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Stakeholder Engagement in the Realization of Universal Health Coverage Among Residents of Embu County, Kenya

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Abstract
Universal Health Coverage (UHC) ensures equitable access to quality healthcare without financial hardship. This study assessed UHC in Embu County, Kenya, using a cross-sectional design combining quantitative and qualitative methods. Data from 365 households and key informants were analyzed using SPSS and thematic analysis, with ethical guidelines strictly followed throughout. The study found higher UHC uptake among those educated or involved in UHC. Respondents felt politics didn't hinder implementation, though statistical analysis showed it did. Legal frameworks from both governments support devolved healthcare. Strengthening civic education and stakeholder involvement is key to improving public awareness and participation in Universal Health Coverage.

Keywords: Universal Health Coverage, Stakeholder Engagement, Health Policy Implementation, Community Participation, Access to Healthcare.

1. Introduction

Universal Health Coverage (UHC) means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost. Thus, fairness of access and financial risk protection are implied by universal healthcare (World Health Organization, 2020). It is also predicated on the idea of equality in funding, which states that people contribute based on their financial capacity rather than on the likelihood that they would become ill. This suggests that prepaid and pooled contributions should be a primary source of health finance rather than fees or charges assessed when a person becomes ill and utilizes services. UHC requires making assessments of the possible recipients, the scope of the services provided, and the standard of the care (Global Challenges Research Fund, 2019). Abdirahman, (2018) stated that universal health coverage ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship has continued to dominate in health care.

In several countries, information and communication technology (ICT) by various stakeholders is used to enhance health literacy, provide health information, support diseases surveillance, improve care and strengthen monitoring and evaluation. Prioritized and coordinated research and innovation by various stakeholders is essential for development of new interventions, such as vaccines, medicines and diagnostic devices, while strengthen research institutions and systems in low and middle-income countries are recommended (World Bank, 2018). Adoption of new health technologies, often expensive and out of reach by the poor, requires improved country capacities to conduct health intervention and technology assessment to guide procurement and management of technologies; this ensures value for money and long-term financial sustainability.

2. Materials and methods

This study employed an analytical cross-sectional design using both qualitative and quantitative approaches to assess the realization of Universal Health Coverage (UHC) in

Embu County, Kenya. The mixed methods approach allowed a comprehensive understanding of community perspectives and statistical trends. Embu County, with high poverty rates and limited healthcare access, was selected as the study area. A sample size of 365 households was determined using Mane's formula and proportionately distributed across three wards in Manyatta Constituency. Multistage sampling techniques, including stratified and systematic sampling, were applied. Quantitative data were collected using structured questionnaires, while qualitative data were gathered through key informant interviews with healthcare workers and local leaders. Validity and reliability of tools were ensured through expert review, pre-testing, and statistical testing including Cronbach's Alpha and Pearson's correlation. Data analysis involved SPSS v26 for descriptive and inferential statistics, including chi-square tests and multiple regression to assess associations among insurance uptake, financial coverage, and stakeholder engagement. Thematic analysis was used for qualitative responses. Ethical approvals were obtained from KNH/UoN ERC and NACOSTI, with informed consent secured from participants. Confidentiality, voluntary participation, and COVID-19 precautions were upheld throughout the study.

3. Results

Socio-Demographic Characteristics

The respondents age ranged from 18 years to 76 years, the mode was 47 years, median 43.0 years and the mean age was 44.21 ± 15.7. The findings showed that 98 (27.3%) were between 40-49 years, 75 (20.9%) were between 30-39 years, and 52 (14.5%) were 60 years and above. Slightly more than half 186 (51.8%) were females and 214 (59.6%) were in marital union during the study period. Approximately 8% of respondents had no formal education with most 131 (36.5%) of respondents had secondary level of education and 137 (38.2%) had tertiary level of education. Most of respondents 207 (57.7%) were participating in income generating activities of which 70 (19.5%) being formally employed and 137 (38.2%) were self-employed, in addition, 201 (56.0%) had an average household monthly income of less than Ksh 30000 (Table 1).

Table 1: Socio-demographic characteristics of the respondents.

Characteristics		Frequency	Percent
Age group	18-29 years	73	20.3%
	30-39 years	75	20.9%
	40-49 years	98	27.3%
	50-59 years	61	17.0%
	≥ 60 years	52	14.5%
Gender	Male	173	48.2%
	Female	186	51.8%
Marital status	Single	102	28.4%
	Married	214	59.6%
	Divorced/separated	25	7.0%
	Widowed	18	5.0%
Level of education	No formal education	29	8.1%
	Primary	62	17.3%
	Secondary	131	36.5%
	College	89	24.8%
	University	48	13.4%
Employment status	Employed	70	19.5%
	Self-employed	137	38.2%
	Unemployed	152	42.3%
	Less than Ksh 10,000	52	14.5%
	Ksh 10,000-19,999	72	20.1%
	Ksh 20,000-29,999	77	21.4%
	Ksh 30,000-39,999	61	17.0%
	Ksh 40,000-49,999	50	13.9%
	≥ Ksh 50,000	47	13.1%

Realization of Universal Health Care

More than half 211 (58.8%) of respondents had utilized universal healthcare services with 112 (31.2%) mentioned that their family utilize the services and 117 (32.6%) were not aware of any family member utilizing UHC. Additionally, almost a third 111 (30.9%) were aware of universal health care between 1-3 years and 80 (22.3%) for more than 6 years (Table 2).

Table 2: Realization of Universal Health Care.

Characteristics		Frequency	Percent
Utilizing universal health services	Yes	211	58.8%
	No	148	41.2%
Family member utilizing UHC	Yes	112	31.2%
	No	130	36.2%
	I don't know	117	32.6%
Duration aware UHC	Less than 1 year	64	17.8%
	1-3 years	111	30.9%
	4-6 years	104	29.0%
	More than 6 years	80	22.3%

Among the key informants, UHC was viable and mentioned that out of the ones registered, they felt that they benefitted from the services, and their health standards had improved. Some of the comments from respondents as below:

"I have experienced the goodness of UHC; with proper implementation, UHC can be viable; Accessibility and availability of basic health services makes the difference in life and death especially in emergency situations; There is commitment of the County Government in the initiative thus political goodwill, this has increased utilization of health services; The management can be better with more drugs and better management" (KII 3).

Stakeholder Engagement Influencing Realization of Universal Health Coverage

The extent of uptake of universal healthcare coverage was higher 136(66.3%) among respondents involved or educated on Universal Health Coverage, and respondents believe political environment doesn't affect implementation of UHC 92(73.6%). Additionally, 39(60.0%), and 58(61.1%) of respondents who mentioned always, and rarely impoverished household considered when implementing UHC. The findings further revealed that been involved or educated on Universal Health Coverage (χ^2=11.294, df=1, p=0.001) and political environment affect implementation of Universal health coverage (χ^2=17.396, df=1, p=0.0001) had a statistically significant association be with realization of universal healthcare coverage (Table 3).

Table 3: Stakeholder Engagement Influencing Realization of Universal Health Coverage.

Variables	Utilizing universal health services			Statistics
	Yes		No	
Educated on UHC	Yes	75(48.7%)	79(51.3%)	χ^2=11.294, df=1, p=0.001
	No	136(66.3%)	69(33.7%)	
Political environments affect implementation of UHC	Yes	119(50.9%)	115(49.1%)	χ^2=17.396, df=1, p=0.0001
	No	92(73.6%)	33(26.4%)	
Impoverished household considered when implementing UHC	Always	39(60.0%)	26(40.0%)	χ^2=0.452, df=3, p=0.929
	Sometimes	31(56.4%)	24(43.6%)	
	Rarely	58(61.1%)	37(38.9%)	
	Never	83(57.6%)	61(42.4%)	

4. Discussion

The study found that the extent of uptake of universal healthcare coverage was higher 136(66.3%) among respondents involved or educated on Universal Health Coverage, and respondents believe political environment doesn't affect implementation of UHC 92(73.6%). This concurs with Abdirahman, (2018) stated that universal health coverage ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship has continued to dominate in health care. Additionally, the study found that 39(60.0%), and 58(61.1%) of respondents who mentioned always, and rarely impoverished household considered when implementing UHC. This concurs with Sumartono & D'Uva, (2017), cutting health system inefficiencies in half would result in an increase of more than one year in the average life expectancy at birth. In contrast, a 10% increase in health care spending per person would only result in a three to four month increase in life expectancy.

Assefa et al., (2020) noted that these various methods for delivering and paying for healthcare, as well as the variations in public health spending among nations, are a reflection of the preferences and limitations of each nation. As a result, there isn't a single, ideal level of public health spending that may serve as a comparison point for nations. Countries may attach various weights to health spending compared to other uses of public cash, place different weights on access equity, or have different fiscal restrictions. However, it's important to make sure that, whatever health care model is chosen, public health services are delivered effectively. Domestic government-led financing offers the clearest foundation to efforts towards universal health coverage, strengthened by political engagement and effective governance. Adaptive support mechanisms and financial instruments, potentially backed by international funding mechanisms, can offer incentives for preparedness and effective response to the impacts of shocks and stresses.

5. Conclusions

The study found that the extent of uptake of universal healthcare coverage was higher among respondents involved or educated on Universal Health Coverage, and respondents believe political environment doesn't affect implementation of UHC. Additionally, most of respondents who mentioned always, and rarely impoverished households considered when implementing UHC. The findings further revealed that been involved or educated on Universal Health Coverage and political environment affect implementation of Universal health coverage had a statistically significant association be with realization of universal healthcare coverage.

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