glaring significance in finding an enduring answer for this gap for the last time by exploring on the different area like the effects of the individual's investment on the universal health care which is foundation of the current study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The present section presented methodology that has been used to answer the objectives of the study.

3.2. Research Site

Former Kenya Eastern Province holds the Makueni County which was Makueni District. Wote is Makueni's largest Sub County and thus its capital town. The decision to settle for this site is due to fact that Makueni County is pioneering in the Universal Health Care (U.H.C). Makueni County has since the year 2014 continued to ensure that its patients receive free health care services in all public facilities especially the County and Sub-County health facilities with only a yearly registration of Kenya Shilling Five Hundreds only (Ksh 500) in each home, where all the children that are under 18 years are covered together with both parents. All the health care at the dispensaries and the health centre provide free healthcare services for all patients in Makueni. Those that are over 65 years are able to receive free treatment in all hospitals without any registration in any government policy due to the Makueni Care plan. In the past 50 years, there were colonial and national governments built hospitals that have been doubled by the county government in the past five years. In 2019, there are 113 dispensaries and health centres that have been added, about 13 Level 4 hospitals which have employed more than 160 doctors where previously only 38 physicians and 3 health facilities were operating in the County.

3.3 Research Design

Apparently, the study problems answers are generated through the scheme, outline or plan which are defined as the research design as defined by Orodho, A.J. (2003). The researcher's structure is thought by Kombo and Tromp (2006) as the study research design. The descriptive research

design has been utilized in studying of the research problem. The phenomenon what, where and how are used in the concern of a descriptive study as per Cooper and Schindler (2003) argument. Nonetheless, this approach allowed the study scholar to collect the data from a broad range of the sampled individuals especially on the effect of the individual involvements on the utilization of the universal healthcare.

3.4 Unit of Analysis and Unit of Observation

This section provides the study's unit of analysis and unit of observation.

3.4.1. Unit of Observations

The unit of observation in research refers to the unit for which data is collected. In this study, the unit of observation was the outpatients in Makueni County. The data collected from these outpatients and analyzed is what the conclusions are based upon. This information is picked by the researcher which they use in making reliable conclusions of the study.

3.4.2 The Unit of Analysis

This study's unit of analysis is the UHCs. The unit of analysis states what the study seeks to analyze, within which various factors and how they relate with each other can be observed. In this study, the various aspects of the UHCs including planning, perception of users, its utilization and the different health services provided under the UHC scheme were analyzed.

3.5 Target Population

The target respondents were the out patients, universal healthcare employees of the community, health staff and also the community leaders within the Makueni County. Therefore, the target respondents of the study were all the adult citizens in the county who can seek outpatient services from the healthcare facilities in the county (Makueni County, 2018).

3.6 Sample Size and Sampling Procedure

Multi-stage sampling procedure was used to obtain the sample size. Multi-stage sampling is a procedure where several methods of sampling are combined to select the sample (Shimizu, 2005).

3.6.1. Health Facilities

The facilities were stratified into three types: Makueni County Referral Hospital, Sub-County hospitals and ward health centres. Data collection for this study was confined to Makueni Referral and two sub-county hospitals which were Tawa Sub County Hospital, and Mukuyuni Sub County Hospital. The researcher confined the research to the three hospitals because they were the ones where UHC was implemented appropriately and thus served as the case studies. Makueni County Referral Hospital in Wote is a referral hospital in that it provides tertiary care, which is a level of health care obtained from specialists in a large hospital after referral from the providers of primary care and secondary care. In addition, it has as a full complement of services including pediatrics, obstetrics, general medicine, gynecology, various branches of surgery and psychiatry.

3.6.2. Outpatients

To get into contact with the respondents (outpatients) of the study, the researcher consulted the senior doctor who assisted her to get to get the contacts of the outpatients and familiarize her with them. The outpatients in this study were selected through judgmental sampling procedure. It is a sampling method that relies on experiences and preferences of the researcher. We chose this method owing to the fact that our target population was outpatients from the three above

hospitals many of whom left the facility after being served. The Makueni Referral Hospital out-patient wing received about 100-150 patients a day while the Sub-County hospitals received about 20-50 patients a day. The researcher took 6 days at Makueni Referral Hospital and another 3 days at each of the two Sub-County hospitals. The reason for taking 6 days was that the researcher would get the adequate population which suit data analysis for the study. In addition, the researcher took 6 days which is more or less equivalent to a week which was the appropriate for the study as it would act as an estimate for the rest days of the month. We selected and interviewed 7 outpatients each day at Makueni referral hospital and 7 outpatients in the two Sub-county hospitals where she ended up with a sample of 85 respondents.

3.6.3. Key Informants

The Key informants were selected deliberately because of the knowledge they had with regard to universal health care in Makueni County Referral hospital. The researcher chose key informants who ranged between 5-10 individuals who were well knowledgeable on matters related to Universal Health Care in the three health facilities in Makueni County.

3.7 Data Collection Methods and Tools

Data was collected using an interview schedule. The researcher also used a questionnaire composed of both closed and open ended questions to gather information from these patients. The researcher interviewed them face to face at the facility as they were sampled. The researcher also gathered information from key informants using key informant interview schedule which they filled by themselves with her own direction. The questionnaires were administered by one research assistant that was duly trained. The researcher also interviewed health staff and county administrators as key informants.

3.8 Ethical Considerations

Observation of research ethics was ensured by the researcher throughout the study. Volunteering in participation were also ensured. Observation of privacy and confidentiality were also ensured. The respondents were assured by the researcher that the sole purpose of the data was for the academic use only and that no personal information were to be provided.

3.9 Data analysis

The data collected was analyzed using descriptive statistics. After the data collection, the researcher processed the data to eradicate unwanted and unusable data which could have been inconsistent or ambiguous. Data was presented through percentages and frequencies. The findings were displayed by use of figures and tables.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1. Introduction

In this chapter we present the UHC system as implemented in Makueni County and follow this up by presenting data on the profiles of the respondents, their participation in the scheme, level of use of UHC, benefits of UHC and their perceptions of the scheme.

4.2. Health Care Scheme in Makueni

Makueni County is currently pioneering Universal Health Care (UHC). The goals of Universal Health Care in Makueni is to create a system of protection which provides equality of opportunity for people of Makueni to enjoy the highest possible level of health. Another goal of UHC in Makueni is to ensure that people have access to the health care they need without suffering financial hardship. Also UHC aims at allowing the County of Makueni to make the most of their strongest asset which is human capital to ensure that people get the best health services within their locality. Makueni County has since 2014 been offering its one million residents free healthcare across all its public facilities, including county and sub-county hospitals.

For an annual subscription of Kenya Shillings Five Hundred (500) per household, which covers parents and all their children under the age of 18 years (or up to 24 years in case of students), Makueni residents can access free primary healthcare at dispensaries and health centre. Makueni Universal Health Care took two years to plan and was preceded and piloted by a programme offering free care to those over the age of 65 years without a requirement for registration. Some of the hospitals that have enrolled the UHC programme in Makueni County include Makindu

Sub-County Hospital, Makindu Sub-County Hospital, Makueni Sub County Hospital, Mavindini Health Centre, Mbooni Sub County Hospital, Miangeni Dispensary in Mbooni, Mukuyuni Health Centre and Tawa Sub-County Hospital.

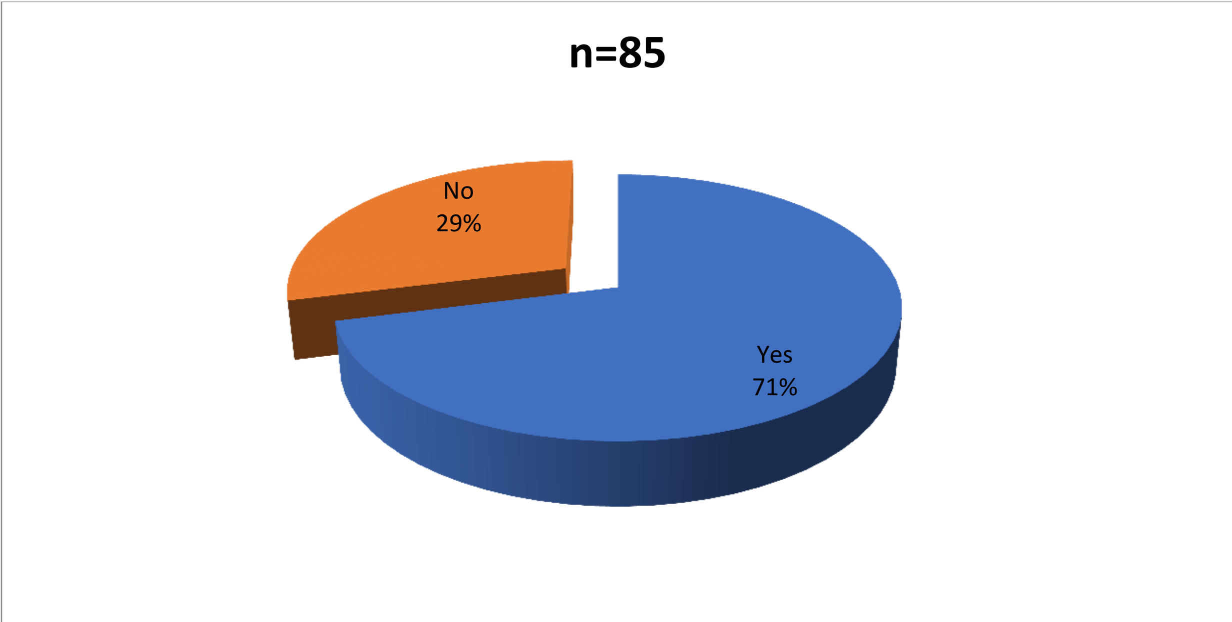
4.3. Effectiveness of Universal Health Care

The first objective of this study was to examine the effectiveness of the UHCS in Makueni County. The indicators were the level of use and benefits of the scheme.

4.3.1. Respondent's benefit from County UHCS

The respondents were asked to indicate whether they had benefited from the County UHC scheme. Their responses are as shown in the Figure 4.2

Figure 4.2: Benefits from the County UHCS



The figure shows that a majority (71%) of the respondents had benefitted from the county UHC scheme while 29% had not done so. This depicted majority of the respondents had benefitted

from enrolling into universal health care. This showed that UHC had created a system of protection which provided equality of opportunity for people to enjoy the highest possible level of health. Thus most of the respondents had seen the importance of the UHC hence high enrollment and getting maximum benefits.

> *Peter indicated that ".... he had benefitted from the UHC for terminal illness which could not be treated due to high cost." Additionally, another respondent indicated that "...UHC had made the medical services more accessible to the common citizens."*
> *James indicated that "......UHC was not beneficial in that he had subscribed to the scheme and the only time he benefited was when he was sick and if he never got sick he would never benefit from it but the subscription will always be deducted from their income." John indicated that ".... he benefited from the UHC particularly on the cost reduction in access to medical services."*

4.3.2. Duration of UHC Benefit

The respondents were asked to indicate the length of time they had benefitted from UHC. The findings are shown in Table 4.1

Table 4.1. Duration of UHC Benefit

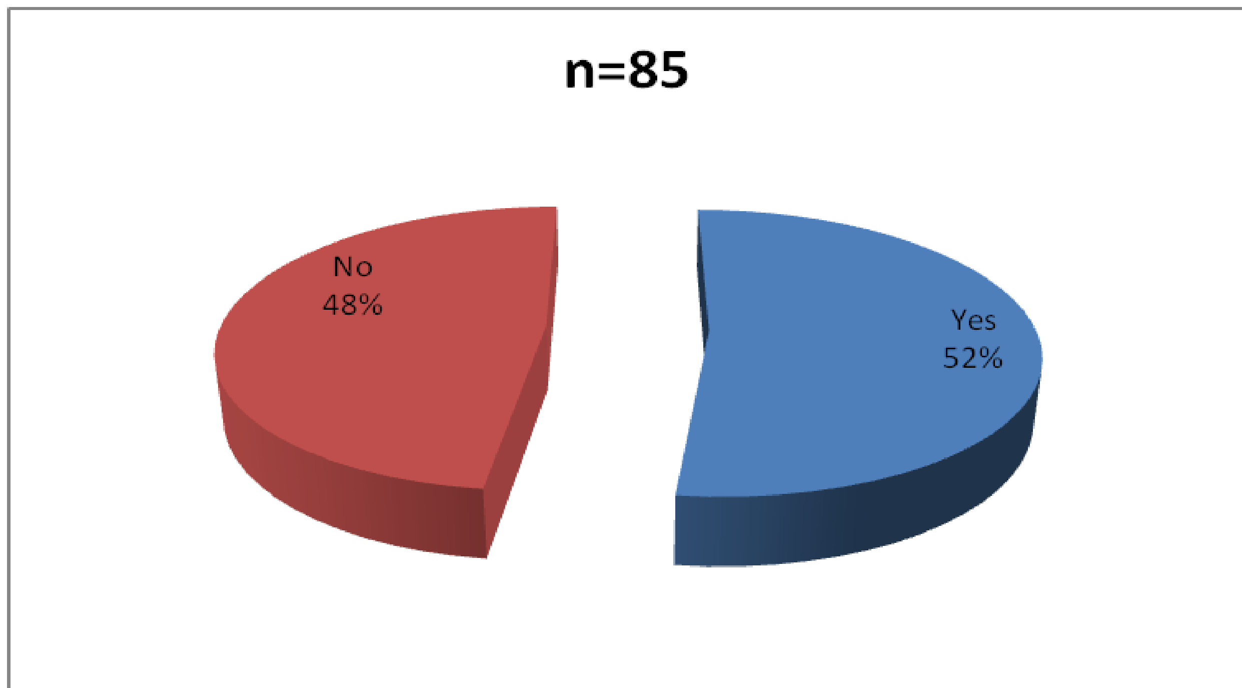
Duration	Number	Percent
Less than 1 year	7	8.2
2-3 years	20	23.5
Over 3 years	58	68.2
Total	**85**	**100**

The table shows that a majority (68.2%) of the respondents indicated they had benefitted from the UHC for a duration of not less than three years from the time it was rolled out in the county.

4.3.3. Requirement for Payment of the Hospitalization Services

The respondents were asked to indicate if they were required to pay for the hospitalization services. The findings are as shown in the figure 4.3

Figure 4.3. Requirement for Payment of the Hospitalization Services



The figure shows that a majority (52%) of the respondents indicated they were required to pay for the hospitalization services, while 48% said they were not required to do so. The payments included the admission fee, charges for miscellaneous services such as hospital card and food. This showed that in the areas where most respondents originated had not implemented UHC appropriately and thus the disparity in response. It also indicated that most of the respondents were not aware of the UHC thus they continued to pay a lot of money in a bid to get quality health care.

> *Mueni indicated that ".... the cost could have been higher if the UHC was not available. This is because UHC is a government subsidy and if not available the hospitals would not be in a position to offer the medical services at a lower cost as when the UHC is available."*

4.4. Perceptions of the respondents on the Universal Health Care

The second objective of this study was to establish the perceptions of households heads sampled about the universal healthcare scheme. The indicators were rating of the various services provided by the hospitals offering UHC services.

4.4.1. Respondent perceptions on UHC in the County

The respondents were asked to indicate their perceptions on the various services provided under the UHC in the county. The findings are as shown in Table 4.2

Table 4.2. Respondents Opinion of UHC in the County

Items	Very good %	Good %	Poor %	Total %
Ambulance Services	20	73	7	100
Level of affection by health staff	40	49	11	100
Availability of drugs/medicine	15	40	45	100
Bed space and blankets	10	50	40	100
Hospital feeding programme	18	52	30	100
Availability of doctors	11	55	34	100
Level of treatment	12	56	32	100
Theatre facilities	5	45	50	100
ICU facilities	8	36	56	100

From the information in the table, majority (73%) of the respondents indicated that the ambulance services in the hospitals were good, 56% indicated level of treatment was good, and 55% indicated that the availability of doctors was good. In addition, a majority (56%) of the

respondents indicated that the ICU facilities were poor and 50% indicated that the theatre facilities were poor. This shows that the important services such as the ICU and the theatre facilities were not appropriate and needed improvement to improve the people perceptions on the implementation of the UHC scheme in the mentioned facilities.

4.5. Level of Participation in the UHCS

The third objective of the study was to determine the level of participation of the people in the planning of the UHCS. Its indicators were: Attendance of UHC planning and, membership in the UHC committee, and other family member's participation in the committee.

4.5.1. Respondents Attendance of Meetings for Planning for UHC

The respondents were requested to indicate whether before and after joining the UHC scheme they had attended any of the meetings for its planning. Their responses are as shown in the Figure 4.4

Figure 4.4. Respondents Attendance of Meetings for Planning for UHC

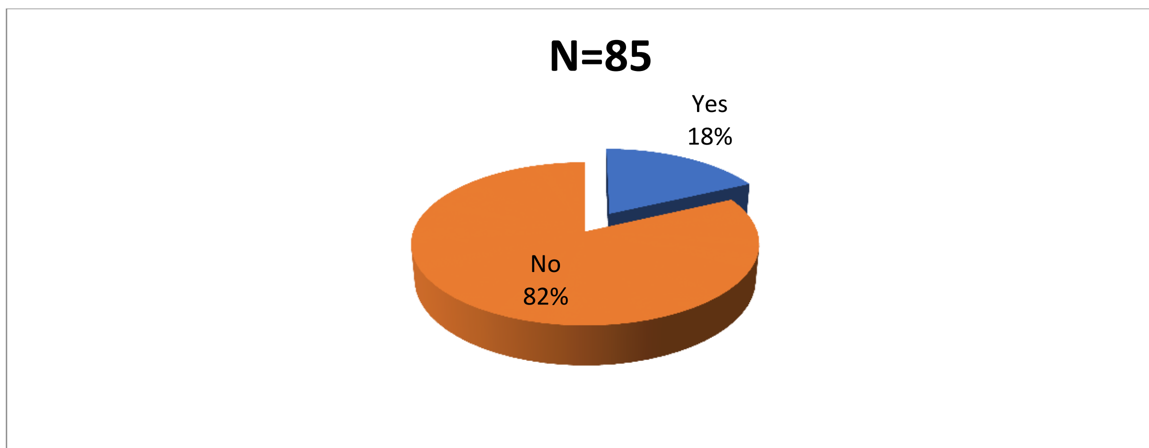


Figure 4.8 shows that a majority (82%) of the respondents indicated before and after joining the UHC scheme they had never attended any of its meetings for planning while 18% had done so.

This depicts most of the respondents had never attended any of the meetings for planning for UHC.

> *According to Jimmy "......involvement in the planning was paramount as they were viewed as the senior health officers in the county. The involvement was important as they were the one to determine on how the programme was to be enrolled in the county."*

4.5.2. Member of a Health Committee

The respondents were asked to indicate whether they were members of a health committee. The findings are as shown in the Table 4.3.

Table 4.3. Member of a Health Committee

	Membership	
Type of Committee	**Yes**	**No**
	Percent	**Percent**
Village	65.9	34.1
Ward	11.8	88.2
Sub-county	5.9	94.1
County	2.4	97.6
TOTAL(n)	85	85

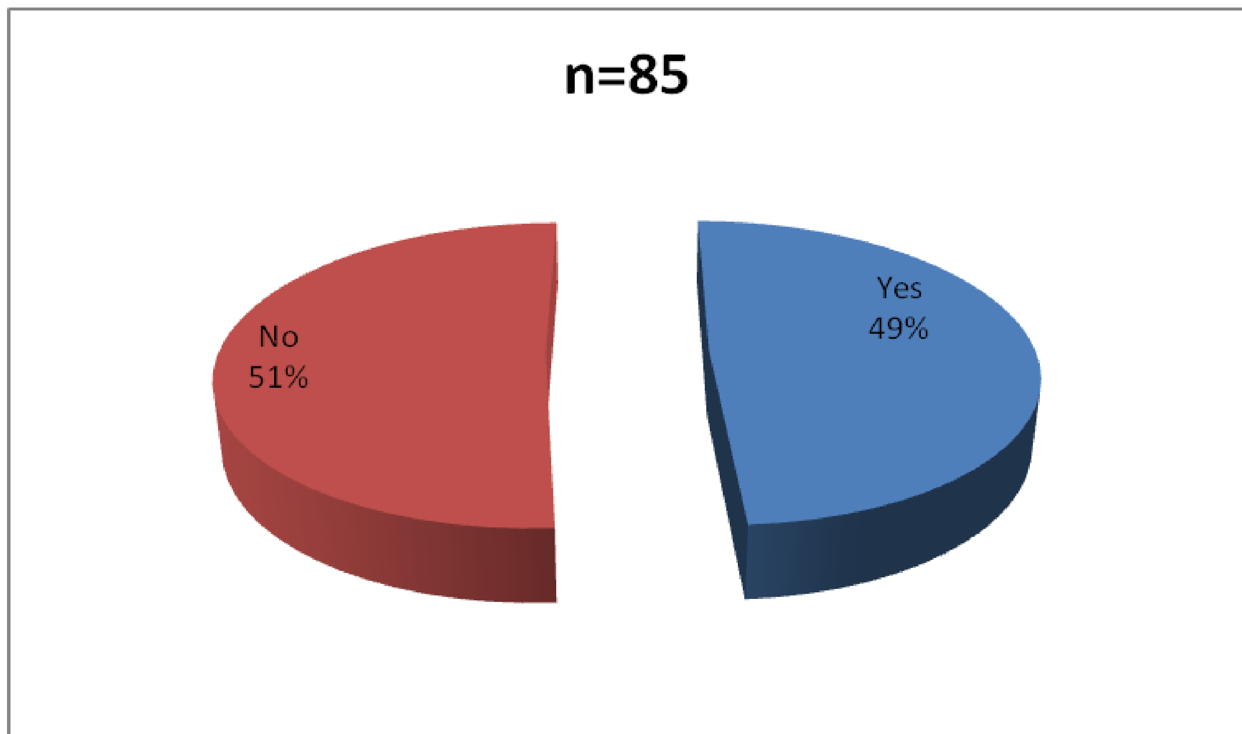
The table shows that a majority (65.9%) of the respondents were members of the village health committee, and very few were members of the ward, sub county and county health committees. This shows that most of the members only participated in the village health committee.

> *John said that, "........he was involved in the health committees in the county. He was involved in planning on how to enrol members into the scheme, the initial payment and also the number of the households to be covered."*

4.5.3. Other Family Members Participation in the Health Committee

The respondents were requested to indicate whether any of their family members participated in the health committees. The findings are shown in Figure 4.5

Figure 4.5: Other Family Members Participation in the Health Committee

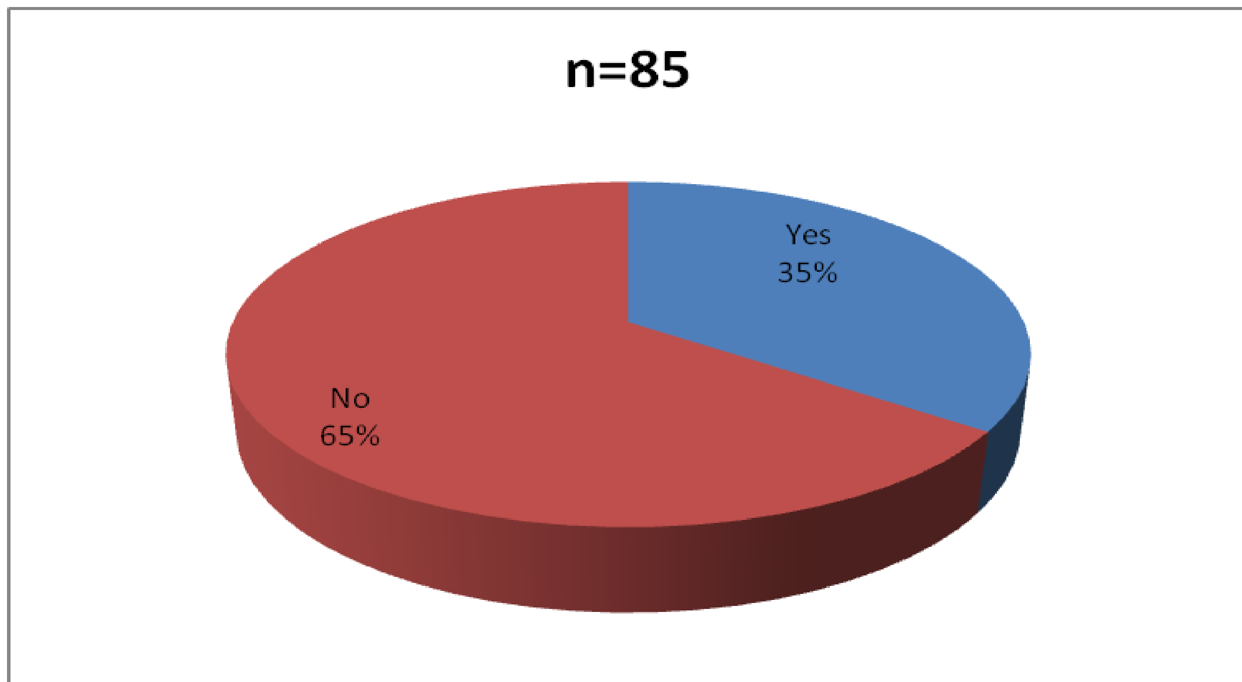


The figure shows that a majority (51%) of the respondents indicated that none of their family members participated in the health committee while 49% said that the family members participated. This shows that majority of the respondents' family members did not participate in health committees.

4.5.4. Relationship with Community Members

The respondents were asked whether the relationship with other community members changed due to your involvement in universal health care system. The findings are shown in figure 4.6.

Figure 4.6: Relationship with Community Members



The figure shows that a majority (65%) of the respondents indicated that their relationship with other community members had not changed due to their involvement in universal health care system while 35% said it had changed. This shows that majority of the respondents' relationship with other community members had not changed due to their involvement in universal health care system.

> *According to Purity ".... the relationship had not changed as such due to my involvement in the UHC."*

However, some people indicated that since they were involved in the UHC their family members thought they would be favoured given an upper hand in the UHC.

4.6. Use of Universal Health Care

The fourth objective of this study was to establish the use of the universal healthcare scheme. The findings are shown in the following subsections

4.6.1. Level of use of Universal Health Care

This was a sub-indicator to measure the level of use of the UHCS. It was guided by whether the respondents had joined the scheme and the ways of joining UHC.

4.6.2. Respondents joining of the UHC in the County

The respondents were requested to indicate whether they had joined the UHC for their County. The findings are as shown in the Figure 4.7

Figure 4.7. Respondents Joining of the UHC in the County

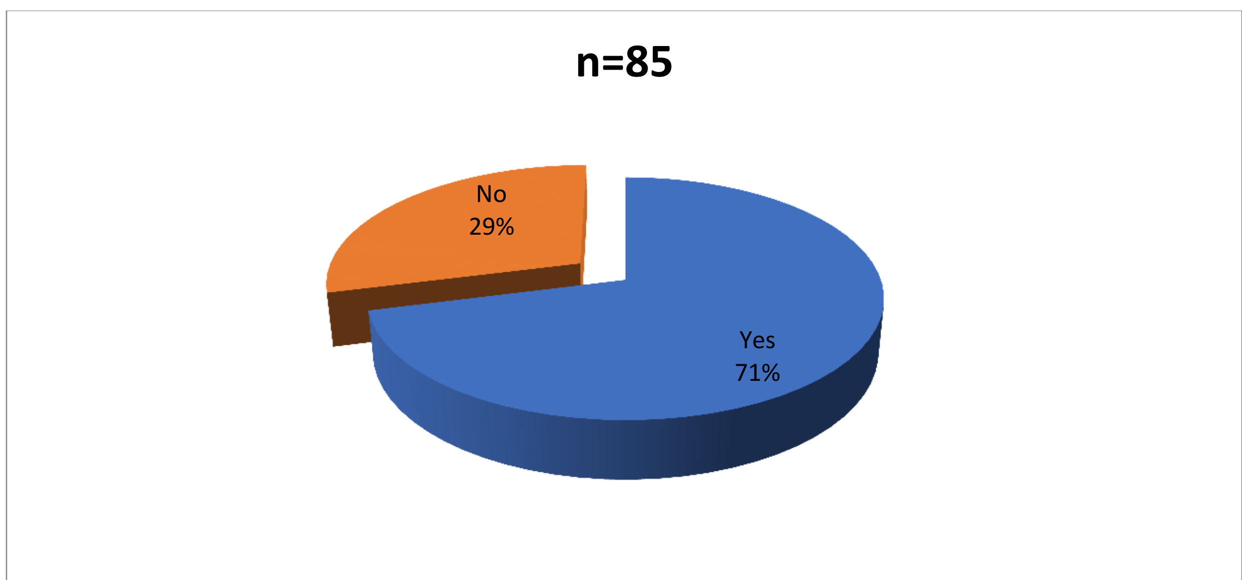
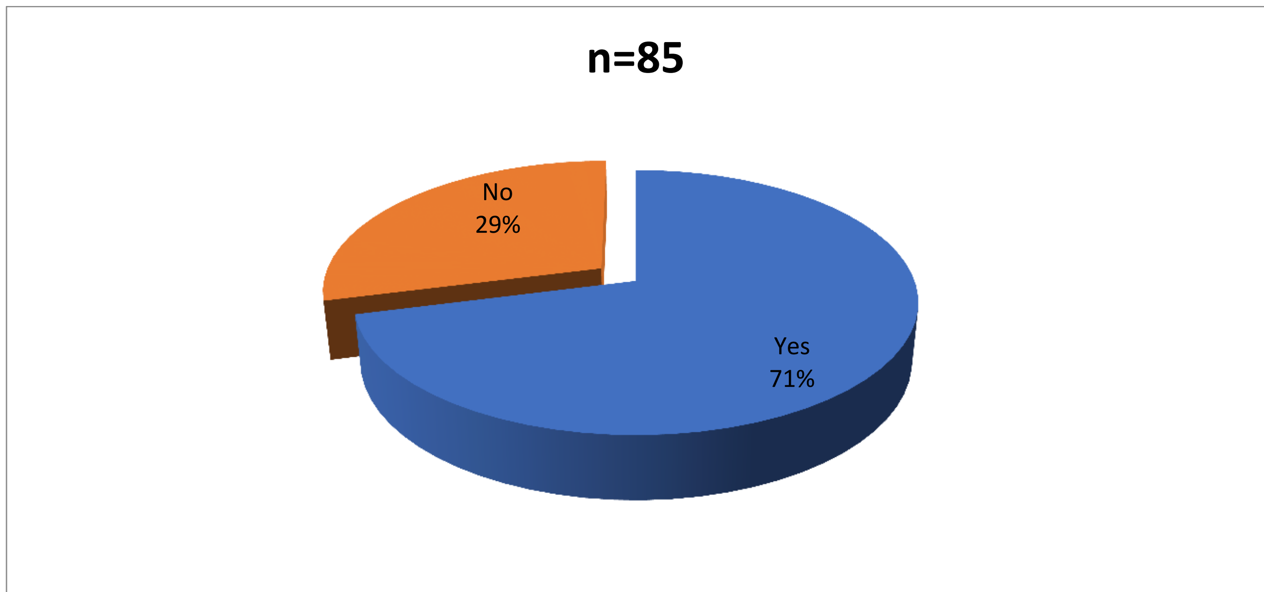


Figure 4.7 indicates that a majority (71%) of the respondents indicated they had joined the UHC in their county while 29% of the respondents had not done so. This implies that most of the respondents had joined the UHC in their county. For those who had joined the UHC, majority of them indicated they had joined the coverage in the year 2014 when it was rolled out in the county.

4.6.3. Ways of Joining UHC

The respondents were requested to indicate whether they joined the UHC as an individual. The findings are as shown in the Figure 4.8

Figure 4.8. Ways of Joining UHC



The figure shows that a majority (71%) of the respondents indicated that they had joined UHC as individuals, while 29% had not joined. This shows that most respondents had joined UHC as individuals. Universal health care is the first line of contact for most people into the health care system. It's the first place people go when they feel unwell, and where diseases are detected and diagnosed. As such, a well-run, functioning primary care system must be accessible and affordable and have the trust of the population. In short, patients need to know where to go to seek care and be confident about the quality of care they will receive. It also requires that providers know and understand the populations they serve, serve them in a timely way, and have access to a well-functioning referral system, so that the patients who need it are able to access higher levels of care.

Alice said ".......I joined UHC as an individual when the programme was rolled out in the county back in 2014. During the enrolment, I was required to pay an initial amount of 150 shilling so as to register as a member."

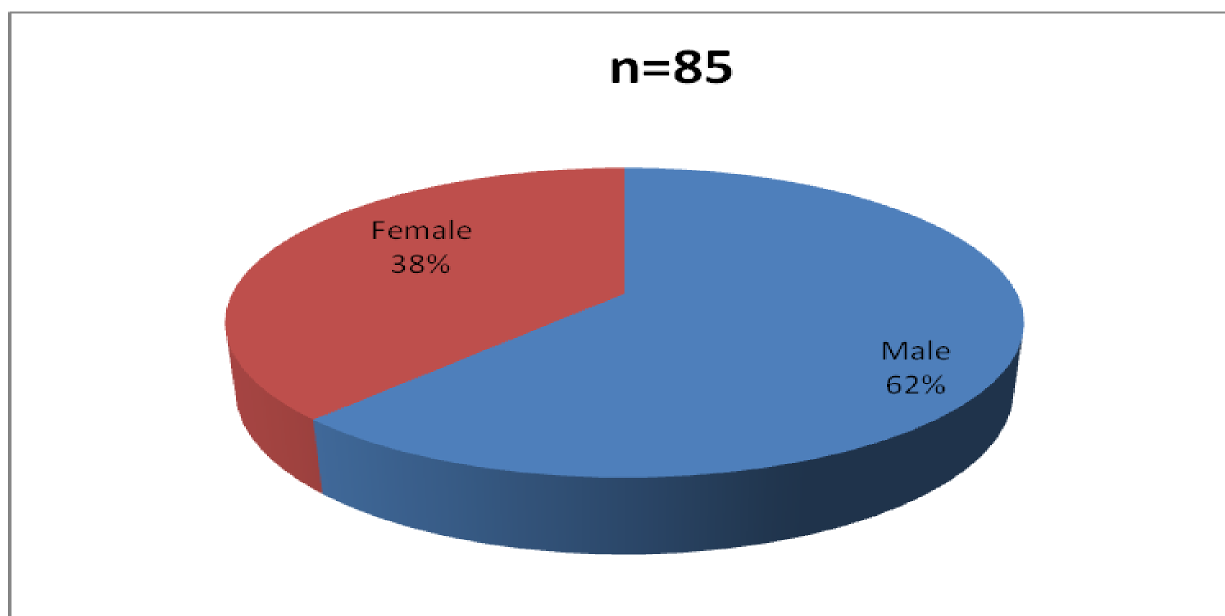
4.6. Profiles of the Household Participating in UHC

The fourth objective of this study was to examine the profiles of the household heads participating in the UHC scheme. The profiles were gender, age, level of education, marital status, and number of children and dependents.

4.6.1. Distribution of Respondents by Gender

The gender of the respondents was examined, and the findings are as presented in Figure 4.9 below

Figure 4.9: Distribution of Respondents by Gender



The figure shows that a majority (62%) of the respondents were males and 38% were females.

4.6.2. Distribution of Respondents by Age

The study sought to establish the age of the respondents and the findings are shown in the Table 4.4 below.

Table 4.4: Distribution of Respondents by Age

Age	Number	Percentage
29 years and below	9	10.6
30-39 years	35	41.2
40-49 years	30	35.3
50 years and above	11	12.9
Total	**85**	100

According to table 4.3, most (41.2%) of the respondents were between 30-39 years, 35.3% were between 40-49 years, 12.9% were above 50 years, while 10.6% were below 29 years. This shows that most of the respondents were old enough and thus could make better decisions about their participation in UHC.

4.6.3. Distribution of Respondents by their Level of Education

The respondents were requested to indicate their level of education. The findings on the respondent's level of education are presented in the Table 4.5 below.

Table 4.5. Distribution of Respondents by their Level of Education

Level of Education	Number	Percentage
Primary	26	30.5
Secondary	45	52.9
Certificate/Diploma	8	9.4
University	6	7.2
Total	**85**	100

From the findings, majority (52.9%) of the respondents had secondary level of education, 30.5 % had primary level, 9.4% had certificate/diploma while 7.2% had university level. The fact that a majority of the respondents had secondary, diploma and university education implied that they were likely to appreciate and participate in the UHC scheme.

4.6.4. Marital Status of the Respondents

The study also sought to establish the marital status of the respondents. The findings are as shown in Table 4.6. below.

Table 4.6. Marital Status of the Respondents

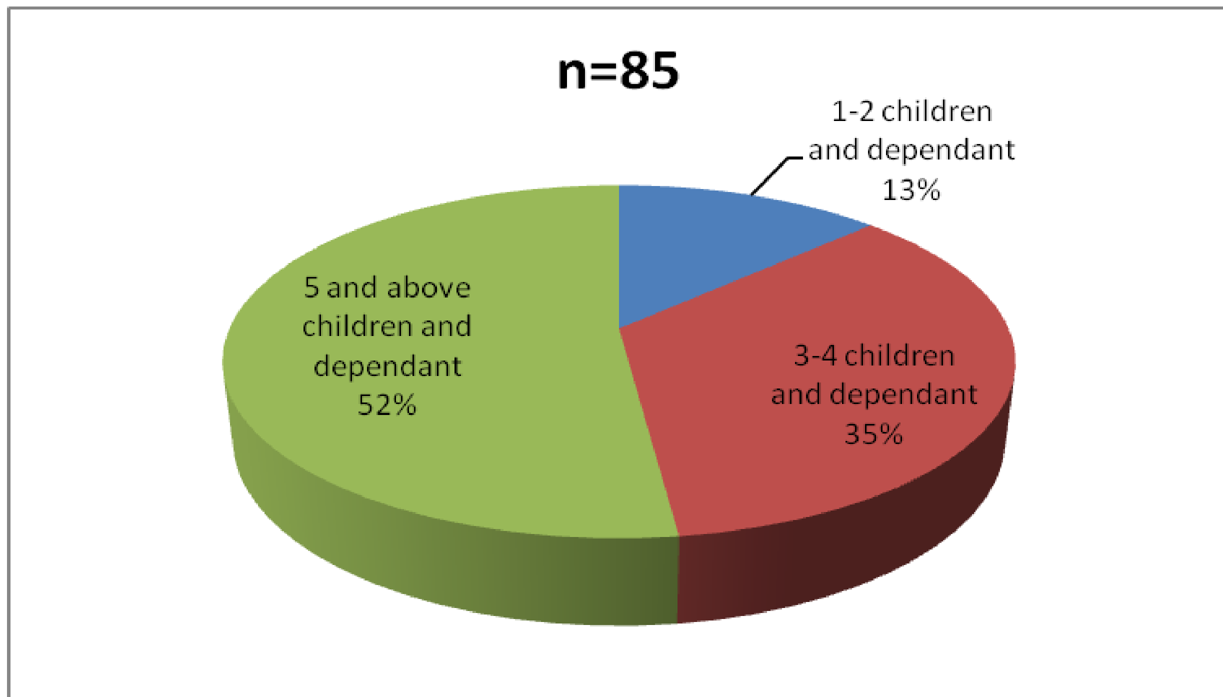
Marital Status	Number	Percentage
Single	9	10.6
Married	68	80.0
Divorced/separated	3	3.5
Widowed	5	5.9
Total	**85**	**100**

The table shows that a majority (80%) of the respondents were married, 10.6% were single, 5.9% were widowed, while 3.5% were divorced/separated. This illustrates that most of the respondents were married and thus could participate in the UHC scheme owing to their household obligations.

4.6.5. Number of Children and Dependents Reported by the Respondents

The study also sought to establish the number of children and dependents of the respondents. The findings are as shown in the Figure 4.10. below

Figure 4.10 Number of Children and Dependents Reported by the Respondents



From Figure 4.3, majority (52%) of the respondents indicated that they had 5 and above children/dependents, 35% indicated 3-4 children/dependents, while 13% indicated 1-2 children/dependents. This implied that the respondents had children/dependents and were likely to be enrolled in UHC scheme for their better health.

4.7. Conclusion

The chapter has presented the findings on objectives on the influence of people's participation on the effectiveness of Universal Health Care Scheme implemented by Makueni County, Kenya. Majority of the respondents had joined the scheme in the year 2014 when it was rolled out of the

county. Most (71%) had benefited from the coverage and (52%)of them were required to pay for the hospitalization services such as admission fee, hospital card and food while (48%) were not required to do so. The respondents' perceptions of the scheme were rated as very good, good and poor. Availability of doctors, ambulance services, affection of staff, bed space and blankets, drugs/medicine and health staff were rated as "good" while availability of ICU and theatre were rated as "poor" by most of the respondents. Regarding profiles of the respondents, majority of them were male (62%) while (38%) were females. Most respondents were older and had obtained secondary, diploma and university education. Majority of the respondents were married and had dependants/children. Most (71%) of the respondents did not participate in meetings held for planning and budgeting of the UHC at the county and sub-county levels.

.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Summary of findings

The first objective looked at the respondent's participation in the planning of the UHC scheme. A majority (82%) of the respondents did not participate by attending the meetings. More (nearly 70%) of them, however, attended meetings of village health committees. Similarly, more (49%) of other family members had not equally participated in meetings of health committees.

The second objective sought to establish the effectiveness of the Universal Health Care Scheme by residents of the Count. Of the 85 patients sampled, a majority (71%) had joined the scheme as individuals in 2014 when it was started. The joining fee at that time was Ksh. 150 and rose to Ksh. 500 at the time of this study. All of those who had joined reported benefitting from the scheme, for example, those who had persistent illnesses they might not have afforded medication if it were not for UHC. More of the respondents (nearly 90%) had benefitted from UHC scheme for more than two years. UHC was a government subsidy which was aimed at lowering the medical cost for the common citizen to have an access. Under UHC, all people who needed health services could receive them without undue financial hardship. UHC is a critical component of sustainable development and poverty reduction, and a key element of any effort to reduce social inequalities and enhance access to care (Kutzin, 2013).

The third objective aimed at finding out the profiles of the people participating in the Universal Health Care Scheme. The profiles were: Gender, age, level of education, marital status and number of children/dependents. Of the 85 patients, more (62%) of them were males, a large

number (48.2%) were older (above 40 years), nearly 70% had obtained secondary and above education, a large proportion (80%) were married and a majority (52%) had more than 5 children/dependents. As more of the respondents were older, with better education, married and with dependents, they were likely to appreciate and use UHC services.

The fourth objective of the study examined the patients' perceptions of the UHC services in terms of: Ambulance services, availability of health staff, drugs/medicines, and so on. We rated the services as: very good, good and poor. Of the various services, availability of health staff (40%), ambulances (20%) and drugs/medicines (15%) were rated as "very good". More of the patients sampled rated the services as "good" ambulances (73%), quality of treatment (56%), availability of doctors (55%) and availability of health staff (49%). The services that were rated as "poor" by more of the respondents were: ICU facilities (56%), theatre facilities (50%) and availability of drugs/medicines (45%).

5.2. Conclusions of the Study

This study sought to establish the influence of people's participation on the effectiveness of UHC in Makueni county. Eighty-five (85) out-patients attending Makueni referral hospital and two sub-county hospitals Mukuyuni Health Centre and Tawa Sub- County hospital were sampled and interviewed using a questionnaire. Ten (10) Key Informants (KIs) who were: health staff and county administrators were purposively sampled and interviewed using an Interview Guide. In terms of profiles of the respondents, more of them were older, had obtained secondary and higher education and had more dependents. Thus they were responsible, enlightened and with obligations and hence in a position to appreciate and use UHC services.

Most (71%) of the respondents did not participate in meetings held for planning and budgeting for the UHC at the county and sub-county levels. The respondents' perceptions of the scheme were rated as very good, good and poor. A few aspects of the scheme such as availability of doctors, drugs/medicines and health staff were rated as "good" while availability of ICU and theatre were rated as "poor" by most of the respondents implying that they needed further improvement.

5.3. Recommendations

5.3.1. Policy recommendations

Based on the study findings we make the following recommendations:

a) The Ministry of Health and the county governments should focus on investments in Universal Health Care through mobilization of resources to improve county health facilities in readiness to achieve equitable access to skilled health delivery services across the country.
b) The county government should involve every stakeholder in the health sector through training and provision of education on Universal Health Care. There is also need for strengthening of civic education for UHC
c) The county and national governments should ensure that the monitoring and evaluation processes are geared to ensure that the Universal health coverage process is implemented in the right manner and with the right strategies

5.3.2. Recommendation for Further Studies

There is need to study UHC schemes in all the counties where they have been rolled out using larger samples and clear methods that could permit replication of studies to more counties and the national level.

REFERENCES

Ayeni, O. (2015). *The Baseline Survey: Health Status and the Utilization of Health Facilities. Ibadan University College Hospital*. *Fertility Research Unit*. 12 (1) 134-141.

Becker, M. H. (1984). *The health belief model:* A decade later. *Health education quarterly*, Vol 11 (1) 1-47.

Carpenter, T. (2010). Public and Private Roles in Health: Theory and Financing Patterns, Health, Nutrition, and Population Discussion Paper No. 29290 (Washington: World Bank).

Carrin G. (2012). Health financing reform in Kenya assessing the social health insurance proposal, *Kenya Medical Journal.* 12(66), 12-66.

Carrin, G., & Chris, J. (2015). Social health insurance: Key factors affecting the transition towards universal coverage. *International Social Security Review, 58(1), 22-27*

Carrin, M. & Chris, T. (2014). Community-based health insurance knowledge, concern, preferences, and financial planning for health care among informal sector workers in a health district of Douala, Cameroon. *Pan African Medical Journal, 16(1), 102-190*

Cooper, D.R. & Schindler, P.S. (2003) Business Research Methods. 8th Edition, McGraw-Hill Irwin, Boston. *31 (2): 120– 200.*

Ekman, B. (2014). Community-based Health Insurance in Low-income Countries: A Systematic Review of the Evidence. *Health Policy and Planning 19 (5): 249– 270.*

Glanz, K., & Bishop, D. B. (2010). The role of behavioral science theory in development and implementation of public health interventions. *Annual Review of Public Health, 31 (2) 399-418.*

Grossman, D. A., & Frieder, O. (2012). Information retrieval: Algorithms and heuristics. *Springer Science & Business Media.* 15 (2), 25-33

Hsiao, M. (2013). *Social health insurance:* Key factors affecting the transition towards universal coverage. *International Social Security Review,* 58(1), 90-129

International Labour Organization (ILO). (2013). Health Care under Social Security in Africa: Taking Stock of Experience and Potential. Working Paper. Geneva Social Security Department, 3(1), 134-140

Kanyiva, K. (2012). Determinants for participation in a public health insurance program among residents of urban slums in Nairobi, Kenya: results from a cross-sectional survey. *BMC Health Services Research, 12(66), 12-66.*

Kelly, J. (2001). Community-based Health Insurance in Low-income Countries: A Systematic Review of the Evidence. *Health Policy and Planning 19 (5): 249– 270.*

Kirigia, J. (2010). Ghana's approach to social health protection: World Health Report. World Health Organization. 21 (5), 93-123.

Kombo, D. K., & Tromp, D. L. (2006). Proposal writing: An introduction. *Nairobi: Pauline Publications Africa*.

Kutzin, J. (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization*, 91, 602-611.

Lane, M. (1995). Building a Performance Based M&E System: The challenges facing the developing countries Readiness. *Evaluation Journal of Australia*, 2, 14-23

Makueni, C. (2013). First county integrated development plan 2013–2017. *Makueni, Kenya: County Government of Makueni*.

Midgley, M (1986). Social Capital Formation and Healthy Communities: Insights from the Colorado Healthy Communities Initiative. *Community Development Journal*, 35 (2), 99-108

Moser, J. (1987). Evaluation Capacity Development: Institutionalization of M&E Systems to Improve Public sector management. *ECD* Working Paper series number 15. Washington D.C.: The World Bank.

Musgrove, P. (2016). Public and Private Roles in Health: Theory and Financing Patterns, Health, Nutrition, and Population Discussion Paper No. 29290. Washington DC: World Bank.

Nick, D. (2010). Health Care Systems: Efficiency and Institutions, Economics Department Working Paper No. 769 Paris: Organization for Economic Cooperation and Development. *Bulletin of the World Health Organization 82, 750-756.*

Omolo, A. (2012). Policy proposals on citizen participation in devolved governance in Kenya. *The Institute for Social Accountability (TISA), Nairobi*.

Orodho, A. J. (2003). Essentials of educational and social sciences research method. *Nairobi: Masola Publishers*.

Ross (2000). Health Financing Policy: A Guide for Decision-makers." Health Financing Policy Papers. pp. 600-606.

Shimizu, R. (2005). Evaluation of Public Policies in South Africa. Issues Paper by UNDP on National Capacity Evaluation, Casablanca Morocco: 5 (1), 33-75

Tallon-Baudry, C. (2012). On the neural mechanisms sub serving consciousness and attention. *Frontiers in psychology*, 13 (*2), 231-* 397.

Wamai, H. (2013). The Kenya health system analysis of the situation and enduring challenges. *Japan Medical Association journal*, 5(2), 134-140

World Bank Group. (2013). Doing business 2014: Understanding regulations for small and medium-size enterprises. *World Bank Publications*.11 (2), 123-198

World Health Organization. (2015). The Selection and Use of Essential Medicines: Report of the WHO Expert Committee, 2015 (including the 19th WHO Model List of Essential Medicines and the 5th WHO Model List of Essential Medicines for Children). World Health Organization.

Appendices

Appendix 1: The questionnaire

Please give the appropriate and the required data and also fill correctly as appropriate.

Name of the health facility attached (Optional)________________

Provide your Name (optional)____________

Out patient (Optional)____________________

Provide the date when the interview was done (Optional)____________

PART A: The demographic data as required.

1. Select your gender from the options provided below;

   Male. { } Female. { }

2. The age of the respondent.

   Under 29 yrs. [ ]

   30-39. years [ ]

   40-49. years [ ]

   50years & above [ ]

3. Provide us with information regarding the highest level of educational you attained chose from the options below.

   No formal education. [ ]

   Primary level of education. [ ]

Secondary level of education. [ ]

Tertiary level or diploma. [ ]

Undergraduate level. [ ]

4. Provide us with information on your marital status?

Married { }

Widowed { }

Single. { }

Separated { }

5. Provide the no. of offspring and the numbers of those who depend on you.

1-2. { }

(3-4). { }

(5 & many other). { }

6. What is your main occupation, Self______________Spouse____________

7. What sources of livelihood do you have (Kshs per M.): Self__________Spouse___________

PART B: The Level of Involvement and Planning.

8. a. Kindly indicate whether you are familiar with the concept of the universal healthcare?

   (Yes) [ ] (No) [ ]

   b. If yes please proceed and explain the meaning?__________________

   c. Where did you learn and become knowledgeable about this?

   (Radio) [ ]

   (Newsletters). [ ]

   (County Staff) [ ]

   (Friends or the Family Members). [ ]

9. a. Are you enrolled with the U.H.C. within your County.?

   (Yes). ( ) (No). ( )

   b. If yes when were you registered with the U.H.C (year and the month.________________________________

   c. How much was your registration fees to join the UHC______________________________-

   d. Other than the cash remittance what were the other necessities for registering with the UHC program?

   (Yes). ( ) (No). ( )

If yes please mention____

e. Other than yourself joining the UHC are there other members of your household registered with the program?

Yes. ( ) No. ( )

Is yes, who please proceed and enlist them------------------------?

f. How did you register with the UHC scheme, did you so as an individual or otherwise?,…(Yes)………………(No)…………...

If you were registered with the scheme through a self-help group, please proceed and provide the name of that group.?

10. Proceed and provide the date or period when you joined the program)?................................Give reasons)…………………………..

11. Before and after you registering with the (UHC) program were you in position to attend any of the meetings for execution…?

(Yes). ( ) (No). ( )

If yes, please provide the number of times you have attended the meeting?____

12. Are you aware on where the planning's and also the budgeting for the committee were carried out__________________

13. Please indicate whether you are a committee members within the below as provided)?

	(Yes)	**(No)**
Village.		
Ward.		
Sub-county.		
County.		

14. Have any members of the extended family been part of the program? Yes. ( ) No. ( )

15. If that is the case please elucidate?____________________

16. Have your connection with the other members of your community changed because of your registration with the universal healthcare program?

(Yes) ( ) (No) ( )

PART C: THE LEVEL OF USE OF UNIVERSAL HEALTHCARE

17. Please indicate whether you and your entire family been beneficiaries from this County (UHC) program?

(Yes). ( ) (No). ( )

If this is the case please explain how this happened.?

....

....

If they have not benefitted please explain why?

………………………………………………………………………………………………

………………………………………………………………………………………………

18. If at all you have been a beneficiary as an inpatient, please explain the duration that it took you indicate in terms of weeks or months that you have benefited?

____

19. Were you required to make some specific payments for the services you received on your hospitalization?

Yes, ( ) No, ( )

If you are on the affirmative, please specify what you paid for.?

____

Please approximate in terms of cost what it cost you in terms of Kenya shilling?

____

Do you think the healthcare would have been higher if given that the (U.H.C) scheme would have not been available?

(Yes). ( ) (No). ( )

If that is not the case please give reasons?

____

PART D: THE PERCEPTIONS OF UNIVERSAL HEALTH CARE

20. What would be your take with regard to the following on (U.H.C) program within your County,? Choose among VG, G and P where; VG means very good, G mean good and P means poor.

Items,	**(VG)**	**(G)**	**(P)**
Availability of the ambulance facilities			
Degree of the affection by the health employees,			
The availability of the drugs and other medicine			
Availability of the space and blankets for use by the patients			
The hospital feeding programme in place,			
The availability of the doctors to respond to the patients			
Degree of treatment provided at the facility,			

Availability of the theatre facilities,			
Affordability and the affordability of the I.C.U facilities			

PART E: EFFECTIVENESS OF UNIVERSAL HEALTH CARE

For the statements provided in the table below, indicate the level of satisfaction with the aspects of the hospital indicated. Use the following rating (1 – Completely dissatisfied; 2 – Somewhat satisfied; 3 – neither satisfied or dissatisfied; 4 – Somewhat satisfied; 5 – Completely satisfied)

Aspect	**1**	**2**	**3**	**4**	**5**
Availability of drugs					
Waiting time					
Competence of health staff					
Quality of services					
Friendliness of staff					
State of healthcare facilities					
Availability of laboratory and imaging services					

Appendix 2: Key Informant Interview Schedule

The Health facility,……………………………………………………………………..

The Name of Respondent (Optional),:…………………………………………………………….

Interview date (Optional),:……………………

---

1. What is your level of acquaintance with the universal healthcare & to what extent does it affect positively the common occupants within the County, elucidate?

   ____

2. Give a brief description on how you registered with the (U.H.C) available with your County giving the time lines when you registered and also the money that you remitted when you got registered as a beneficiary?

   ____

3. Please give a brief description of the requirements for one to register with the (U.H.C) scheme and also demonstrate why you think it's of importance?

   ____

4. Other than yourself have other people from your own household been registered with the scheme and if that is the case please explain how the process was like?

   ____

5. Describe in brief how the process of participation is all about with regards to the meetings for planning and also the budgeting process for the (U.H.C) scheme?

____

6. Explain in brief the responsibilities that you were responsible for and also all other role that you played as a beneficiary of the then constituted health committee within your own county.

____

7. What would be your own take on your relationship with the rest of the community members?, would you say that there has been any change due to you being actively participating in the universal health care program elucidate?

____

8. Give a brief account on the approaches by which your family members have profited from this County (U.H.C) program?,

____

9. Give a brief account on how the amount of the hospital bill could be assuming that the (UHC) program was not instituted?.

____.

10. Explain how your belief is like especially with regard to the different services that are offered within the Makueni health facility.

____

Appendix 3: The Letter from Ministry of Health

MINISTRY OF HEALTH

Telegrams Health "TAWA:
TEL-0734787489
When replying please quote.
Ref tawasch

COUNTY GOVERNMENT OF MAKUENI
MEDICAL SUPERINTENDENT
TAWA SUB-COUNTY HOSPITAL
P.O. BOX 70
TAWA

28.8.2018

TO WHOM IT MAY CONCERN

RE: CANDY MUMBUA NDETI-C50/84598/2016

The above student from the University of Nairobi has been permitted to collect data on UHC at Tawa sub county hospital.

Kindly accord her the necessary assistance.

MEDICAL SUPERINTENDENT
TAWA SUB-COUNTY HOSPITAL
28 AUG 2018
P. O. Box 70 - 90133
TAWA

Justus S.Kilonzo
H.A.O-Tawa sub county hospital

Appendix 4: The Research Permit from County Government of Makueni

REPUBLIC OF KENYA

GOVERNMENT OF MAKUENI COUNTY

OFFICE OF CHIEF OFFICER HEALTH SERVICES
PO BOX 89-90300 MAKUENI
Email:countyhealthmakueni@gmail.com *contact@makueni.go.ke*
Website: www.makueni.go.ke

REF: GOMC/DOH/CDH/GEN.III/(195)

11th September, 2018

To
Medical Superintendent
Makueni County Referral Hospital

RE: AUTHORITY TO COLLECT RESEARCH DATA – CANDY MUMBUA NDETI
ADM. NO. C50/84598/2016

Reference is made to the letter NACOSTI/P/18/55237/25215 and dated 6th September, 2018.

The above named is a student at Nairobi University undertaking masters in Rural Sociology and Community Development course. She is hereby authorized to collect data on "Effect of people participation in Universal Health Care" a case study of Makueni County Referral Hospital for a period ending 5th September 2019.

Please accord her the necessary assistance and support.

Dr. Kiio S. Ndolo
Director Medical Services
Makueni County

COUNTY DIRECTOR OF HEALTH
MAKUENI COUNTY
11 SEP 2018

Cc

- ECM Health Services - Makueni
- CO-Health Services
- Director(s) Health

MEDICAL SUPERINTENDENT
MAKUENI COUNTY REFERRAL HOSPITAL
10 SEP 2018
P. O. Box 95, MAKUENI - 90300
TEL: 044 - 33175/33195

Appendix 5: The Letter from Mukuyuni Health Center

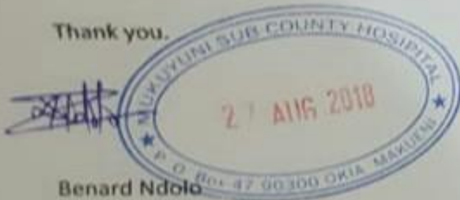
Mukuyuni Health Centre
P.O BOX 47- UKIA
MAKUENI

TO WHOM IT MAY CONCERN

RE: CANDY MUMBUA NDETI

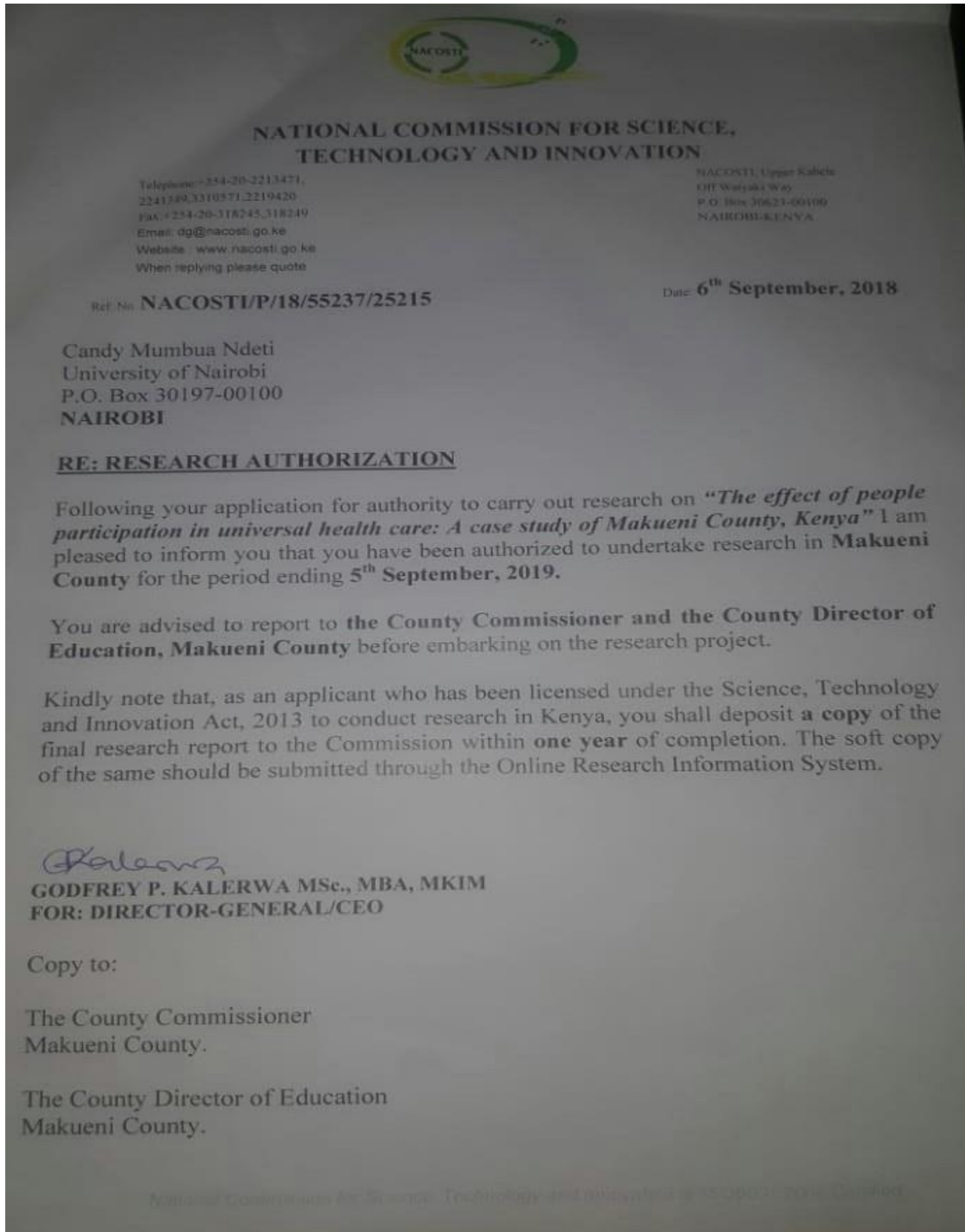
Through this letter, I approve the following student from the University of Nairobi permission to collect data in this health facility for her school project.

Thank you.



Benard Ndolo
Clinical Officer Incharge
Mukuyuni Health Centre

Appendix 6: Nacosti Letter



NACOSTI

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/18/55237/25215**

Date: **6th September, 2018**

Candy Mumbua Ndeti
University of Nairobi
P.O. Box 30197-00100
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"The effect of people participation in universal health care: A case study of Makueni County, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Makueni County** for the period ending **5th September, 2019.**

You are advised to report to **the County Commissioner and the County Director of Education, Makueni 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.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Makueni County.

The County Director of Education
Makueni County.