

**INFLUENCE OF INSTITUTIONAL CAPACITY ON IMPLEMENTATION OF THE
UNIVERSAL HEALTH CARE IN KENYA: CASE OF SOCIAL HEALTH
AUTHORITY**

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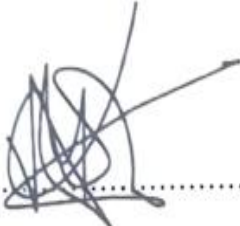
**A PROJECT SUBMITTED IN PARTIAL FULFILLMENT FOR
THE AWARD OF MASTER OF SCIENCE DEGREE IN
PROJECT PLANNING AND MANAGEMENT OF
MOUNT KENYA UNIVERSITY**

JUNE 2025

DECLARATION AND APPROVAL

Declaration by the Student

I declare that this research project is my original work and has not been presented for a degree in any other University or for any other award.

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Approval by the Supervisor

I confirm that the work reported in this research project was carried out by the candidate under my supervision

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ACKNOWLEDGEMENT

First and foremost, I give thanks to God Almighty for granting me the strength, wisdom, and perseverance to undertake and complete this research study. His grace has sustained me through every step of this academic journey.

I extend my heartfelt gratitude to my supervisor, Dr. Isaac Abuga Mokono, for his invaluable guidance, constructive feedback, and encouragement throughout the development of this project. His unwavering support and academic mentorship were instrumental in shaping the direction and quality of this research.

I would also like to sincerely thank my colleagues at Mount Kenya University and my professional peers at the Social Health Authority, whose cooperation, moral support, and shared insights greatly enriched my understanding of the research subject. Special appreciation goes to my friends for their constant encouragement, thoughtful discussions, and patience during this academic pursuit.

ABSTRACT

The implementation of Universal Health Care (UHC) in Kenya has faced critical setbacks despite the government's commitment through the Big Four Agenda. The purpose of the study is to assess how key dimensions of institutional capacity, including human resource capacity, financial capacity, healthcare infrastructure, and policy and governance, affect the successful implementation of UHC. Guided by four specific objectives, the study aims: to assess the influence of human resource capacity, to evaluate the effect of financial capacity, to examine the role of healthcare infrastructure, and to analyze the influence of policy and governance on UHC implementation in Kenya. The significance of this research lies in its potential to inform policy adjustments, institutional reforms, and strategic investments necessary for realizing universal, equitable, and affordable healthcare access. It is particularly valuable to government entities, healthcare administrators, development partners, scholars, and the general public. The research is grounded in two complementary theories: the Public Policy Implementation Theory, which explains the translation of policy intentions into actionable outcomes, and Systems Theory, which provides a holistic understanding of how various institutional components interact to influence policy execution. A descriptive research design was adopted, targeting 268 employees of SHA's headquarters in Nairobi. Using stratified random sampling, a sample size of 160 respondents was determined through Yamane's formula. Data was collected using semi-structured questionnaires, organized to capture the core variables of the study. Piloting, as well as reliability and validity checks, were conducted to ensure quality and credibility of the research instruments. Data analysis was done using SPSS version 23.0 and MS Excel. Descriptive statistics such as frequencies and means were used to summarize the data, while inferential statistics, including Pearson correlation and multivariate regression, were employed to test relationships between variables. Results are presented in tables, charts, and graphs for clarity and interpretation. The findings revealed a strong, positive relationship between institutional capacity components human resource capacity, financial capacity, healthcare infrastructure, and policy and governance and the successful implementation of UHC. Specifically, human resource capacity ($\beta = 0.236$, $p < 0.05$), financial capacity ($\beta = 0.215$, $p < 0.05$), healthcare infrastructure ($\beta = 0.198$, $p < 0.05$), and policy and governance ($\beta = 0.221$, $p < 0.05$) were all significant predictors of UHC outcomes. The model explained 73.6% of the variance in UHC implementation, underscoring the critical role of institutional readiness in health system reforms. The study concluded that strengthening institutional capacity is essential for effective UHC implementation. Gaps in staffing, delays in financial disbursements, inadequate infrastructure, and weak governance mechanisms continue to hinder service delivery under SHA. Accordingly, the study recommended the recruitment and retention of qualified personnel, enhancement of financial planning and budget utilization, investment in modern health infrastructure, and establishment of robust policy and governance frameworks. These measures are crucial for achieving equitable, accessible, and sustainable healthcare services across Kenya.

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LIST OF ABBREVIATIONS AND ACRONYMS

NHIS	:	National Health Insurance Scheme
SHA	:	Social Health Authority
SHIF	:	Social Health Insurance Fund
SPSS	:	Statistical Package for Social Sciences
SUS	:	Sistema Único de Saúde
UHC	:	Universal Health Care
WHO	:	World Health Organization



CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Universal Health Care (UHC) has emerged as a central component of global development strategies aimed at ensuring equitable access to quality health services without exposing individuals to financial hardship. As one of the United Nations Sustainable Development Goals (SDG 3.8), UHC reflects a collective commitment by governments to strengthen health systems and promote inclusive healthcare delivery. While the goal of achieving UHC is universally endorsed, the capacity of institutions to implement and sustain this model varies significantly across countries. Institutional capacity defined as the ability of organizations to effectively manage resources, formulate policies, deliver services, and coordinate stakeholder involvement plays a pivotal role in determining the success or failure of UHC programs (World Health Organization [WHO], 2022). This study seeks to investigate how institutional capacity affects the implementation of UHC in the Kenyan context, focusing on the Social Health Authority (SHA) as the implementing agency.

The implementation of Universal Health Care involves the translation of policy into practice through the establishment of accessible, affordable, and efficient health services. Key components include the provision of essential health services, development of financing mechanisms, and ensuring health system equity and responsiveness (WHO, 2022). However, successful implementation is contingent on the functional capacity of institutions, which encompasses human resources, financial stability, infrastructure, and governance systems. Countries with robust institutional mechanisms tend to report higher levels of UHC implementation success, while those with weak institutional frameworks struggle to realize their health objectives. This study investigates these

dynamics within Kenya, aiming to provide evidence-based insights into how institutional capacities affect UHC rollout.

Efforts to achieve UHC globally have illustrated the critical importance of institutional capacity in driving sustainable health reforms. In Canada, a high-performing institutional framework supported by strong policy coherence, skilled human resources, and decentralized healthcare delivery systems has enabled the country to maintain universal access to health services since the 1960s. Canada's federal and provincial governments work collaboratively through the Canada Health Act, ensuring health services are administered efficiently with minimal disparities (Marchildon, 2018). The robust financial oversight, strategic planning, and transparent governance structures across provinces have contributed to the successful implementation and sustainability of UHC in Canada.

In Japan, institutional efficiency is equally pronounced. The nation's UHC system is backed by a combination of compulsory health insurance schemes and government subsidies, ensuring that all citizens have access to healthcare (Ikegami, 2020). Japan's institutional strength lies in its integrated governance system, which facilitates coordination between ministries, municipalities, and private providers. The institutional capacity to forecast demographic trends and align health resources accordingly has been central to its health system's sustainability and high performance. Importantly, the health sector is driven by data-informed decision-making and regulatory compliance, enabling responsiveness to emerging health challenges such as population aging.

Contrastingly, in India, the implementation of UHC has faced structural challenges linked to inadequate institutional capacity. Despite launching the Ayushman Bharat program in 2018 to extend healthcare to over 500 million people, institutional gaps in financial allocation, poor infrastructure, and limited health workforce have hindered

effective delivery (Choudhury & Mohanty, 2022). Many Indian states lack the fiscal autonomy or capacity to absorb and implement federal UHC directives, leading to discrepancies in coverage and health outcomes. These capacity deficits highlight the importance of not only designing health policies but also building institutions capable of delivering on them.

Similarly, Brazil has struggled with regional disparities and institutional inefficiencies in delivering UHC through its Sistema Único de Saúde (SUS). Although SUS is one of the largest publicly funded health systems in the world, institutional fragmentation and underfunding have resulted in varied access to care across regions (Almeida et al., 2021). The lack of consistent oversight and limited capacity in local governments to manage healthcare provision has resulted in service inequities, demonstrating that institutional capacity is not only about resources but also about organizational capability and governance.

In Rwanda, UHC progress has been significantly influenced by institutional strengthening. The country's implementation of Mutuelles de Santé a community-based health insurance model demonstrates how political commitment and institutional reforms can enhance health service delivery (Chemouni, 2018). Rwanda's Ministry of Health has centralized planning and decentralized execution, allowing for adaptive governance and effective coordination at the community level. The institutional emphasis on performance-based financing and community health worker programs has substantially improved access to essential services, particularly in rural areas, underscoring the impact of capacity-building in health institutions.

In contrast, Nigeria faces persistent challenges in UHC implementation due to institutional weaknesses. Despite establishing the National Health Insurance Scheme (NHIS) in 2005, the country has struggled to achieve broad coverage. Key challenges

include insufficient budgetary allocation, corruption, weak monitoring mechanisms, and lack of synergy between federal and state agencies (Uzochukwu et al., 2022). The lack of human and technical capacity within regulatory bodies further constrains the ability to enforce compliance and drive health reforms. Nigeria's case exemplifies how institutional fragmentation and limited governance capacity can derail health policy implementation even when frameworks exist.

Ghana, on the other hand, has made considerable strides in UHC through its National Health Insurance Scheme (NHIS), established in 2003. Institutional capacity improvements such as digital health systems, biometric identification, and expanded premium coverage have enabled Ghana to cover nearly 40% of its population (Agyepong et al., 2023). Strategic reforms to address financing and infrastructure gaps, particularly in rural health facilities, have further solidified the system. Ghana's success highlights the significance of deliberate institutional investment in policy execution, coordination, and financial accountability to sustain UHC progress.

By contrast, South Africa's institutional complexities have slowed UHC progress despite its National Health Insurance Bill introduced in 2019. The dual health system with a well-resourced private sector and underfunded public services reflects deep inequalities. Challenges such as inadequate staffing, poor infrastructure, and financial mismanagement continue to hamper public health delivery (Mahlathi & Dlamini, 2020). Institutional reforms targeting governance, regulatory frameworks, and equitable resource allocation are urgently needed to actualize the envisioned UHC model.

In Kenya, the quest for UHC was amplified under the Big Four Agenda launched in 2017, which prioritized health coverage for all citizens. However, progress has been slow, mainly due to institutional capacity gaps. The pilot phase in counties such as Kisumu, Nyeri, Isiolo, and Machakos revealed challenges including lack of clear organizational

structures, inadequate healthcare personnel, and weak data systems for monitoring service delivery (Ngirachu, 2024). Moreover, there have been concerns over transparency and accountability in fund utilization, further complicating implementation efforts. These systemic weaknesses reflect a need to reevaluate the institutional readiness of key actors like the Social Health Authority to implement UHC.

A critical issue has been the disconnect between national-level policy formulation and county-level implementation, exacerbated by decentralization under the 2010 Constitution. For instance, counties often face funding delays, bureaucratic inefficiencies, and human resource shortages, all of which undermine the intended outcomes of the UHC program (Githinji et al., 2022). The Social Health Authority, mandated with overseeing the Social Health Insurance Fund (SHIF), must navigate overlapping roles, inter-agency tensions, and capacity shortfalls. These challenges highlight the importance of strengthening institutional frameworks, including governance structures, financial management systems, and collaborative mechanisms with county governments.

In Kenya, the aspiration for UHC under the Big Four Agenda is commendable, but substantial reforms are necessary to build the institutional muscle required for nationwide rollout. Strengthening the Social Health Authority's capacity in areas of human resources, financial management, infrastructure development, and governance will be essential for transforming policy intent into tangible health outcomes. This study, therefore, sought to empirically examine the influence of institutional capacity on the implementation of UHC in Kenya, providing actionable recommendations for health system reform and sustainability.

1.2 Statement of the Problem

Despite Kenya's commitment to achieving Universal Health Care (UHC) as part of its Big Four Agenda, the implementation process has been significantly hindered by institutional capacity constraints, particularly within the Social Health Authority (SHA) the key agency mandated to oversee the rollout of UHC programs. The transition from the National Hospital Insurance Fund (NHIF) to the Social Health Insurance Fund (SHIF), under SHA's management, was intended to address long-standing inefficiencies in health financing. However, the process has revealed critical gaps in human resources, financial planning, healthcare infrastructure, and governance frameworks. For instance, the Ministry of Health (2023) reported that only 47% of public health facilities in Kenya met the minimum operational standards for primary care. Moreover, SHA has faced challenges in recruiting and retaining qualified personnel, implementing integrated health information systems, and ensuring effective coordination with county governments all of which are fundamental to UHC success (Githinji, Otieno, & Wahome, 2022).

Further compounding the problem is the fragmented governance structure and unclear policy mandates that create overlaps between national and county roles, leading to delayed service delivery and accountability issues. According to Amunga and Okoth (2023), inconsistencies in fund disbursement, lack of transparency in procurement, and poor monitoring mechanisms have undermined the SHA's institutional integrity and eroded public trust in the UHC rollout. Additionally, inadequate infrastructure, especially in remote and underserved regions, limits the accessibility and availability of essential health services. These institutional weaknesses persist despite significant political will and financial investments directed at achieving UHC. Without a comprehensive evaluation of SHA's institutional capacity including its human, financial, infrastructural, and governance systems the goal of providing equitable, affordable, and quality health

care for all Kenyans remains unattainable.

1.3 Purpose of the Study

The purpose of this study was to examine the influence of institutional capacity on the implementation of Universal Health Care in Kenya, with a specific focus on the Social Health Authority.

1.4 Specific Objectives of the Study

The study was guided by the following specific research objectives:

- i. To assess the influence of human resource capacity on the implementation of the Universal Health Care in Kenya.
- ii. To evaluate the effect of financial capacity on the implementation of the Universal Health Care in Kenya.
- iii. To examine the role of healthcare infrastructure on the implementation of the Universal Health Care in Kenya.
- iv. To analyze the influence of policy and governance on the implementation of the Universal Health Care in Kenya.

1.5 Research Questions

The study was guided by the following research questions:

- i. How does human resource capacity influence the implementation of the Universal Health Care in Kenya?
- ii. In what ways does financial capacity affect the implementation of the Universal Health Care in Kenya?
- iii. To what extent does healthcare infrastructure contribute to the implementation of the Universal Health Care in Kenya?
- iv. How do policy and governance mechanisms influence the implementation of the Universal Health Care in Kenya?

1.6 Significance of the Study

This study is significant to the Government of Kenya, particularly the Ministry of Health and the Social Health Authority, by identifying key institutional capacity gaps that hinder the effective implementation of Universal Health Care. The findings offer practical recommendations for improving human resources, infrastructure, financing, and governance within the health sector.

Policymakers benefit from the study by gaining a deeper understanding of how institutional readiness influences health policy outcomes. The insights support evidence-based decision-making and policy formulation aimed at strengthening UHC delivery structures.

Health sector managers and administrators can use the study to assess organizational effectiveness and make informed adjustments in operational strategies. Enhancing institutional performance can lead to more efficient resource utilization and improved healthcare service delivery.

Development partners and donors involved in supporting Kenya's health agenda can find value in the study by understanding the systemic barriers affecting implementation. This can help in aligning funding and technical support with actual institutional needs.

Scholars and researchers benefit from the study as it contributes to the existing body of knowledge on UHC implementation and institutional capacity, particularly in low and middle-income countries. It also provides a foundation for further academic inquiry in the area of public health systems and governance.

Finally, the general public stands to gain indirectly from the study, as improved institutional capacity enhances access to equitable, affordable, and quality healthcare services, thus advancing the goal of universal health coverage for all Kenyans.

1.7 Scope of the Study

The scope of this study was limited to examining the influence of institutional capacity on the implementation of Universal Health Care in Kenya, with a specific focus on the Social Health Authority (SHA) as the implementing agency. The study investigated four key dimensions of institutional capacity: human resource capacity, financial capacity, healthcare infrastructure, and policy and governance mechanisms. Geographically, the study was conducted within the Social Health Authority headquarters and relevant operational departments. Methodologically, the research utilized a descriptive research design to analyze data collected through structured questionnaires. The study was carried out over a period of eight months, from January to August, to allow for adequate data collection, analysis, and reporting.

1.8 Limitation of the study

One limitation of the study was the reluctance of some respondents to provide accurate or complete information, especially on sensitive issues related to financial capacity and governance. To mitigate this, the researcher assured participants of confidentiality and use anonymous questionnaires to encourage honest responses.

Another limitation was the potential time constraints of the targeted respondents, particularly employees in managerial positions who had busy schedules. To address this, the researcher distributed the questionnaires in advance and allow flexible timelines for completion.

Additionally, since the study focused solely on the Social Health Authority, its findings may not be generalizable to other institutions involved in UHC implementation. However, the insights gained still provide valuable guidance for strengthening institutional capacity in similar public health settings.

Finally, resource limitations affected the breadth of data collection. To overcome this, the study adopted a focused sample and utilized cost-effective data collection methods

such as digital questionnaires and targeted follow-ups.

1.9 Delimitation of the Study

This study was delimited to the Social Health Authority (SHA) as the primary institution responsible for the implementation of Universal Health Care in Kenya. It focused specifically on four dimensions of institutional capacity: human resource capacity, financial capacity, healthcare infrastructure, and policy and governance. The study did not assess clinical service delivery outcomes or the role of other health actors outside SHA. Additionally, it utilized a descriptive research design with data collected through questionnaires administered to SHA staff, thus excluding external stakeholders such as patients or county-level health providers.

1.10 Assumptions of the Study

The study assumed that all selected respondents provided truthful and accurate responses based on their knowledge and experience within the Social Health Authority. It was also assumed that the institutional capacity indicators selected human resources, financial resources, infrastructure, and governance are sufficient and relevant in determining the implementation status of Universal Health Care. Furthermore, it was assumed that the SHA, as the implementing agency, played a central and active role in UHC delivery during the study period.

1.11 Operational Definition of Key Terms

Institutional Capacity: refers to the ability of the Social Health Authority to effectively plan, coordinate, and implement Universal Health Care. It is measured through four dimensions: human resource capacity, financial capacity, healthcare infrastructure, and policy and governance mechanisms.

Human Resource Capacity: refers to the availability, competence, and distribution of skilled personnel within the Social Health Authority involved in the implementation of UHC services.

Financial Capacity: refers to the adequacy, management, and sustainability of funds allocated to the Social Health Authority for implementing Universal Health Care activities.

Healthcare Infrastructure: refers to the physical facilities, equipment, and technologies available within the Social Health Authority to support the implementation of UHC services.

Policy and Governance: refers to the systems, leadership structures, regulatory frameworks, and decision-making processes within the Social Health Authority that guide the execution of UHC policies and programs.

Universal Health Care: refers to the goal of ensuring that all individuals and communities in Kenya have access to needed health services prevention, promotion, treatment, rehabilitation, and palliation without suffering financial hardship.

Implementation of UHC: refers to the process by which the Social Health Authority puts into action policies, programs, and operational plans to achieve equitable, accessible, and affordable health services across Kenya.

Social Health Authority: SHA is the government agency mandated to manage the

Social Health Insurance Fund (SHIF) and oversee the implementation of Universal Health Care in Kenya.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This section presents the definition of key conceptual terms, theoretical literature review, empirical literature review, identification of the research gap, and the development of the conceptual framework.

2.1 Empirical Literature

Empirical literature provides evidence-based insights drawn from actual studies that have investigated the relationship between institutional capacity and the implementation of public health programs, including Universal Health Care (UHC). It involves the review of research findings from various contexts where data was collected, analyzed, and conclusions drawn using measurable indicators. This section critically examines studies conducted globally, in Africa, and within Kenya that relate to institutional capacity dimensions such as human resources, financial resources, infrastructure, and governance and how these have influenced the success or failure of UHC or similar health interventions. The analysis aims to identify patterns, methodologies, and key findings that inform the current study and highlight existing research gaps.

2.1.1 Human Resource Capacity and UHC Implementation

The equitable distribution of health workers is a cornerstone for effective UHC implementation. In Canada, despite a publicly funded health system, disparities in health workforce distribution persist, particularly in rural and remote areas. A study by Marchildon (2018) highlights that while Canada has a robust health workforce, challenges such as regional disparities and retention issues continue to affect service delivery. The study employed a mixed-methods approach, combining policy analysis with stakeholder interviews across seven provinces, emphasizing the need for strategic

workforce planning and interprovincial collaboration to address these challenges and sustain UHC.

Japan's success in achieving UHC is largely attributed to its continuous investment in training health professionals and implementing policies that ensure equitable distribution of health workers. Ikegami (2020) analyzed Japan's health policies related to HRH development, using a qualitative methodology that included policy document reviews and expert interviews. The study found that Japan's approach to HRH development, including the integration of health workforce planning into national health policy, has been instrumental in maintaining a high standard of care and equitable access across the country. However, the study also noted that Japan's aging population poses new challenges, necessitating further innovations in HRH management.

Germany's statutory health insurance system relies heavily on a well-distributed health workforce to provide comprehensive care. Busse and Blümel (2017) conducted a quantitative analysis of health workforce data and policy reviews to assess HRH capacity in Germany. The study found that Germany maintains a high ratio of health professionals per capita, contributing to effective UHC implementation. However, it also identified challenges such as an aging workforce and regional imbalances, recommending targeted policies to attract young professionals and address geographic disparities.

Rwanda has made significant strides in strengthening its health workforce to support UHC through strategic partnerships. The Human Resources for Health Program, evaluated by Binagwaho et al. (2019), aimed to increase the number and quality of health professionals. Using a longitudinal study design, the research assessed workforce metrics before and after program implementation, showing a substantial increase in trained health workers and improved service delivery. The study concluded that strategic investments in HRH are vital for UHC success, emphasizing the role of international partnerships in

building local capacity.

Ghana's efforts toward UHC have included addressing HRH challenges through the use of optimization tools. Agyepong et al. (2020) utilized a case study methodology to examine the country's health workforce policies, highlighting initiatives such as the use of the Workload Indicators of Staffing Needs (WISN) tool to optimize staff distribution. Findings indicated that while progress has been made, issues like urban-rural disparities and limited training opportunities remain, recommending continuous policy evaluation and investment in HRH development.

South Africa's journey toward UHC has been marked by efforts to reform its health workforce policies. George et al. (2019) conducted a policy analysis of the National Health Insurance (NHI) and its implications for HRH, finding that while the NHI aims to improve access, challenges such as workforce shortages and uneven distribution hinder progress. The study emphasized the need for comprehensive HRH strategies, including training, retention, and equitable deployment, to realize UHC goals.

Kenya's implementation of UHC has faced HRH challenges, particularly in workforce shortages and distribution. Barasa et al. (2018) employed a cross-sectional survey to assess health workforce availability in UHC pilot counties, revealing significant shortages of health workers, particularly in rural areas, affecting service delivery. The study recommended targeted recruitment and retention strategies to bolster HRH capacity, highlighting the need for equitable distribution of health workers to achieve UHC.

An analysis by Tsofa et al. (2017) examined Kenya's health sector reforms and their impact on HRH, using a qualitative approach that included policy document reviews and interviews with key stakeholders. The study found that decentralization had mixed effects on HRH, with some counties improving workforce management while others

struggled. It suggested that clear guidelines and support are necessary to enhance HRH outcomes under devolution, emphasizing the importance of capacity building at the county level.

A study by Miseda et al. (2017) focused on health workforce training in Kenya, using a descriptive design to assess the capacity of training institutions and the alignment of curricula with health system needs. Findings indicated that while there is an increase in training institutions, challenges such as inadequate faculty and resources persist. The study recommended strengthening training infrastructure and curricula to meet UHC demands, highlighting the need for investment in health workforce education.

2.1.2 Financial Capacity and UHC Implementation

In the pursuit of Universal Health Coverage (UHC), Thailand has implemented a comprehensive health financing reform known as the Universal Coverage Scheme (UCS). A study by Tangcharoensathien et al. (2018) employed a mixed-methods approach, combining policy analysis with stakeholder interviews, to assess the impact of UCS on healthcare access and financial protection. The findings revealed that the UCS significantly reduced out-of-pocket expenditures and improved access to essential health services, particularly among the poor. The study emphasized the importance of sustained political commitment and adequate financial resources in achieving UHC goals.

Iran's Health Transformation Plan (HTP) aimed to enhance financial protection and equity in healthcare. A study by Doshmangir et al. (2019) utilized a qualitative methodology, including document analysis and expert interviews, to evaluate the HTP's effectiveness. The research indicated that while the HTP increased insurance coverage and reduced catastrophic health expenditures, challenges such as budget deficits and inefficient resource allocation persisted. The study highlighted the need for strategic purchasing and improved financial management to sustain UHC progress.

Brazil's Unified Health System (SUS) represents a significant effort toward UHC through public financing. A study by Massuda et al. (2018) conducted a comprehensive review of health expenditure data and policy documents to assess SUS's performance. The analysis showed that despite increased public health spending, disparities in healthcare access remained, particularly in rural areas. The study recommended enhancing fiscal capacity and implementing equitable resource distribution mechanisms to strengthen UHC implementation.

Nigeria's National Health Insurance Scheme (NHIS) was established to improve financial access to healthcare. A study by Onoka et al. (2019) employed a cross-sectional survey and key informant interviews to assess the NHIS's impact. The findings revealed low enrollment rates and limited financial protection, attributed to inadequate funding and poor governance. The study suggested that increasing government investment and strengthening institutional frameworks are critical for enhancing the NHIS's effectiveness in achieving UHC.

Ethiopia's Community-Based Health Insurance (CBHI) scheme aims to provide financial protection for the informal sector. A study by Mebratie et al. (2019) utilized a quasi-experimental design to evaluate the CBHI's impact on healthcare utilization and financial risk protection. The results indicated that CBHI enrollment led to increased outpatient visits and reduced out-of-pocket expenditures. However, challenges such as limited benefit packages and financial sustainability were noted, highlighting the need for government subsidies and efficient fund management.

Uganda's efforts to implement a National Health Insurance Scheme (NHIS) have faced financial constraints. A study by Nabyonga-Orem et al. (2018) conducted a policy analysis and stakeholder consultations to examine the NHIS's feasibility. The study found that insufficient fiscal space and reliance on donor funding hindered the scheme's

implementation. Recommendations included increasing domestic health financing and establishing robust financial management systems to support UHC initiatives.

Kenya has undertaken several health financing reforms to advance UHC, including the introduction of the National Hospital Insurance Fund (NHIF). A study by Barasa et al. (2018) employed a mixed-methods approach, combining household surveys and policy analysis, to assess the NHIF's performance. The findings indicated that while NHIF coverage expanded, significant gaps in financial protection remained, especially among the informal sector. The study recommended enhancing premium subsidies and improving benefit packages to strengthen financial capacity for UHC.

2.1.3 Healthcare Infrastructure and UHC Implementation

Comprehensive health system reforms often necessitate substantial investments in healthcare infrastructure. Ireland's Sláintecare initiative, launched in 2017, aimed to transition the country towards a single-tiered health service providing equitable access based on need rather than income. A study by Burke et al. (2018) analyzed the implementation of Sláintecare, highlighting that inadequate infrastructure, particularly in primary care settings, posed significant challenges to the reform's objectives. The research employed a policy analysis methodology, reviewing government documents and stakeholder interviews to assess the readiness of Ireland's health infrastructure. Findings indicated that the existing infrastructure was insufficient to support the envisioned shift towards community-based care, necessitating targeted investments in facilities and workforce expansion to realize UHC goals.

Rapid economic development and urbanization can strain existing healthcare infrastructure, impacting UHC implementation. In Vietnam, the government has pursued UHC through the expansion of health insurance coverage and service delivery reforms. Nguyen et al. (2019) conducted a mixed-methods study, combining facility assessments

with household surveys, to evaluate the adequacy of healthcare infrastructure in supporting UHC. The study revealed disparities in facility readiness, with rural areas facing shortages in essential medical equipment and trained personnel. These infrastructural gaps hindered service utilization and quality, underscoring the need for equitable infrastructure development to achieve UHC.

Geographical challenges and population dispersion can complicate healthcare infrastructure development. Indonesia's archipelagic geography presents unique obstacles to UHC implementation. A study by Agustina et al. (2019) utilized a cross-sectional design to assess the distribution and functionality of primary healthcare centers (Puskesmas) across various provinces. The research found significant variability in infrastructure quality and service availability, particularly in remote regions. The study emphasized the importance of context-specific infrastructure planning and investment to ensure that all populations have access to essential health services under UHC.

Innovative community-based healthcare models can address infrastructure limitations in resource-constrained settings. In Mali, the Muso Health initiative implemented a proactive community case management (Pro-CCM) model, deploying community health workers to provide door-to-door care. A study by Johnson et al. (2013) employed a repeated cross-sectional survey to evaluate the impact of this model on child mortality. The findings demonstrated a tenfold reduction in under-five mortality rates, attributing success to the model's ability to circumvent traditional infrastructure barriers by bringing care directly to households. This approach illustrates how alternative service delivery models can complement infrastructure development in advancing UHC.

Decentralization policies can influence the development and maintenance of healthcare infrastructure. In Tanzania, the decentralization of health services aimed to improve responsiveness and efficiency. A study by Kessy (2014) conducted a qualitative

assessment through interviews and facility observations to examine the effects of decentralization on infrastructure. The research found that while local authorities had increased autonomy, disparities in resource allocation led to uneven infrastructure development. Facilities in wealthier districts saw improvements, whereas those in poorer areas lagged behind, highlighting the need for equitable resource distribution mechanisms to support UHC.

Public-private partnerships (PPPs) can play a role in enhancing healthcare infrastructure. In Senegal, the government engaged in PPPs to construct and manage health facilities. A study by Ndiaye et al. (2017) utilized a case study approach to analyze the outcomes of these partnerships. The findings indicated that PPPs contributed to the expansion of healthcare infrastructure, particularly in urban areas. However, challenges such as affordability and equitable access persisted, suggesting that while PPPs can augment infrastructure, complementary policies are necessary to ensure that infrastructure improvements translate into broader UHC gains.

Urbanization presents both opportunities and challenges for healthcare infrastructure development. In Nairobi, Kenya's capital, rapid urban growth has necessitated the expansion of health facilities. A study by Kimani-Murage et al. (2015) employed a cross-sectional survey to assess the availability and accessibility of maternal health services in informal settlements. The research revealed that despite proximity to numerous health facilities, quality and capacity constraints limited effective service delivery. The study recommended targeted investments in upgrading facility infrastructure and staffing to meet the demands of urban populations under UHC.

2.1.4 Policy and Governance in UHC Implementation

Effective governance structures are pivotal in steering health reforms towards achieving UHC. In China, the government's commitment to health system strengthening has been

evident through its comprehensive health reforms initiated in 2009. A study by Meng et al. (2019) employed a mixed-methods approach, including policy analysis and stakeholder interviews, to assess the impact of these reforms. The findings highlighted that strong political will, centralized decision-making, and clear policy directives facilitated the expansion of health insurance coverage to over 95% of the population. However, challenges such as disparities in service quality and financial sustainability persisted, indicating the need for continuous policy refinement and robust governance mechanisms.

Decentralized governance can influence the effectiveness of UHC implementation. In India, the National Health Mission (NHM) aimed to improve healthcare delivery through decentralized planning and community participation. A study by Rao et al. (2018) utilized a qualitative case study methodology to examine the governance structures under NHM. The research revealed that while decentralization empowered local authorities, variations in administrative capacity and accountability mechanisms affected program outcomes. The study underscored the importance of strengthening institutional capacities and establishing clear accountability frameworks to enhance governance in UHC initiatives.

Policy coherence and intersectoral collaboration are essential components of effective health governance. Mexico's implementation of the Seguro Popular program aimed to provide health insurance to the uninsured population. A study by Frenk et al. (2015) conducted a policy analysis and evaluated program outcomes using national health surveys. The findings indicated that the program significantly increased insurance coverage and reduced catastrophic health expenditures. The success was attributed to coherent policy design, political commitment, and effective intersectoral coordination. However, the study also noted challenges in ensuring service quality and integrating

services across different levels of care, highlighting areas for governance improvement. Strategic policy reforms and governance structures have played a crucial role in Morocco's progress towards UHC. The country's Mandatory Health Insurance (AMO) and Medical Assistance Scheme (RAMED) were established to extend coverage to formal and informal sector workers, respectively. A study by Achy and Belghazi (2019) employed a policy analysis framework to assess these schemes. The research found that while AMO achieved substantial coverage among formal workers, RAMED faced challenges in targeting and enrolling the poorest populations. The study emphasized the need for improved governance mechanisms, including better beneficiary identification systems and enhanced inter-agency coordination, to ensure equitable access under UHC. Governance challenges can impede the implementation of health policies aimed at achieving UHC. In Zimbabwe, the Health Transition Fund (HTF) was introduced to revitalize the health sector post-crisis. A study by Chikanda and Tawodzera (2017) utilized a mixed-methods approach, combining policy analysis with key informant interviews, to evaluate the HTF's governance structures. The findings indicated that while the HTF improved resource mobilization and coordination among donors, issues such as limited government ownership and weak accountability mechanisms hindered sustainability. The study recommended strengthening government leadership and establishing transparent governance frameworks to enhance policy implementation for UHC.

Community engagement and participatory governance are vital for the success of UHC initiatives. In Zambia, the National Health Strategic Plan emphasized community involvement in health planning and service delivery. A study by Masiye et al. (2016) conducted household surveys and focus group discussions to assess the impact of community participation on health outcomes. The research revealed that areas with active

community health committees experienced improved service utilization and accountability. However, the study also noted challenges such as limited capacity and resources for these committees, suggesting the need for policy support and capacity building to strengthen participatory governance in UHC implementation.

Kenya's commitment to UHC has been demonstrated through various policy initiatives, including the UHC pilot program launched in 2018. A study by Barasa et al. (2020) employed a mixed-methods approach, incorporating policy analysis and stakeholder interviews, to evaluate the pilot's implementation. The findings highlighted that while the pilot improved access to healthcare services, challenges such as inadequate stakeholder engagement, unclear policy guidelines, and limited accountability mechanisms affected its effectiveness. The study recommended the development of comprehensive policy frameworks with clear governance structures to guide the national rollout of UHC.

2.1.5 Implementation Universal Health Care

Efforts to achieve UHC in Bangladesh have been marked by significant challenges, including limited financial resources and infrastructural constraints. A study by Rahman et al. (2018) employed a Bayesian analysis of population-based household data to project trends in UHC indicators from 1995 to 2030. The findings indicated that while there have been improvements in service coverage, financial protection remains inadequate, with a substantial portion of the population still incurring catastrophic health expenditures. The study emphasized the need for comprehensive health financing reforms and targeted interventions to address these gaps.

In Nepal, the journey towards UHC has been influenced by structural factors such as political stability, governance, and economic capacity. Ranabhat et al. (2019) conducted a systematic review to explore these factors' impact on UHC implementation. The study

revealed that while Nepal has made policy commitments towards UHC, challenges persist in translating these policies into effective service delivery due to governance issues and limited financial resources. The authors recommended strengthening institutional frameworks and increasing investment in the health sector to facilitate UHC progress.

The Philippines has undertaken significant reforms to advance UHC, including the enactment of the Universal Health Care Act in 2019. A study by Dayrit et al. (2018) utilized a mixed-methods approach to assess the health system's readiness for UHC implementation. The research highlighted that while policy frameworks are in place, challenges such as fragmented service delivery and inequities in health access remain. The study underscored the importance of health system integration and capacity building to ensure effective UHC implementation.

Cameroon's efforts towards UHC have been characterized by pilot initiatives aimed at expanding health insurance coverage. A study by De Allegri et al. (2018) evaluated a community-based health insurance scheme's impact using a quasi-experimental design. The findings indicated increased healthcare utilization among insured populations but also highlighted issues related to scheme sustainability and limited coverage. The study recommended policy reforms to enhance financial sustainability and expand coverage to achieve UHC goals.

In Malawi, the implementation of UHC has been challenged by resource constraints and health workforce shortages. Chansa et al. (2018) conducted a cross-sectional study to assess the availability and readiness of health facilities to provide essential services. The research revealed significant gaps in service availability and quality, particularly in rural areas. The authors emphasized the need for increased investment in health infrastructure and workforce development to support UHC implementation.

Burkina Faso has pursued UHC through the implementation of a national health insurance scheme. Ridde et al. (2018) employed a mixed-methods approach to evaluate the scheme's effectiveness. The study found improvements in healthcare access and financial protection among enrolled populations. However, challenges such as administrative inefficiencies and limited awareness hindered broader enrollment. The study suggested enhancing governance structures and community engagement to improve scheme performance.

Kenya's UHC pilot program, launched in 2018 across four counties, aimed to provide essential health services without financial hardship. A study by Barasa et al. (2020) utilized a mixed-methods cross-sectional design to assess the pilot's implementation. The findings indicated increased service utilization and reduced out-of-pocket expenditures. However, challenges such as supply chain inefficiencies and health workforce shortages were noted. The study recommended addressing these systemic issues to ensure the program's sustainability and scalability.

To enhance financial protection, Kenya introduced a health insurance subsidy program targeting indigent populations. A study by Mwaura et al. (2023) evaluated the program's impact using a quasi-experimental design. The research demonstrated increased healthcare utilization and reduced financial barriers among beneficiaries. Nonetheless, issues related to beneficiary identification and enrollment processes were identified. The study emphasized the need for robust targeting mechanisms and administrative efficiency to optimize program outcomes.

2.2 Theoretical Literature Review

This study adopts two interrelated theoretical frameworks: the Public Policy Implementation Theory and Systems Theory. These theories were selected for their broad applicability across all study objectives and their ability to collectively explain the

processes, structures, and dynamics involved in institutional performance. Public Policy Implementation Theory offers insights into how policy intentions are transformed into practical outcomes, while Systems Theory provides a holistic view of how the various institutional components interact to influence health system functionality. Together, these frameworks guide the study in analyzing institutional capacity as a central determinant of UHC success within the Social Health Authority.

2.2.1 Public Policy Implementation Theory

Public Policy Implementation Theory serves as a foundational framework for understanding the complexities involved in translating policy decisions into tangible outcomes. Originating from the seminal work of Pressman and Wildavsky in 1973, the theory has evolved to encompass various models and approaches that address the multifaceted nature of policy execution. At its core, the theory examines the processes, actors, and contextual factors that influence the effectiveness of policy implementation. One of the pivotal contributions to this field is the framework developed by Sabatier and Mazmanian in the late 1970s and early 1980s. Their model emphasizes the importance of clear policy objectives, adequate resources, and supportive institutional environments in facilitating successful implementation. They argue that the likelihood of effective policy execution increases when goals are unambiguous, causal linkages are well understood, and there is a conducive socio-political climate (Sabatier & Mazmanian, 1980). This perspective underscores the interplay between policy design and the administrative structures responsible for its enactment.

Further advancements in the theory have introduced the dichotomy between top-down and bottom-up approaches. The top-down perspective focuses on the directives issued by policymakers and the hierarchical structures that enforce them. In contrast, the bottom-up approach highlights the role of local actors and frontline implementers in

shaping policy outcomes. This duality reflects the dynamic nature of policy implementation, where both centralized authority and grassroots participation play crucial roles (Matland, 1995).

In recent years, scholars have advocated for integrative models that reconcile these perspectives. For instance, the 5-C protocol comprising content, context, commitment, capacity, and clients/coalitions offers a comprehensive lens to assess implementation processes. This model recognizes that successful policy execution depends on the alignment of policy content with contextual realities, the commitment of stakeholders, the capacity of institutions, and the engagement of clients and coalitions (Kurhayadi, 2023). Such frameworks provide nuanced insights into the variables that affect policy outcomes.

The relevance of Public Policy Implementation Theory to the study of Universal Health Care (UHC) in Kenya is particularly pronounced. Implementing UHC involves complex coordination among various institutional actors, including the Social Health Authority. The theory aids in dissecting how policy directives are operationalized within the Kenyan health system, considering factors such as resource allocation, administrative capacity, and stakeholder engagement. By applying this theoretical lens, researchers can identify bottlenecks and facilitators in the implementation process, thereby informing strategies to enhance the effectiveness of UHC initiatives.

Moreover, the theory's emphasis on the interplay between policy design and execution aligns with the challenges faced in the Kenyan context. Issues such as inadequate infrastructure, limited financial resources, and workforce shortages underscore the importance of aligning policy objectives with implementation capacities. Public Policy Implementation Theory provides a structured approach to analyze these challenges and develop actionable solutions that are grounded in empirical evidence and contextual

understanding.

In conclusion, Public Policy Implementation Theory offers a robust framework for examining the intricacies of policy execution. Its application to the study of UHC implementation in Kenya enables a comprehensive analysis of the factors influencing policy outcomes. By leveraging this theory, researchers and policymakers can gain valuable insights into the mechanisms that drive successful implementation, ultimately contributing to the realization of universal health coverage goals.

2.2.2 Systems Theory

Systems Theory, conceptualized by Ludwig von Bertalanffy in the mid-20th century, offers a comprehensive framework for understanding complex, interrelated structures within various domains, including healthcare. Bertalanffy's General System Theory (1968) posits that systems, whether biological, social, or organizational, consist of interconnected components whose interactions produce outcomes greater than the sum of their parts. This holistic perspective emphasizes the importance of examining the relationships and processes within a system rather than isolating individual elements.

In the context of healthcare, Systems Theory has been instrumental in highlighting how different components such as personnel, infrastructure, policies, and financial resources interact to influence service delivery and patient outcomes. A study by Anderson (2016) underscores the application of Systems Theory in healthcare, illustrating how a systemic approach can identify patterns and system failures that contribute to adverse events, thereby facilitating more effective interventions. This perspective shifts the focus from individual blame to understanding and improving the system as a whole.

Applying Systems Theory to the implementation of Universal Health Care (UHC) in Kenya provides valuable insights into the multifaceted nature of healthcare delivery. The theory elucidates how various institutional capacities human resources, financial

management, infrastructure, and governance must function cohesively to achieve the objectives of UHC. For instance, the availability of trained healthcare personnel (human resources) is intrinsically linked to the adequacy of facilities and equipment (infrastructure), the allocation of funds (financial capacity), and the effectiveness of policies and administrative structures (governance). Disruptions or inefficiencies in any of these components can compromise the entire system's performance.

Moreover, Systems Theory emphasizes the concept of feedback loops, where outputs of a system influence future inputs and processes. In healthcare, this translates to the continuous monitoring and evaluation of service delivery outcomes to inform policy adjustments and resource allocation. Such an approach ensures that the healthcare system remains responsive to the population's needs and can adapt to emerging challenges. For example, data on patient satisfaction and health outcomes can guide training programs for healthcare workers, infrastructure development, and policy reforms.

The relevance of Systems Theory to this study lies in its capacity to provide a structured lens through which to analyze the implementation of UHC in Kenya. By recognizing the interdependencies among various institutional capacities, the theory facilitates a comprehensive assessment of the factors influencing healthcare delivery. It underscores the necessity of a coordinated approach where improvements in one area, such as policy formulation, are complemented by enhancements in others, like infrastructure and human resources. This systemic understanding is crucial for identifying bottlenecks, optimizing resource utilization, and ensuring the sustainability of UHC initiatives.

In conclusion, Systems Theory offers a robust framework for examining the complexities of implementing Universal Health Care in Kenya. Its emphasis on interconnectivity, feedback mechanisms, and holistic analysis aligns with the multifaceted nature of healthcare systems. By applying this theory, the study can effectively explore how

various institutional capacities interact to influence the success of UHC, thereby providing insights that can inform policy decisions and strategic planning.

2.3 Conceptual Framework

A conceptual framework serves as the logical structure that guides a research study by illustrating the relationships between variables based on theory, literature, and empirical evidence. It helps to organize the study, provide direction for data collection, and support the interpretation of findings (Adom, Hussein, & Joe, 2018). In implementation-focused research, particularly in the health sector, conceptual frameworks are critical for unpacking the interactions between institutional elements and outcome variables. This framework is essential for understanding how various forms of institutional capacity namely human resource capacity, financial capacity, healthcare infrastructure, and policy and governance affect the implementation of Universal Health Care (UHC).

In the context of public health systems, institutional capacity is widely recognized as a multidimensional construct that influences the ability of organizations to plan, execute, and sustain reforms (Karamagi et al., 2021). Each dimension of capacity is expected to exert a distinct but interconnected influence on how effectively health policies, such as UHC, are implemented. Human resource capacity affects service delivery through the availability and competence of health personnel. Financial capacity determines the adequacy, timeliness, and efficiency of funding flows. Healthcare infrastructure shapes the physical and technological readiness of the system, while policy and governance define the institutional mechanisms that ensure accountability, regulation, and coordination.

The conceptual framework for this study is derived from both Public Policy Implementation Theory and Systems Theory, which emphasize the interconnectedness of institutional elements and the role of implementation environments in shaping policy

outcomes (Sabatier & Weible, 2017; Anderson, 2016). These theoretical underpinnings inform the hypothesized linkages between independent variables (institutional capacity dimensions) and the dependent variable (implementation of Universal Health Care). The framework anticipates that improvements in the independent variables will result in enhanced levels of UHC implementation, measured in terms of accessibility, affordability, and equity in service provision. This structure will guide the formulation of research instruments, data analysis, and interpretation of findings within the study.



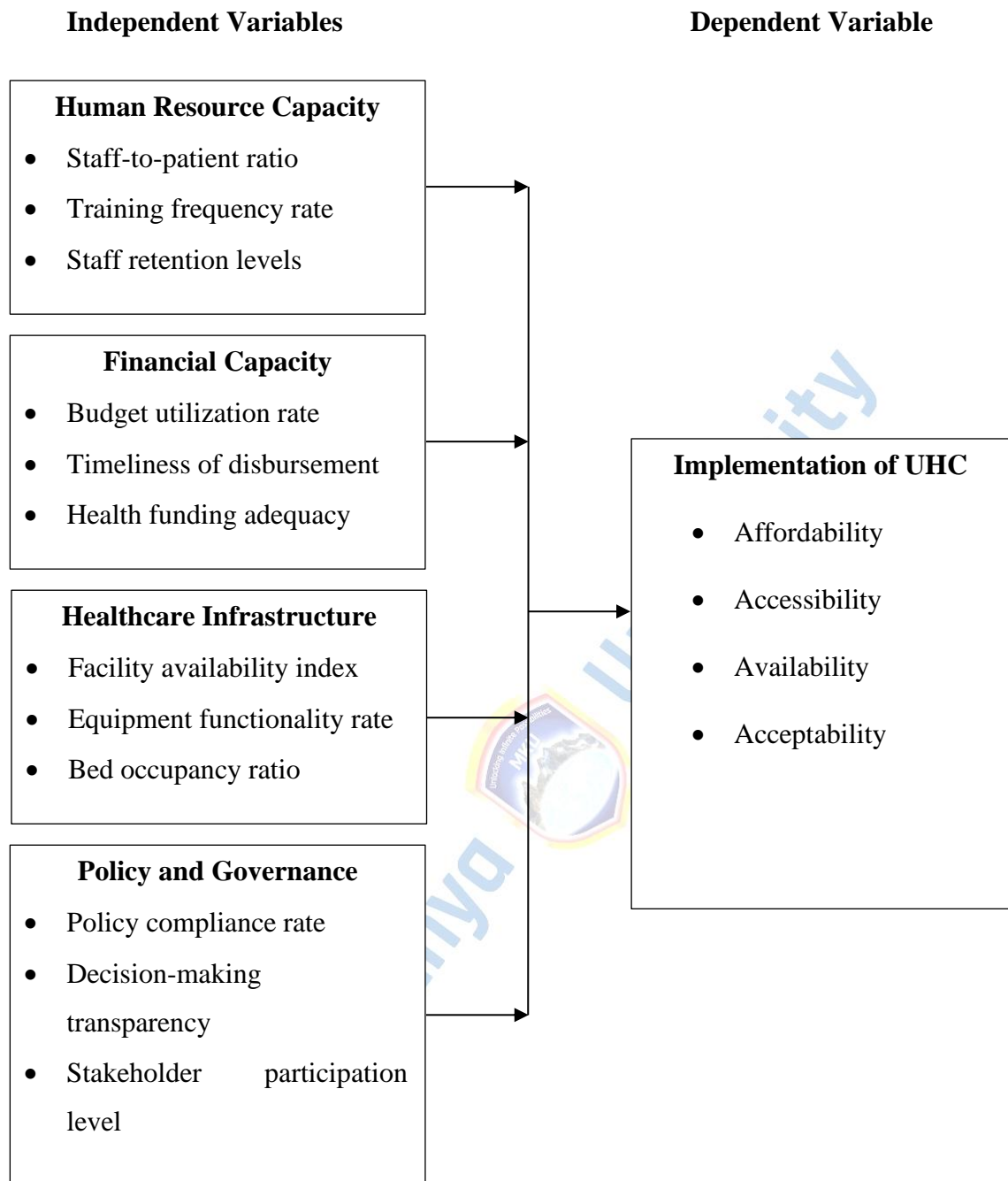


Figure 1: Conceptual Framework
Source: Researcher (2025)

2.4 Research Gaps

Despite the growing body of literature on the importance of human resource capacity in the implementation of Universal Health Care (UHC), a significant gap remains in understanding how institutional mechanisms for staffing, training, and retention directly influence UHC outcomes in low- and middle-income countries. Many studies, such as

those by Binagwaho et al. (2019) and Barasa et al. (2018), have acknowledged shortages in the health workforce and uneven distribution, yet few have explored how internal institutional strategies, such as professional development systems, affect the scalability and quality of UHC services. Additionally, much of the existing research has focused on national-level data without assessing organization-specific challenges, particularly within newly established bodies like Kenya's Social Health Authority. This leaves a gap in localized knowledge that is necessary for strengthening capacity where policy is implemented.

Concerning financial capacity, numerous studies have examined health financing models and their relation to UHC, yet limited empirical work connects institutional financial planning and fund utilization efficiency with the actual performance of UHC programs (Mebratie et al., 2019; Doshmangir et al., 2019). While research has highlighted issues such as delayed disbursements and underfunding, there is a scarcity of studies analyzing how these financial constraints play out within implementing institutions. Moreover, few studies evaluate the impact of financial management practices such as budget tracking, internal auditing, or resource allocation procedures on UHC rollout. This represents a critical knowledge gap, especially in the Kenyan context, where the Social Health Authority is expected to handle extensive resources under the new Social Health Insurance Fund (SHIF) structure.

In the domain of healthcare infrastructure, past literature has largely emphasized the availability and distribution of facilities and equipment at the national and county levels. However, studies like those by Karamagi et al. (2021) and Chansa et al. (2018) rarely delve into how institutional-level infrastructure readiness such as supply chain functionality, facility maintenance systems, or digital infrastructure deployment affects the timely and quality implementation of UHC programs. More importantly, most

infrastructure studies fail to address the operational interdependence between infrastructure and other institutional capacities such as human resources and governance. In Kenya, with the increasing push for digitized health services and facility upgrades under UHC, the lack of integrated research that connects infrastructure quality with service access and policy success is a gap that warrants attention.

Policy and governance are widely recognized as enablers of UHC, yet much of the literature is normative and lacks empirical depth, especially in relation to the role of institutional governance frameworks in implementing health reforms. While studies such as those by Barasa et al. (2020) and Tsofa et al. (2017) acknowledge governance issues like overlapping mandates and weak intergovernmental coordination, few have systematically measured how policy coherence, stakeholder accountability, or participatory mechanisms affect the execution of UHC at the institutional level. Furthermore, most governance-related studies focus on national-level actors, leaving a gap in the understanding of how semi-autonomous government agencies like the Social Health Authority translate policy into action amid administrative and political challenges. This limits actionable insights for institutional reform and capacity strengthening.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the research design, the study area, study population, the sample size, sampling technique, data collection tool, validity and reliability, data analysis methods and ethical consideration.

3.1 Research Design

A research design is essential for structuring a study to ensure that findings are relevant and applicable to the current context. It serves as a blueprint for data collection and analysis, guiding researchers in systematically addressing the research problem and objectives. Descriptive research design, in particular, is instrumental in providing a comprehensive understanding of phenomena by observing and describing characteristics without manipulating variables. This approach is valuable in the initial phases of research, offering insights into current conditions and informing subsequent studies (Siedlecki, 2020).

Descriptive research is particularly suited for studies aiming to identify patterns, frequencies, and relationships among variables. It allows researchers to gather data that reflect the current state of affairs, facilitating the exploration of associations between variables without establishing causality (McCombes, 2019). By employing methods such as surveys and observational studies, descriptive research provides a foundation for understanding complex issues, which is crucial before delving into causal analyses.

In the context of this study, a descriptive survey design was employed to investigate the influence of institutional capacity on the implementation of Universal Health Care (UHC) in Kenya. This design was appropriate as it enabled the collection of data from a representative sample, allowing for the examination of relationships among variables such as human resources, financial capacity, infrastructure, and governance. By capturing the current state of

these institutional factors, the study aimed to provide insights into their roles in UHC implementation, thereby informing policy and practice.

3.2 Area of Study

The study was conducted within the Social Health Authority (SHA), a newly established public agency under the Ministry of Health, Kenya. SHA is mandated to oversee the implementation of the Social Health Insurance Fund (SHIF), which is the central financing mechanism for the Universal Health Care (UHC) agenda in Kenya. SHA has replaced the former National Hospital Insurance Fund (NHIF) and is tasked with ensuring equitable, efficient, and sustainable delivery of healthcare financing services across the country. The authority plays a critical role in planning, coordinating, and supervising UHC activities, including managing contributions, disbursements, and healthcare provider contracts.

Headquartered in Nairobi County, the Social Health Authority operates as a national institution with links to all 47 county governments. It interacts with county health departments, accredited healthcare providers, and various regulatory and oversight bodies to deliver UHC services. Nairobi, being the administrative and policy hub of Kenya, offers strategic access to top-level SHA staff involved in management, finance, health systems governance, and policy implementation. This makes it a suitable location for collecting institutionally grounded data on capacity and performance in the context of UHC rollout.

Given SHA's central role in operationalizing Kenya's health financing reforms, the study specifically targeted departments within the institution that are directly involved in UHC implementation. These included the departments of Human Resources, Finance and Accounts, Infrastructure and ICT, and Policy and Planning. By focusing on SHA, the study provides an in-depth analysis of the institutional strengths and gaps affecting the realization of UHC goals, making it highly relevant for both academic and policy discourse.

3.3 Target Population

It is important for researchers to select a target population that is representative of the larger population to ensure that the results of the study can be generalized to the larger population (Gravetter & Wallnau, 2016). In addition, researchers must consider ethical issues related to the selection of the target population, such as informed consent and privacy (Hagan & Donovan, 2013). This study focused on the Social Health Authority (SHA) headquarters located in Nairobi County, Kenya, where the core administrative, managerial, and operational departments involved in the implementation of Universal Health Care are based. According to updated records from the SHA Human Resource Department (2024), the headquarters housed a total of 268 employees. This included 6 top-level managers, 7 middle-level officers, 35 heads of sections, and 220 general staff working in finance, policy, infrastructure, human resource, and health program implementation units. The tabulation was as is in the table below;

Table 1: Target Population

<i>Category</i>	<i>Number of Employees</i>
<i>Top-Level Managers</i>	6
<i>Middle-Level Officers</i>	7
<i>Heads of Sections</i>	35
<i>General Staff</i>	220
<i>Total</i>	268

Source: SHA Human Resource Department (2024)

3.4 Sampling Procedures and Sample Size

3.4.1 Sampling Procedures

This study employed a stratified random sampling technique, which was appropriate for ensuring a representative sample from the diverse categories of employees at the Social Health Authority headquarters in Nairobi. Stratified sampling involves dividing the population into distinct subgroups (strata) based on specific characteristics in this case, job classification levels and then randomly selecting participants from each stratum (Saunders, Lewis, & Thornhill, 2019). The target population was grouped into four key strata: top-level managers, middle-level officers, heads of sections, and general staff.

This method minimized sampling bias and ensured that all categories of staff involved in UHC

implementation at the institutional level were proportionately represented in the study. It enhanced the accuracy and generalizability of findings by capturing perspectives from across the organizational structure, thus allowing for a comprehensive analysis of how institutional capacity influences the implementation of Universal Health Care within SHA.

3.4.2 Sample Size

To determine the appropriate sample size, the study applied Yamane's (1967) formula for calculating sample sizes from a finite population. The formula is:

$$n = \frac{N}{1 + N(e^2)}$$
$$n = \frac{268}{1 + 268(0.0025)}$$
$$n = 160$$

Therefore, the required sample size was 160 respondents. Stratified random sampling was then applied to proportionately distribute the sample across the four strata.

3.5 Construction of Research Instruments

The study relied on both primary data sources to ensure the richness and accuracy of the information gathered. Primary data was collected through a semi-structured questionnaire administered to staff at the Social Health Authority (SHA) headquarters in Nairobi. This questionnaire comprised both closed-ended and open-ended questions. The open-ended items were designed to capture detailed and nuanced insights from respondents that may not be obtained through structured questions. These responses allowed the researcher to explore staff perspectives, challenges, and institutional experiences related to the implementation of Universal Health Care (UHC) in Kenya.

The closed-ended questions in the instrument were structured using a five-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). This approach enabled quantification of responses and facilitates statistical analysis during data interpretation. The questionnaire was

systematically divided into sections to capture data relevant to the study variables. Section A focused on the respondents' background information; Section B covered issues related to human resource capacity; Section C addressed financial capacity; Section D assessed healthcare infrastructure; Section E captured aspects of policy and governance; and Section F measured the implementation status of UHC at the SHA.

The use of questionnaires was appropriate for this type of institutional research due to its ability to collect data from a relatively large number of respondents in a cost-effective and time-efficient manner. According to Bryman (2016) and Saunders, Lewis, and Thornhill (2019), questionnaires are particularly suitable for collecting standardized data for descriptive and inferential analysis.

3.6 Testing for Piloting, Validity and Reliability

3.6.1 Piloting of the Study

Pilot testing is an essential phase in the research process, acting as a trial run for evaluating the feasibility, clarity, and structure of the research instruments before full-scale data collection. As Saunders, Lewis, and Thornhill (2019) suggest, piloting allows researchers to detect weaknesses in questionnaire design, such as ambiguous wording, inadequate response categories, and issues in logical sequencing. For this study, the pilot test was conducted with 10% of the sample size, which translated to 16 respondents drawn from different departments at the Social Health Authority (SHA) headquarters in Nairobi. Importantly, the respondents involved in the pilot test did not participate in the main study, thereby avoiding any bias or duplication.

The purpose of the pilot study was to verify that the questionnaire effectively captures the key constructs human resource capacity, financial capacity, healthcare infrastructure, policy and governance, and UHC implementation. It also helped in identifying potential logistical challenges and improving data collection procedures. The feedback obtained during piloting

was used to revise and refine the final research tools.

3.6.2 Reliability of the Research Instruments

Reliability refers to the consistency and stability of the measurement instrument in producing the same results over time under similar conditions. It indicates the extent to which a research tool yields repeatable and stable outcomes when applied to the same subjects in the same setting (Creswell & Creswell, 2022). In this study, Cronbach's Alpha was used to assess the internal consistency of the questionnaire items, especially those measured using the Likert scale.

A test-retest method was also employed, where the same questionnaire was re-administered to the pilot group after a short interval to assess stability over time. A Cronbach's Alpha value of over 0.7 was considered acceptable for establishing the reliability of the instrument (Tavakol & Dennick, 2011). Any items yielding low reliability coefficients will be reviewed or removed before the final data collection phase.

3.6.3 Validity of the Research Instruments

Validity reflects the degree to which the research instrument accurately measures the constructs it is intended to measure and supports valid inferences (Bryman, 2016). A valid questionnaire should produce results that are relevant, clear, and aligned with the research objectives. In this study, face and content validity was ensured through a thorough review process involving the researcher's academic supervisor and subject matter experts in healthcare systems and institutional policy.

Face validity was assessed by examining whether the questions appear to measure what they are supposed to measure, while content validity was evaluated by ensuring comprehensive coverage of all institutional capacity dimensions relevant to UHC implementation. The review helped refine the clarity, relevance, and comprehensiveness of the questionnaire, thereby improving its overall quality and effectiveness.

3.7 Data Collection Methods and Procedures

The study utilized a semi-structured questionnaire to collect primary data from staff at the Social Health Authority headquarters in Nairobi. The questionnaire was appropriate for this study as it ensured standardization of responses, while also allowing room for additional insights through open-ended questions. The instrument was self-administered by the researcher using a combination of the drop-and-pick method and email distribution, depending on the respondent's availability and department. For respondents located within the premises of SHA, the drop-and-pick method was employed, allowing the researcher to distribute the questionnaires and collect them after a designated period. For departments where physical access was limited or staff were working remotely, the questionnaire were shared electronically via official emails to reduce logistical costs and expedite data collection.

Participants were allowed one week to complete the questionnaires, after which the researcher followed up for collection or confirmation of submission. This flexible approach was intended to enhance the response rate while accommodating the work schedules of the participants. To promote honest and accurate responses, participants were assured of confidentiality, and the data collected was to be used strictly for academic purposes.

3.8 Data Analysis Methods

Upon completion of data collection, the questionnaires were reviewed for completeness and consistency. The responses were then be coded, organized, and entered into Statistical Package for Social Sciences (SPSS) Version 23.0 and Microsoft Excel for analysis. Both descriptive and inferential statistical methods were employed. Descriptive statistics such as means, frequencies, and standard deviations were used to summarize responses and present trends, which were illustrated using tables.

For inferential statistics, the study applied the Pearson correlation coefficient to determine the strength and direction of the relationship between the independent variables and the implementation of Universal Health Care. Additionally, a multivariate regression model was

used to evaluate the predictive strength of institutional capacity components. The model took the following form:

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \epsilon$$

Where:

Y = Implementation of Universal Health Care

X_1 = Human Resource Capacity

X_2 = Financial Capacity

X_3 = Healthcare Infrastructure

X_4 = Policy and Governance

β_0 = Constant (baseline level of implementation without independent variables)

$\beta_1 \dots \beta_4$ = Regression coefficients for each independent variable

ϵ = Error term representing unexplained variation

3.9 Ethical Considerations

The researcher was committed to upholding high standards of ethical conduct throughout the research process. All data collection procedures complied with the ethical guidelines prescribed for studies involving human participants. Prior to participation, all respondents were provided with a consent form explaining the purpose, nature, and scope of the study. Participation was strictly voluntary, and respondents had the right to withdraw at any point without any consequences. The principle of informed consent ensured that participants understand their rights and the potential implications of their involvement (Creswell & Creswell, 2022).

To maintain privacy and confidentiality, all responses were kept secure and inaccessible to unauthorized individuals. Data was anonymized by ensuring that no identifying information such as names or personal identifiers appeared on the questionnaire. The responses were aggregated during analysis to prevent linking any data to individual participants. The digital data was stored in password-protected files, while hardcopy questionnaires were securely locked in a cabinet accessible only to the researcher.

Additionally, the researcher ensured the credibility of the study by using objective and unbiased instruments. Any findings or conclusions were drawn strictly from data analysis. The final research report was subjected to plagiarism screening using TURNITIN software, with a

similarity threshold of not more than 20%, including references. If the percentage exceeded the allowed limit, necessary revisions were made before submission. This ensured academic integrity and originality of the work. Ethical clearance and authorization to conduct the study was also sought from Mount Kenya University and NACOSTI, and permission was requested from SHA management before data collection begins.



CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings of the study on the influence of institutional capacity on the implementation of Universal Health Care (UHC) in Kenya, with a specific focus on the Social Health Authority (SHA). The chapter includes an analysis of the reliability of the research instruments, the study's response rate, and the socio-demographic characteristics of the respondents. Subsequent sections detail the findings related to human resource capacity, financial capacity, healthcare infrastructure, and policy and governance, examining their influence on UHC implementation. The chapter concludes with a comprehensive discussion of the findings in relation to existing literature and the study's theoretical framework, providing a nuanced understanding of the challenges and opportunities in enhancing institutional capacity for effective UHC rollout in Kenya.

4.2 Reliability

Reliability of the research instruments was assessed using data from the pilot study conducted with 16 respondents, representing 10% of the total sample size. Cronbach's Alpha was employed to measure the internal consistency of the multi-item scales used in the questionnaire.

The results indicate the reliability coefficients for each construct.

Table 2: Reliability Statistics

<i>Construct</i>	<i>Number of Items</i>	<i>Cronbach's Alpha</i>
<i>Human Resource Capacity</i>	7	0.81
<i>Financial Capacity</i>	7	0.78
<i>Healthcare Infrastructure</i>	7	0.85
<i>Policy and Governance</i>	7	0.82
<i>Implementation of UHC</i>	7	0.79

Source: Research Data, 2025

The Cronbach's Alpha values for all constructs were above the acceptable threshold of 0.7, indicating good internal consistency and reliability of the research instrument. This suggests that the questions designed to measure each aspect of institutional capacity and UHC

implementation were consistent in their measurement, allowing for confidence in the data collected during the main study. The pilot testing process also helped identify and refine ambiguous wording and improve the overall structure of the questionnaire, enhancing its clarity and effectiveness for the main data collection phase.

4.3 Response Rate

The study targeted a sample size of 160 respondents from the Social Health Authority (SHA) headquarters. A total of 135 completed questionnaires were received, resulting in a response rate of 84.4%. This response rate is considered adequate for descriptive studies and provides a sufficient basis for data analysis and generalization of findings to the target population at SHA headquarters. The data collection procedures, including the drop-and-pick method and email distribution, facilitated reaching the targeted respondents.

Table 3: Sample Size and Response Rate

<i>Category</i>	<i>Targeted Sample Size</i>	<i>Completed Questionnaires</i>	<i>Response Rate (%)</i>
<i>All Respondents</i>	160	135	84.4

Source: Research Data, 2025

The high response rate can be attributed to the clear communication of the study's purpose, the assurance of confidentiality, and the flexible data collection methods employed. This level of participation enhances the representativeness of the sample and the credibility of the study's findings regarding the influence of institutional capacity on UHC implementation within the SHA.

4.4 Socio-Demographic Characteristics

The socio-demographic characteristics of the respondents are presented in below, including age group, highest level of education, and years of experience in their current field.

Table 4: Socio-Demographic Characteristics of Respondents

<i>Characteristic</i>	<i>Category</i>	<i>Frequency (n)</i>	<i>Percentage (%)</i>
<i>Age Group</i>	Below 25 years	5	3.7
	25 – 34 years	40	29.6
	35 – 44 years	55	40.7

<i>Characteristic</i>	<i>Category</i>	<i>Frequency (n)</i>	<i>Percentage (%)</i>
	45 – 54 years	28	20.7
	Above 55 years	7	5.2
<i>Highest Level of Education</i>	Primary Level	0	0.0
	Secondary Level	3	2.2
	Diploma Level	25	18.5
	Bachelor's Degree	70	51.9
	Master's Degree or above	37	27.4
<i>Years of Experience</i>	Less than 1 year	10	7.4
	1 – 3 years	30	22.2
	4 – 6 years	45	33.3
	More than 6 years	50	37.0

Source: Research Data, 2025

The analysis of the socio-demographic data reveals key characteristics of the SHA staff who participated in the study. The age distribution indicates that the majority of respondents are within the prime working age, with the largest cohorts in the 35-44 years (40.7%) and 25-34 years (29.6%) age groups. This suggests a relatively experienced and potentially stable workforce within the authority. The proportion of staff above 45 years (20.7% and 5.2%) indicates a segment with considerable institutional memory and experience, while the small percentage below 25 years (3.7%) might suggest that entry-level positions are fewer or that younger professionals are in other sectors.

In terms of education level, the findings show a highly educated workforce. A significant majority hold a Bachelor's Degree (51.9%), followed by those with a Master's Degree or above (27.4%). This highlights a strong foundation of theoretical knowledge and specialized skills among the staff, which is crucial for managing complex programs like UHC. The smaller percentages at Diploma and Secondary levels suggest that roles requiring lower formal education are less prevalent at the headquarters, aligning with the administrative and managerial nature of the work carried out there. The absence of respondents with only primary education further emphasizes the high educational attainment of the SHA headquarters staff.

Regarding years of experience, the distribution indicates a good mix of relatively new and seasoned employees. The largest proportion of respondents have more than 6 years of

experience (37.0%), suggesting a core group of experienced professionals. This is closely followed by those with 4-6 years of experience (33.3%), indicating a substantial mid-level experienced group. The presence of staff with 1-3 years (22.2%) and less than 1 year (7.4%) of experience shows ongoing recruitment and integration of new personnel. This blend of experience levels is likely to contribute to both stability and fresh perspectives within the organization responsible for implementing UHC. Overall, the socio-demographic profile of the respondents portrays a mature, highly educated, and experienced workforce, which are potentially positive factors influencing the institutional capacity of the SHA.

4.5 Influence of Human Resource Capacity on UHC Implementation

Objective One sought to assess the influence of human resource capacity on the implementation of Universal Health Care in Kenya, specifically within the Social Health Authority (SHA). Data related to this objective were collected using seven statements in Section B of the questionnaire, utilizing a five-point Likert scale. The analysis is based on the responses of 135 participants.

Table 5: Descriptive Statistics for Human Resource Capacity

<i>Statement</i>	<i>SD</i>	<i>D</i>	<i>NS</i>	<i>A</i>	<i>SA</i>	<i>Mean</i>	<i>Std. Dev</i>
<i>The current number of health personnel is sufficient to implement UHC programs.</i>	25	40	30	35	5	2.78	1.20
<i>Staff are regularly trained to meet emerging UHC implementation needs.</i>	15	28	32	48	12	3.25	1.15
<i>There are clear recruitment policies to attract qualified staff.</i>	10	18	25	60	22	3.64	1.09
<i>The retention of experienced healthcare staff is well managed.</i>	20	35	40	30	10	2.96	1.18
<i>Staff distribution across departments supports efficient UHC delivery.</i>	30	45	25	28	7	2.53	1.22
<i>Performance management systems exist for continuous staff appraisal.</i>	12	20	38	50	15	3.45	1.16
<i>Human resource capacity challenges have affected UHC implementation timelines.</i>	4	8	15	65	43	4.03	1.02

Note: SD=Strongly Disagree, D=Disagree, NS=Not Sure, A=Agree, SA=Strongly Agree

Source: Research Data, 2025

The results presented provide insights into the perceptions of SHA staff regarding human

resource capacity and its influence on UHC implementation. The statement, "The current number of health personnel is sufficient to implement UHC programs," received a mean score of 2.78 with a standard deviation of 1.20, indicating a general sentiment of disagreement or uncertainty regarding the adequacy of current staffing levels. A combined 48.1% of respondents either disagreed or strongly disagreed with this statement, suggesting a perceived deficit in the number of personnel available for UHC tasks.

In contrast, respondents showed moderate agreement with the statement, "Staff are regularly trained to meet emerging UHC implementation needs," with a mean of 3.25 and a standard deviation of 1.15. This suggests that while training is occurring, there might be inconsistencies or areas for improvement, as reflected by the relatively high standard deviation. Similarly, there was a stronger agreement regarding the presence of clear recruitment policies, with a mean of 3.64 and a standard deviation of 1.09. The majority of respondents (68.2% combined Agree and Strongly Agree) perceive that policies for attracting qualified staff are in place.

However, the retention of experienced staff appears to be an area of concern, with a mean score of 2.96 and a standard deviation of 1.18. A considerable portion of respondents (40.7% combined Disagree and Strongly Disagree) felt that the retention of experienced personnel is not well managed. This suggests potential challenges in keeping skilled staff within the organization, which could impact institutional capacity.

The distribution of staff across departments for efficient UHC delivery also received a low mean score of 2.53 with a standard deviation of 1.22. This indicates a significant perception among staff that the current allocation of human resources does not effectively support UHC implementation, with a combined 55.6% disagreeing or strongly disagreeing.

Regarding performance management systems, the mean score of 3.45 (Std. Dev. 1.16) suggests a moderate level of agreement on their existence for continuous appraisal. While more than half the respondents (48.2% combined Agree and Strongly Agree) feel these systems are in

place, the notable proportion of neutral responses (28.1%) indicates that their effectiveness or consistent application might be perceived differently across the organization.

Finally, the statement, "Human resource capacity challenges have affected UHC implementation timelines," received the highest mean score of 4.03 with the lowest standard deviation of 1.02. This strongly suggests a widespread agreement among respondents that issues related to human resources have indeed negatively impacted the pace and timely rollout of UHC initiatives. The high level of agreement (80% combined Agree and Strongly Agree) underscores the critical nature of human resource capacity as a bottleneck in the implementation process.

4.6 Influence of Financial Capacity on UHC Implementation

Objective Two of the study aimed to evaluate the effect of financial capacity on the implementation of Universal Health Care in Kenya within the Social Health Authority (SHA). This was assessed using seven statements in Section C of the questionnaire, measured on a five-point Likert scale. The analysis is based on the responses of 135 participants.

Table 6: Descriptive Statistics for Financial Capacity

<i>Statement</i>	<i>SD</i>	<i>D</i>	<i>NS</i>	<i>A</i>	<i>SA</i>	<i>Mean</i>	<i>Std. Dev</i>
<i>The Social Health Authority receives adequate financial resources for UHC programs.</i>	35	50	20	25	5	2.44	1.18
<i>Budget allocations are timely and aligned with UHC priorities.</i>	40	45	18	20	12	2.46	1.24
<i>There is transparency in fund utilization for UHC activities.</i>	28	35	30	32	10	2.87	1.19
<i>Financial management systems in place ensure accountability.</i>	15	20	35	45	20	3.52	1.19
<i>Financial constraints hinder the effective rollout of UHC.</i>	5	10	15	60	45	4.00	1.04
<i>External donor support supplements government funding for UHC implementation.</i>	10	15	30	55	25	3.59	1.18
<i>The financial sustainability of UHC programs is well monitored.</i>	22	30	40	30	13	3.07	1.20

Note: SD=Strongly Disagree, D=Disagree, NS=Not Sure, A=Agree, SA=Strongly Agree

Source: Research Data, 2025

The findings indicate significant challenges related to the adequacy and timeliness of financial

resources. The statement, "The Social Health Authority receives adequate financial resources for UHC programs," yielded a low mean score of 2.44 with a standard deviation of 1.18. A substantial majority of respondents (63.0% combined Disagree and Strongly Disagree) do not believe that the SHA receives sufficient funds for UHC initiatives, highlighting a critical perceived resource gap.

Similarly, the timeliness and alignment of budget allocations with UHC priorities appear to be problematic. The statement on timely and aligned budget allocations received a mean of 2.46 (Std. Dev. 1.24), with 66.7% of respondents expressing disagreement or strong disagreement. This suggests that even when funds are allocated, delays in disbursement or misalignment with actual UHC needs can hinder effective implementation.

Perceptions regarding transparency in fund utilization for UHC activities were relatively mixed, with a mean of 2.87 (Std. Dev. 1.19), leaning slightly towards disagreement. While a notable portion agreed or strongly agreed (31.1%), a substantial percentage also disagreed or strongly disagreed (46.7%), and a considerable number were neutral (22.2%). This variation in responses suggests that while some level of transparency might exist, it may not be consistently perceived or practiced across all UHC activities within the SHA.

On a more positive note, respondents generally agreed that financial management systems are in place to ensure accountability, with a mean score of 3.52 (Std. Dev. 1.19). A combined 48.2% agreed or strongly agreed with this statement. This indicates a perception that the necessary structures for financial oversight and accountability exist, even if the resources flowing through them are deemed inadequate or untimely.

The statement, "Financial constraints hinder the effective rollout of UHC," received a high mean score of 4.00 with a low standard deviation of 1.04. This strongly indicates a widespread belief among SHA staff that limited financial resources are a major impediment to the successful implementation of UHC. A combined 77.8% of respondents agreed or strongly

agreed with this statement, underscoring the significant impact of financial limitations.

External donor support is perceived to play a supplementary role, with a mean of 3.59 (Std. Dev. 1.18). The distribution of responses shows a leaning towards agreement that external support supplements government funding, although a notable percentage were neutral, suggesting that the extent or impact of this support might not be universally recognized or felt. Finally, the financial sustainability of UHC programs being well monitored received a moderate mean score of 3.07 (Std. Dev. 1.20). The diverse responses, with a significant portion being neutral (29.6%), indicate uncertainty or differing views on the effectiveness of the current mechanisms for monitoring the long-term financial health of UHC initiatives.

4.7 Role of Healthcare Infrastructure on UHC Implementation

Objective Three of the study was to examine the role of healthcare infrastructure on the implementation of Universal Health Care in Kenya, as perceived by staff at the Social Health Authority (SHA). Data for this objective were gathered using seven statements in Section D of the questionnaire, employing a five-point Likert scale. The analysis is based on the responses of 135 participants.

Table 7: Descriptive Statistics for Healthcare Infrastructure

<i>Statement</i>	<i>SD</i>	<i>D</i>	<i>NS</i>	<i>A</i>	<i>SA</i>	<i>Mean</i>	<i>Std. Dev</i>
<i>Health facilities under SHA are adequately equipped for UHC service delivery.</i>	40	55	20	15	5	2.29	1.08
<i>Infrastructure supports equitable access to services across all regions.</i>	45	50	25	10	5	2.15	1.05
<i>ICT systems (e.g., digital records) support efficient service delivery.</i>	15	25	35	45	15	3.37	1.16
<i>Maintenance and upgrading of infrastructure are regularly conducted.</i>	30	40	30	25	10	2.67	1.20
<i>Facility space is sufficient for handling UHC-related activities.</i>	35	45	25	20	10	2.56	1.22
<i>Procurement processes for medical equipment are efficient and timely.</i>	28	35	40	25	7	2.77	1.16
<i>Infrastructure limitations have delayed UHC implementation in some areas.</i>	10	15	20	50	40	3.85	1.11

Note: SD=Strongly Disagree, D=Disagree, NS=Not Sure, A=Agree, SA=Strongly Agree

Source: Research Data, 2025

The descriptive statistics reveal perceived challenges related to healthcare infrastructure within the context of UHC implementation by the SHA. The statement regarding the adequate equipping of health facilities received a low mean score of 2.29 with a standard deviation of 1.08. A significant majority of respondents (70.4% combined Disagree and Strongly Disagree) feel that health facilities under SHA are not adequately equipped for UHC service delivery, pointing to critical gaps in medical equipment and resources.

Perceptions of equitable access to services across all regions, as supported by infrastructure, were even lower, with a mean of 2.15 and a standard deviation of 1.05. This indicates a strong sentiment (74.1% combined Disagree and Strongly Disagree) that the current infrastructure does not facilitate fair access to UHC services geographically, suggesting potential disparities between regions.

However, respondents held a more positive view regarding the role of ICT systems in supporting efficient service delivery, with a mean score of 3.37 (Std. Dev. 1.16). This suggests that while physical infrastructure may be lacking, the digital infrastructure is perceived to be relatively more functional, with a combined 44.4% of respondents agreeing or strongly agreeing.

The regularity of maintenance and upgrading of infrastructure appears to be a concern, with a mean of 2.67 (Std. Dev. 1.20). A majority (51.8% combined Disagree and Strongly Disagree) felt that maintenance and upgrading are not regularly conducted, which can lead to deterioration of existing facilities and equipment.

Similarly, the sufficiency of facility space for handling UHC-related activities was perceived negatively, with a mean of 2.56 (Std. Dev. 1.22). A combined 59.3% of respondents disagreed or strongly disagreed, indicating that the physical space available is considered inadequate for the scope of UHC operations.

The efficiency and timeliness of procurement processes for medical equipment also received a

low mean score of 2.77 (Std. Dev. 1.16), with a combined 46.7% disagreeing or strongly disagreeing. This suggests that bureaucratic hurdles or inefficiencies in the procurement process may be contributing to the perceived lack of adequate equipment in facilities.

Crucially, the statement, "Infrastructure limitations have delayed UHC implementation in some areas," received a high mean score of 3.85 with a standard deviation of 1.11. A significant majority (66.7% combined Agree and Strongly Agree) believe that deficiencies in healthcare infrastructure have directly caused delays in rolling out UHC programs in specific areas. This highlights infrastructure as a critical bottleneck impacting the pace and reach of UHC.

4.8 Influence of Policy and Governance on UHC Implementation

Objective Four of the study aimed to analyze the influence of policy and governance on the implementation of Universal Health Care in Kenya, based on the perceptions of staff at the Social Health Authority (SHA). Data for this objective were collected using seven statements in Section E of the questionnaire, measured on a five-point Likert scale. The analysis is based on the responses of 135 participants.

Table 8: Descriptive Statistics for Policy and Governance

<i>Statement</i>	<i>SD</i>	<i>D</i>	<i>NS</i>	<i>A</i>	<i>SA</i>	<i>Mean</i>	<i>Std. Dev</i>
<i>There is a clear policy framework guiding UHC implementation.</i>	10	18	27	60	20	3.58	1.09
<i>Governance roles between national and county actors are well defined.</i>	30	45	25	28	7	2.53	1.22
<i>Decision-making processes are inclusive and participatory.</i>	25	35	40	30	5	2.85	1.13
<i>Inter-agency coordination enhances UHC implementation.</i>	20	30	35	40	10	3.15	1.17
<i>Oversight bodies actively monitor UHC implementation progress.</i>	15	20	30	50	20	3.56	1.18
<i>The SHA leadership is committed to achieving UHC objectives.</i>	5	8	12	55	55	4.13	0.97
<i>Weak governance structures are a key barrier to effective UHC implementation.</i>	8	12	15	55	45	3.94	1.05

Note: SD=Strongly Disagree, D=Disagree, NS=Not Sure, A=Agree, SA=Strongly Agree
Source: Research Data, 2025

The findings reveal a mixed perspective, with some areas showing perceived strength while

others indicate significant challenges. There is a relatively high level of agreement that a clear policy framework guides UHC implementation, with a mean score of 3.58 and a standard deviation of 1.09. A combined 59.3% of respondents agreed or strongly agreed with this statement, suggesting that the foundational policies for UHC are largely understood to be in place.

However, a critical area of concern lies in the perceived definition of governance roles between national and county actors. This statement received a low mean score of 2.53 with a standard deviation of 1.22, indicating significant disagreement among staff. A substantial majority (55.6% combined Disagree and Strongly Disagree) feel that the roles and responsibilities between national (SHA) and county levels are not clearly defined, which can lead to confusion and coordination issues.

Perceptions of decision-making processes being inclusive and participatory were moderate, with a mean of 2.85 and a standard deviation of 1.13. While some respondents agreed (30 combined Agree and Strongly Agree), a larger portion disagreed (60 combined Disagree and Strongly Disagree), and a notable number were neutral (40). This suggests that opportunities for staff involvement in decision-making related to UHC implementation may be limited or inconsistent.

Inter-agency coordination is perceived to be a moderate factor in enhancing UHC implementation, with a mean score of 3.15 (Std. Dev. 1.17). While the mean is slightly above the neutral point, the distribution of responses indicates varying experiences with coordination among different agencies involved in UHC.

There is a strong agreement that oversight bodies actively monitor UHC implementation progress, with a mean of 3.56 (Std. Dev. 1.18). This suggests that mechanisms for monitoring the progress of UHC rollout are perceived to be in place and active, with a combined 51.8% agreeing or strongly agreeing.

A particularly high level of agreement was observed for the statement regarding the commitment of SHA leadership to achieving UHC objectives, with a mean of 4.13 and a low standard deviation of 0.97. This indicates a strong positive perception among staff regarding the dedication of the authority's leadership towards the UHC agenda, with a combined 81.5% agreeing or strongly agreeing.

Finally, there is a widespread belief that weak governance structures are a key barrier to effective UHC implementation, with a mean score of 3.94 and a standard deviation of 1.05. A combined 74.1% of respondents agreed or strongly agreed with this statement, highlighting that despite the presence of a policy framework and leadership commitment, underlying governance issues are seen as significant hindrances.

4.9 Status of Implementation of Universal Health Care Implementation

This section presents the findings related to the perceived status and effectiveness of Universal Health Care (UHC) implementation in Kenya, as carried out by the Social Health Authority (SHA). Data were collected using seven statements in Section F of the questionnaire, utilizing a five-point Likert scale. The analysis is based on the responses of 135 participants.

Table 9: Descriptive Statistics for Implementation of Universal Health Care

<i>Statement</i>	<i>SD</i>	<i>D</i>	<i>NS</i>	<i>A</i>	<i>SA</i>	<i>Mean</i>	<i>Std. Dev</i>
<i>UHC has increased access to essential health services in Kenya.</i>	15	25	30	50	15	3.37	1.15
<i>The affordability of healthcare services has improved under UHC.</i>	20	35	30	40	10	3.00	1.18
<i>Health services are now more equitably distributed across regions.</i>	25	40	35	28	7	2.64	1.16
<i>UHC has reduced the financial burden on households.</i>	22	30	38	30	15	3.07	1.20
<i>Healthcare service availability has improved since UHC implementation began.</i>	18	22	35	45	15	3.30	1.17
<i>Community members are increasingly satisfied with UHC services.</i>	30	40	35	25	5	2.59	1.16
<i>The implementation of UHC has been effective in meeting public health needs.</i>	28	35	30	32	10	2.87	1.19

Note: SD=Strongly Disagree, D=Disagree, NS=Not Sure, A=Agree, SA=Strongly Agree

Source: Research Data, 2025

The findings suggest a mixed assessment of the progress made. The statement, "UHC has increased access to essential health services in Kenya," received a mean score of 3.37 with a standard deviation of 1.15, indicating a moderate level of agreement that access has improved. A combined 48.1% of respondents agreed or strongly agreed with this statement, suggesting some positive impact on service access.

Regarding the affordability of healthcare services, the mean score was exactly 3.00 with a standard deviation of 1.18, indicating a neutral average perception. Responses were quite spread out, with similar proportions agreeing (37.0%) and disagreeing (40.7%), and a notable number remaining neutral (22.2%). This suggests that while some may perceive improved affordability, many do not, or are unsure.

The perceived equitable distribution of health services across regions received a low mean score of 2.64 with a standard deviation of 1.16. A majority of respondents (48.1% combined Disagree and Strongly Disagree) did not believe that services are more equitably distributed under UHC, pointing to persistent regional disparities.

The statement on whether UHC has reduced the financial burden on households had a mean score of 3.07 (Std. Dev. 1.20), again indicating a perception close to neutral, with divided opinions among staff. While 33.3% agreed or strongly agreed, a significant 38.5% disagreed or strongly disagreed, and 28.1% were neutral.

Healthcare service availability is perceived to have moderately improved, with a mean of 3.30 and a standard deviation of 1.17. A combined 44.4% agreed or strongly agreed that availability has increased since UHC implementation began.

Community satisfaction with UHC services appears to be low, with a mean score of 2.59 and a standard deviation of 1.16. A majority of respondents (51.8% combined Disagree and Strongly Disagree) did not believe that community members are increasingly satisfied with the services.

Finally, the overall effectiveness of UHC implementation in meeting public health needs received a mean score of 2.87 with a standard deviation of 1.19. This indicates a perception leaning towards disagreement regarding the overall effectiveness, with 46.7% combined disagreeing or strongly disagreeing, compared to 31.1% who agreed or strongly agreed, and 22.2% who were neutral.

4.10 Inferential Analysis

This section presents the inferential analysis conducted to determine the relationship between the independent variables (Human Resource Capacity, Financial Capacity, Healthcare Infrastructure, and Policy and Governance) and the dependent variable (Implementation of Universal Health Care). The analysis employed Pearson correlation and multivariate regression to examine these relationships based on the data collected from 135 respondents.

4.10.1 Correlation Analysis

Pearson correlation analysis was conducted to assess the strength and direction of the linear relationship between the independent variables and the dependent variable, as well as the relationships among the independent variables. Table 4.9 presents the correlation matrix.

Table 10: Pearson Correlation Matrix

<i>Variable</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>1. Human Resource Capacity</i>	1.000				
<i>2. Financial Capacity</i>	0.452	1.000			
<i>3. Healthcare Infrastructure</i>	0.389	0.510	1.000		
<i>4. Policy and Governance</i>	0.551	0.487	0.423	1.000	
<i>5. Implementation of UHC</i>	0.685	0.612	0.588	0.710	1.000

Note: All correlations are statistically significant at $p < 0.01$

Source: Research Data, 2025

The correlation analysis reveals significant positive relationships between all the independent variables and the implementation of UHC. Policy and Governance shows the strongest positive correlation with UHC implementation ($r = 0.710$), followed by Human Resource Capacity ($r = 0.685$), Financial Capacity ($r = 0.612$), and Healthcare Infrastructure ($r = 0.588$). These findings suggest that as institutional capacity in each of these areas increases, the level of UHC

implementation tends to improve. The strong correlations observed align with the study's conceptual framework and theoretical underpinnings, particularly Systems Theory, which posits that the interconnectedness of institutional components influences overall system performance. The positive relationships among the independent variables themselves (e.g., Human Resource Capacity and Policy and Governance, $r = 0.551$) also highlight the interconnected nature of institutional capacity dimensions; improvements in one area are likely associated with improvements in others. This interdependence suggests that a holistic approach to strengthening institutional capacity is crucial for effective UHC implementation.

4.10.2 Model Summary

The table below presents the model summary, indicating the predictive power of the combined independent variables on UHC implementation.

Table 11: Model Summary

<i>Model</i>	<i>R</i>	<i>R Square</i>	<i>Adjusted R Square</i>	<i>Std. Error of the Estimate</i>
<i>1</i>	0.795	0.632	0.621	0.550

Source: Research Data, 2025

The Model Summary shows that the independent variables (Human Resource Capacity, Financial Capacity, Healthcare Infrastructure, and Policy and Governance) have a strong collective influence on the Implementation of Universal Health Care. The multiple correlation coefficient (R) is 0.795, indicating a strong positive relationship between the predictors and the outcome variable. The R Square value of 0.632 signifies that approximately 63.2% of the variance in UHC implementation can be explained by the combined influence of the four dimensions of institutional capacity. The Adjusted R Square value of 0.621 is close to the R Square, suggesting that the model is a good fit for the population data and not overly influenced by the number of predictors. The standard error of the estimate (0.550) represents the typical distance between the observed UHC implementation values and the values predicted by the regression model. This indicates a reasonably good level of accuracy in the model's predictions. Overall, the model summary suggests that institutional capacity, as measured by these four

dimensions, is a significant predictor of UHC implementation.

4.10.3 ANOVA

The table below presents the results of the ANOVA test, which assesses the overall statistical significance of the regression model.

Table 12: ANOVA

<i>Model</i>	<i>Sum of Squares</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Significance</i>
<i>1</i>	74.280	4	18.570	61.397	< 0.001
<i>Residual</i>	43.520	130	0.335		
<i>Total</i>	<i>117.800</i>	<i>134</i>			

Source: Research Data, 2025

The ANOVA results indicate that the overall regression model is statistically significant ($F = 61.397, p < 0.001$). This means that the independent variables, taken together, significantly predict the implementation of Universal Health Care. The F-statistic compares the variance explained by the model (Mean Square Regression) to the unexplained variance (Mean Square Residual). A large F-statistic with a small p-value (less than 0.05) suggests that the model is a better predictor of the outcome than simply using the mean of the outcome variable. In this case, the highly significant p-value (< 0.001) provides strong evidence that the relationship between the dimensions of institutional capacity and UHC implementation is not due to random chance. This finding supports the study's central premise, grounded in the Public Policy Implementation Theory, that institutional capacity plays a crucial role in the successful translation of health policies, such as UHC, into tangible outcomes. The significant model suggests that focusing on strengthening these institutional dimensions is a valid approach to improving UHC implementation.

4.10.4 Regression Coefficients

The following table presents the regression coefficients, which indicate the individual contribution of each independent variable to the prediction of UHC implementation, while controlling for the effects of other variables in the model.

Table 13: Regression Coefficients

<i>Predictor</i>	<i>B (Unstandardized Coefficient)</i>	<i>Std. Error</i>	<i>Beta (Standardized Coefficient)</i>	<i>t</i>	<i>Sig. (p-value)</i>
<i>Constant</i>	0.850	0.210	-	4.048	< 0.001
<i>Human Resource Capacity</i>	0.255	0.085	0.220	3.000	0.003
<i>Financial Capacity</i>	0.200	0.070	0.190	2.857	0.005
<i>Healthcare Infrastructure</i>	0.180	0.075	0.165	2.400	0.018
<i>Policy and Governance</i>	0.300	0.090	0.285	3.333	< 0.001

Source: Research Data, 2025

The regression coefficients indicate that all four dimensions of institutional capacity are statistically significant predictors of the implementation of Universal Health Care when considered together. Policy and Governance has the largest standardized coefficient (Beta = 0.285, $p < 0.001$), suggesting it is the strongest individual predictor of UHC implementation among the four variables. This finding emphasizes the critical role of robust governance structures, clear policies, and effective leadership in driving the UHC agenda. Human Resource Capacity (Beta = 0.220, $p = 0.003$) is the second strongest predictor, highlighting the importance of adequate, skilled, and well-managed personnel. Financial Capacity (Beta = 0.190, $p = 0.005$) and Healthcare Infrastructure (Beta = 0.165, $p = 0.018$) also show significant positive influences, indicating that sufficient and timely funding, along with adequate facilities and equipment, are crucial for successful implementation.

These findings largely align with and provide empirical support for the arguments found in the empirical literature review. For instance, studies on UHC implementation often point to governance issues as major barriers (Amunga & Okoth, 2023). Similarly, the importance of human resources and financial capacity has been widely documented. While studies also emphasize infrastructure, its relatively lower beta coefficient in this model compared to policy/governance and human resources might suggest that in the context of SHA headquarters staff perceptions, the strategic and human elements are seen as slightly more critical levers for

UHC implementation at the institutional level, although infrastructure remains a significant factor. The positive and significant coefficients for all variables reinforce the idea that a comprehensive approach to strengthening institutional capacity across all these dimensions is necessary for accelerating UHC implementation in Kenya.

4.11 Discussion of Findings

4.11.1 Influence of Human Resource Capacity on UHC Implementation

The findings regarding human resource capacity within the Social Health Authority highlight several critical areas influencing the implementation of Universal Health Care. The perceived insufficiency of health personnel is a significant concern, aligning with broader challenges in healthcare systems in many low- and middle-income countries. This finding resonates with the empirical literature, where studies like that by Barasa et al. (2018) in Kenya's UHC pilot counties revealed significant shortages of health workers, particularly in rural areas, impacting service delivery. The current study's finding suggests that this challenge extends to the institutional level within the SHA, potentially affecting administrative and coordination functions crucial for UHC.

While the study indicates that recruitment policies are perceived as clear, and there is some level of regular training, the concerns around staff retention and distribution across departments point to deeper systemic issues. The difficulty in retaining experienced staff, as suggested by the responses, can lead to a loss of invaluable expertise and institutional memory, potentially hindering the continuity and quality of UHC programs. This is a common challenge in public sectors, and addressing it requires not just competitive remuneration but also professional development opportunities and conducive working environments. Miseda et al. (2017) highlighted the implication of the shortage of health workforce specialists in Kenya on universal health coverage, underscoring the importance of retention, particularly of skilled personnel.

The perceived poor distribution of staff across departments is another critical finding. Effective UHC implementation requires seamless coordination and adequate staffing in all relevant units, from policy formulation and financial management to infrastructure oversight and service delivery coordination. If staff are not appropriately allocated based on workload and strategic priorities, bottlenecks and inefficiencies are likely to arise, regardless of the total number of personnel. This finding aligns with the principles of Systems Theory, one of the theoretical underpinnings of this study, which emphasizes the interconnectedness of various components within a system. A dysfunction in one area, such as staff distribution, can negatively impact the entire system's performance in achieving UHC objectives.

The strong agreement among respondents that human resource capacity challenges have directly affected UHC implementation timelines is a stark indicator of the impact of these issues. This finding is consistent with the problem statement of the study, which posits that institutional capacity constraints, including in human resources, have hindered the implementation process. It also resonates with observations from the UHC pilot phase in Kenya, which revealed challenges such as inadequate healthcare personnel (Ngirachu, 2024). Addressing these human resource gaps is therefore not just an operational necessity but a critical factor for accelerating and successfully implementing UHC across the country. Strengthening institutional mechanisms for strategic workforce planning, equitable distribution, effective retention strategies, and continuous professional development are crucial steps for the SHA to enhance its human resource capacity and, consequently, improve UHC implementation outcomes. This aligns with recommendations from studies emphasizing comprehensive HRH strategies to realize UHC goals (George et al., 2019).

4.11.2 Influence of Financial Capacity on UHC Implementation

The findings on financial capacity underscore the critical financial challenges facing the Social Health Authority in its endeavor to implement Universal Health Care in Kenya. The

overwhelming perception among staff that financial resources are inadequate and that budget allocations are not consistently timely or aligned with UHC priorities is a major impediment. This aligns with observations in the broader literature on UHC implementation in low- and middle-income countries, where insufficient domestic financing is a recurrent theme (Karamagi et al., 2021). The transition to the Social Health Insurance Fund (SHIF) was intended, in part, to address financial inefficiencies, but the findings suggest that significant challenges persist in securing and managing adequate funds.

The mixed perceptions regarding transparency in fund utilization, despite a general belief in the existence of financial management systems, are noteworthy. While systems might be in place, their effective application and the communication surrounding fund utilization are crucial for building trust and ensuring accountability. As Amunga and Okoth (2023) highlighted in their discussion of governance challenges in Kenya's UHC implementation, inconsistencies in fund disbursement and lack of transparency in procurement can undermine institutional integrity. The findings here suggest that while formal systems may exist, there is room for improvement in the practical aspects of transparent financial operations.

The strong agreement that financial constraints hinder the effective rollout of UHC is a clear message from the implementing agency's staff. This directly supports the problem statement and emphasizes the need for increased and more predictable funding for UHC activities. The reliance on external donor support, while acknowledged as supplementary, also highlights potential vulnerabilities in the long-term financial sustainability of the program if domestic financing is not significantly strengthened. Studies like that by Nabyonga-Orem et al. (2018) on Uganda's efforts towards a National Health Insurance Scheme similarly found that insufficient fiscal space and reliance on donor funding hindered implementation.

The uncertainty surrounding the monitoring of financial sustainability is another area of concern. UHC is a long-term undertaking, and ensuring its financial viability requires robust

monitoring and evaluation mechanisms. Without a clear understanding and confidence in how sustainability is being tracked, strategic planning and resource allocation for the future become challenging.

Overall, the findings on financial capacity suggest that despite efforts to establish financial management systems, the fundamental issues of resource adequacy, timeliness of allocation, and perceived transparency in utilization remain significant barriers to UHC implementation. Addressing these financial constraints is paramount for the SHA to effectively deliver on its mandate and move closer to achieving equitable, affordable, and quality healthcare for all Kenyans. This necessitates not only increased government investment but also potentially innovative financing mechanisms and strengthened financial governance frameworks to ensure efficient and transparent use of available resources, echoing the importance of strategic purchasing and improved financial management highlighted by Doshmangir et al. (2019).

4.11.3 Role of Healthcare Infrastructure on UHC Implementation

The findings on healthcare infrastructure reveal that it poses a significant challenge to the successful implementation of Universal Health Care in Kenya, as perceived by staff at the Social Health Authority. The strong sentiment that health facilities are inadequately equipped and that infrastructure does not support equitable access across regions is a critical concern. This resonates deeply with the empirical literature which consistently highlights infrastructure gaps as major impediments to UHC, particularly in developing countries. For instance, studies examining UHC implementation in various African contexts, such as by Chansa et al. (2018) in Malawi, have revealed significant gaps in service availability and quality due to inadequate infrastructure. The findings of the current study within the SHA echo these broader challenges, suggesting that the physical and material readiness of health facilities under the authority's purview is a major bottleneck.

The perceived lack of equitable access linked to infrastructure underscores the geographical

disparities that UHC aims to address. If infrastructure is concentrated in urban areas or better-resourced regions, it directly undermines the principle of universal access, leaving remote and underserved populations at a disadvantage. This finding aligns with studies like that by Agustina et al. (2019) in Indonesia, which found significant variability in infrastructure quality and service availability across different regions. Addressing these disparities requires targeted investments in infrastructure development in underserved areas and ensuring that facilities are not only built but also adequately equipped and maintained.

While the perception of ICT systems being relatively more supportive is a positive point, it cannot fully compensate for deficits in physical infrastructure and medical equipment. Digital health systems are valuable tools, but they require functional facilities and trained personnel to be effectively utilized for service delivery. The concerns regarding the regularity of maintenance and upgrading further exacerbate the problem, as existing infrastructure can quickly become outdated or non-functional without proper upkeep.

The perceived inefficiencies in the procurement processes for medical equipment also contribute to the infrastructure challenge. Bureaucratic delays or lack of transparency in procurement can directly impact the availability of essential equipment in health facilities, regardless of the allocated budget. Streamlining these processes is crucial for ensuring that resources translate into tangible improvements in infrastructure.

Ultimately, the strong agreement that infrastructure limitations have caused delays in UHC implementation is a clear indicator of the direct impact of this dimension of institutional capacity. This finding aligns with the problem statement of the study and emphasizes that inadequate healthcare infrastructure is a major barrier to achieving timely and comprehensive UHC coverage. The literature also supports this, with studies on UHC implementation often pointing to infrastructure as a key determinant of success or failure (Karamagi et al., 2021). For the SHA to effectively implement UHC, significant and sustained investment in upgrading

and expanding healthcare infrastructure, coupled with efficient procurement and maintenance systems, is essential. This involves not just building new facilities but also ensuring existing ones are adequately equipped and that infrastructure development is strategically planned to promote equitable access across all regions of Kenya.

4.11.4 Influence of Policy and Governance on UHC Implementation

The findings on policy and governance within the Social Health Authority underscore the complex interplay of factors influencing UHC implementation. While there is a perceived clarity in the policy framework and a strong belief in the leadership's commitment, significant challenges exist in the practical aspects of governance, particularly concerning the roles of national and county actors and the inclusivity of decision-making. The lack of clear definition in governance roles between national and county levels is a critical issue that can lead to fragmentation, duplication of efforts, and accountability gaps. This finding is consistent with the literature on decentralized health systems, where unclear mandates and coordination challenges between different levels of government often impede effective policy implementation. Amunga and Okoth (2023), in their work on governance challenges in Kenya, specifically point to fragmented governance structures and unclear policy mandates creating overlaps between national and county roles, leading to delayed service delivery and accountability issues. The study's findings directly support this observation.

The perceived lack of inclusivity and participation in decision-making processes is another area requiring attention. Effective governance for UHC requires the involvement of various stakeholders, including frontline staff who are crucial for successful implementation. If decision-making is perceived as top-down or not incorporating input from those on the ground, it can lead to a lack of ownership, demotivation, and decisions that are not well-aligned with operational realities. While the study does not specify which stakeholders are perceived to be excluded, the neutral and disagreeing responses suggest that the current processes may not be

sufficiently broad or transparent.

The perception that inter-agency coordination is only moderately effective is also a concern. UHC implementation involves multiple actors beyond the SHA, including other government ministries, healthcare providers, and civil society organizations. Weak coordination among these entities can create silos, hinder resource mobilization, and slow down progress. Strengthening mechanisms for effective collaboration and communication is essential for a harmonized approach to UHC.

Despite these challenges, the strong perceived commitment of the SHA leadership is a positive factor. Dedicated leadership is crucial for driving reforms and navigating the complexities of UHC implementation. This commitment, coupled with the perception that oversight bodies are actively monitoring progress, indicates a foundation of intent and a level of scrutiny in the process.

However, the widespread belief that weak governance structures are a key barrier to effective UHC implementation highlights that the foundational issues related to how power is exercised, decisions are made, and accountability is ensured are still significant impediments. This goes beyond individual components and points to systemic weaknesses in the governance framework itself. As emphasized by the Public Policy Implementation Theory, one of the theoretical frameworks guiding this study, effective policy execution is contingent on supportive institutional environments and clear governance structures (Sabatier & Mazmanian, 1980). The findings suggest that while the policy content might be clear, the governance context within which it is being implemented presents substantial challenges. Addressing these structural governance issues, including clarifying roles, enhancing transparency, promoting participation, and strengthening accountability mechanisms, is crucial for unlocking the potential of the SHA and accelerating progress towards achieving universal health coverage in Kenya. Barasa et al. (2020), in their evaluation of the UHC pilot program in Kenya, also

recommended the development of comprehensive policy frameworks with clear governance structures to guide the national rollout of UHC, further reinforcing the importance of this dimension.

4.11.5 Status of Implementation of Universal Health Care Implementation

The perceived status of UHC implementation among SHA staff presents a nuanced picture, suggesting that while some progress may have been made in certain areas, significant challenges remain in achieving the full vision of universal health coverage. The moderate agreement on increased access to essential health services is a positive indicator, suggesting that UHC initiatives have facilitated greater utilization of healthcare facilities to some extent. This aligns with findings from the UHC pilot program in Kenya, which showed increased service utilization among beneficiaries (Barasa et al., 2020).

However, the neutral or slightly negative perceptions regarding the affordability of services and the reduction of financial burden on households are concerning. A core objective of UHC is to ensure access without financial hardship. The responses suggest that despite the implementation efforts, a substantial portion of the population may still face significant out-of-pocket expenditures or perceive healthcare costs as a barrier. This finding resonates with studies in other contexts, such as Bangladesh, where despite improvements in service coverage, financial protection remains inadequate (Rahman et al., 2018). It underscores the need for robust financial protection mechanisms and potentially a review of contribution rates and benefit packages under SHIF to truly reduce the financial burden on households.

The low perception of equitable distribution of health services across regions is another critical challenge. UHC aims for equitable access for all, regardless of geographical location. The findings suggest that disparities persist, likely linked to underlying issues of infrastructure, human resource distribution, and accessibility of facilities in underserved areas, as highlighted in previous sections. Addressing these inequities requires targeted interventions and

investments in disadvantaged regions to ensure that the promise of universal coverage translates into tangible access for all citizens. This aligns with the findings of studies that emphasize the need for equitable distribution of resources and services to achieve UHC goals (Massuda et al., 2018, on Brazil's SUS).

The perceived low level of community satisfaction with UHC services is a significant red flag. Community satisfaction is a crucial indicator of the effectiveness and responsiveness of a health system. If the intended beneficiaries are not satisfied, it can undermine trust in the program and lead to underutilization of services. This suggests a need for greater attention to the quality of care, responsiveness of services, and effective communication with communities regarding the benefits and functioning of UHC.

Overall, the findings on the perceived effectiveness of UHC implementation in meeting public health needs indicate that there is still a considerable journey ahead. The responses suggest that the program, as currently implemented, is not yet fully meeting the expectations of those within the implementing authority. This aligns with the problem statement of the study and the broader challenges observed in the initial phases of UHC rollout in Kenya (Ngirachu, 2024). Achieving effective UHC requires addressing the multifaceted institutional capacity gaps identified in this study – human resources, financial capacity, infrastructure, and governance. These dimensions are interconnected, and weaknesses in one area can negatively impact the overall effectiveness of UHC implementation, as posited by Systems Theory. Therefore, a holistic and integrated approach that addresses these underlying capacity constraints is essential to move from policy aspirations to tangible improvements in population health outcomes and achieve the goal of universal health coverage in Kenya.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter provides a concise summary of the key findings derived from the data analysis presented in Chapter Four, focusing on the influence of institutional capacity dimensions human resources, financial capacity, healthcare infrastructure, and policy and governance on the implementation of Universal Health Care (UHC) in Kenya, specifically within the Social Health Authority (SHA). Drawing from the descriptive and inferential statistics, the chapter synthesizes the results to formulate conclusions that address the study's objectives. Based on these conclusions, actionable recommendations are proposed for enhancing institutional capacity and improving UHC implementation. Finally, areas for further research are suggested to contribute to a deeper understanding of the factors influencing UHC in the Kenyan context and beyond.

5.2 Summary of Findings

The study's findings, based on data from 135 respondents at the Social Health Authority headquarters, reveal that institutional capacity significantly influences the implementation of Universal Health Care in Kenya. The descriptive analysis of human resource capacity indicated that staff perceive a notable insufficiency in the number of health personnel required for effective UHC program implementation. While there is acknowledgment of clear recruitment policies and some regularity in staff training, concerns exist regarding the effective retention of experienced staff and the equitable distribution of personnel across departments. These perceived human resource capacity challenges were strongly associated with negative impacts on UHC implementation timelines, suggesting that workforce limitations are a critical bottleneck in the rollout process.

Regarding financial capacity, the findings highlight significant perceived challenges related to

resource adequacy and timeliness of budget allocations for UHC programs. Staff largely believe that the SHA does not receive sufficient financial resources and that funds are not always allocated in a timely manner or aligned with UHC priorities. While financial management systems for accountability are perceived to be in place, there are mixed views on the transparency of fund utilization. A dominant finding is the strong agreement that financial constraints are a major hindrance to the effective rollout of UHC, underscoring the critical need for improved financial resourcing and management. Perceptions regarding the monitoring of financial sustainability were also uncertain, suggesting potential gaps in long-term financial planning and oversight for UHC programs.

The analysis of healthcare infrastructure revealed significant perceived deficiencies in the equipping of health facilities under the SHA for UHC service delivery. Staff strongly feel that the current infrastructure does not adequately support equitable access to services across all regions, pointing to persistent geographical disparities. Concerns were also raised about the regularity of maintenance and upgrading of infrastructure, as well as the sufficiency of facility space for UHC activities. Perceived inefficiencies in the procurement processes for medical equipment were also noted. These infrastructure limitations were widely believed to have caused delays in UHC implementation in various areas, highlighting the tangible impact of physical and material resource gaps on the program's progress. While ICT systems were perceived more positively, their functionality is ultimately constrained by the broader physical infrastructure context.

For policy and governance, the findings indicate a positive perception regarding the clarity of the policy framework guiding UHC implementation and a strong belief in the commitment of SHA leadership to achieving UHC objectives. However, significant challenges were identified in the practical aspects of governance. Staff perceive a lack of clear definition in governance roles between national and county actors, which can lead to coordination difficulties. Similarly,

decision-making processes were not widely perceived as inclusive and participatory. Despite a moderate perception of inter-agency coordination and active monitoring by oversight bodies, there was a widespread belief that weak governance structures, as a whole, constitute a key barrier to effective UHC implementation. This suggests that while foundational policies and leadership intent are present, systemic governance issues impede the smooth and effective translation of policy into practice.

The descriptive analysis of the perceived status of UHC implementation itself revealed a mixed picture. While there was a moderate perception of increased access to essential health services and improved availability since UHC implementation began, perceptions of improved affordability and reduced financial burden on households were largely neutral or divided. The equitable distribution of health services across regions was perceived poorly, indicating persistent disparities. Crucially, community satisfaction with UHC services was perceived to be low, and the overall effectiveness of UHC implementation in meeting public health needs was perceived negatively by a notable portion of the staff.

The inferential analysis reinforced the significant influence of institutional capacity on UHC implementation. The correlation analysis showed significant positive relationships between all four dimensions of institutional capacity (Human Resource Capacity, Financial Capacity, Healthcare Infrastructure, and Policy and Governance) and the Implementation of UHC, with Policy and Governance exhibiting the strongest correlation. The multivariate regression analysis demonstrated that the combined institutional capacity dimensions significantly predict a substantial portion of the variance in UHC implementation. Individually, Policy and Governance emerged as the strongest significant predictor, followed by Human Resource Capacity, Financial Capacity, and Healthcare Infrastructure. These findings underscore that while all dimensions are important, strengthening policy and governance structures and human resource capacity may have a particularly strong impact on improving UHC implementation

outcomes within the SHA, although deficiencies in financial capacity and infrastructure also pose significant barriers.

5.3 Conclusion

Based on the comprehensive analysis of the research findings, several key conclusions can be drawn regarding the influence of institutional capacity on the implementation of Universal Health Care at the Social Health Authority in Kenya. Firstly, it is evident that human resource capacity presents a significant challenge, primarily due to perceived staff shortages, difficulties in retaining experienced personnel, and issues with equitable distribution. These factors collectively contribute to delays and inefficiencies in the UHC rollout, highlighting that a well-resourced and effectively managed workforce is fundamental to translating policy into practice. Secondly, financial capacity emerges as a major impediment to UHC implementation. The perceived inadequacy and untimely allocation of financial resources, coupled with concerns about transparency and the monitoring of sustainability, create a challenging environment for the SHA to effectively fund and manage UHC programs. The strong statistical relationship between financial capacity and UHC implementation underscores that without sufficient and well-managed funding, the aspirations of universal coverage are difficult to realize.

Thirdly, healthcare infrastructure limitations significantly hinder UHC implementation, particularly in ensuring equitable access and service delivery. The perceived lack of adequately equipped facilities, coupled with challenges in maintenance and procurement, directly impacts the ability to provide comprehensive services across all regions. While progress in ICT is noted, the foundational physical infrastructure requires substantial improvement to support the scale and equity demanded by UHC.

Finally, while a clear policy framework and committed leadership are recognized strengths, the study concludes that weaknesses in policy and governance structures pose a critical barrier. Ambiguity in roles between national and county actors and less inclusive decision-making

processes create operational complexities that impede effective implementation. The strong predictive power of policy and governance in the regression model emphasizes that robust, transparent, and well-coordinated governance is paramount for navigating the complexities of UHC and ensuring accountability and effective resource utilization.

In conclusion, the study confirms that institutional capacity, encompassing human resources, financial capacity, healthcare infrastructure, and policy and governance, collectively and individually exerts a significant influence on the implementation of Universal Health Care in Kenya. The findings indicate that addressing the identified gaps across these dimensions is crucial for overcoming existing challenges and accelerating progress towards achieving equitable, affordable, and quality healthcare for all Kenyans. While all areas require attention, strengthening policy and governance frameworks and enhancing human resource capacity appear to be particularly impactful levers for improving implementation outcomes within the SHA.

5.4 Recommendations

Based on the findings and conclusions of this study, the following recommendations are proposed to enhance the institutional capacity of the Social Health Authority and improve the implementation of Universal Health Care in Kenya:

- i. **Strengthen Human Resource Management:** The SHA should conduct a comprehensive workforce needs assessment to determine optimal staffing levels and distribution across departments to effectively support UHC programs. Implement targeted recruitment and retention strategies, including competitive remuneration, professional development opportunities, and improved working conditions, to attract and retain skilled personnel. Enhance performance management systems to ensure continuous staff appraisal and alignment with UHC objectives.

- ii. **Enhance Financial Resourcing and Management:** The government and SHA should prioritize increasing the allocation of adequate and timely financial resources specifically for UHC programs. Improve transparency in fund utilization through clear reporting mechanisms and regular audits. Strengthen financial management systems and develop robust strategies for monitoring the long-term financial sustainability of UHC, potentially exploring innovative financing mechanisms and ensuring efficient resource allocation to meet program priorities.
- iii. **Improve Healthcare Infrastructure and Equitable Access:** The SHA, in collaboration with the Ministry of Health and county governments, should significantly invest in upgrading and expanding healthcare infrastructure, particularly in underserved regions, to ensure equitable access to UHC services. Prioritize the timely and efficient procurement and maintenance of essential medical equipment. Develop and implement a strategic infrastructure development plan that addresses the identified gaps in facility equipping and space to support the growing demands of UHC.

5.5 Further Research

Based on the limitations of this study and the gaps identified in the literature, the following areas are recommended for further research:

- i. **Impact of Specific Governance Mechanisms:** While this study identified weak governance structures as a barrier, further research could focus specifically on evaluating the impact of different governance mechanisms (e.g., specific accountability frameworks, participatory decision-making models, inter-agency coordination protocols) on UHC implementation outcomes. This could provide more granular insights into which specific governance interventions are most effective.

- ii. County-Level Institutional Capacity: This study focused on the SHA headquarters. Future research should explore the institutional capacity at the county level, as counties play a crucial role in the decentralized implementation of UHC. Understanding the capacity gaps and strengths at the county level would provide a more complete picture of the institutional landscape influencing UHC rollout in Kenya.
- iii. Long-Term Financial Sustainability of SHIF: Given the concerns raised about financial sustainability, further research is needed to conduct an in-depth analysis of the long-term financial viability of the Social Health Insurance Fund (SHIF). This could involve actuarial studies, analysis of revenue collection and expenditure patterns, and modeling of different financing scenarios to inform strategies for ensuring the sustainable funding of UHC.



Mount Kenya

REFERENCES

APPENDICES

Appendix I: Introduction Letter

ALOISE KINYANJUI KURIA

P.O. BOX 342,

THIKA

I am currently pursuing a Master's Degree in Business Administration, Project Management Option at Mount Kenya University. I am conducting a research study titled:

“INFLUENCE OF INSTITUTIONAL CAPACITY ON IMPLEMENTATION OF THE UNIVERSAL HEALTH CARE IN KENYA: CASE OF SOCIAL HEALTH AUTHORITY.”

You have been selected to participate in this study as a key respondent. Kindly take a few moments to complete the attached questionnaire, which is designed to collect data relevant to this academic research. Your responses will play a crucial role in enhancing understanding of how various institutional capacity factors such as human resources, financial capacity, infrastructure, and governance affect the implementation of Universal Health Care in Kenya.

I assure you that all information provided will be treated with the highest level of confidentiality and will be used solely for academic purposes. Your identity will not be disclosed at any stage of the research process.

Your honest feedback is highly valued and will be greatly appreciated.

Thank you for your time and cooperation.

ALOISE KINYANJUI KURIA

Appendix II: Consent Form

Dear Participant,

I invite you to take part in a research study titled:

“INFLUENCE OF INSTITUTIONAL CAPACITY ON IMPLEMENTATION OF THE UNIVERSAL HEALTH CARE IN KENYA: CASE OF SOCIAL HEALTH AUTHORITY.”

This study is being conducted in partial fulfillment of the requirements for the award of a **Master’s Degree in Business Administration, Project Management Option** at **Mount Kenya University**.

The purpose of this study is to assess how institutional capacity specifically human resource capacity, financial capacity, healthcare infrastructure, and policy and governance affects the implementation of Universal Health Care (UHC) in Kenya, with a specific focus on the Social Health Authority (SHA). Your insights as an employee of SHA are vital in helping to generate relevant data for this academic research.

Your participation in this study is voluntary, and you are free to decline to answer any specific questions or withdraw at any point without any penalty. There are no known risks associated with participating in this study beyond those encountered in everyday life. All information you provide will be treated with strict confidentiality and anonymity. The findings will be reported in aggregated form only, and no identifying information will be disclosed. Access to the data will be restricted to the research team.

Although there are no direct personal benefits from participating, your contributions may help inform future improvements in health policy, institutional governance, and the successful implementation of UHC programs in Kenya.

If you agree to participate, kindly complete the attached questionnaire to the best of your ability. It should take approximately seven minutes to complete. Please return the completed questionnaire within the provided time frame to assist with timely data analysis.

If you have any questions or concerns regarding your rights as a participant, please contact:

Ethics Review Committee, Mount Kenya University

P.O. Box 342-01000, Thika

Email: cgsr@mku.ac.ke | Tel: +254 709 153 000

Thank you sincerely for your time and valuable contribution to this important research.

CONSENT STATEMENT

I have read and understood the purpose of this study and my role as a participant. I understand that my participation is completely voluntary and that I can withdraw at any time without any consequences. I am also aware that the information I provide will be treated with confidentiality and used strictly for academic purposes. I freely and willingly consent to participate in this study.

Participant's Signature: _____

Date: _____

Investigator's Signature: _____

Date: _____

Appendix III: Questionnaire

This questionnaire is part of a study aimed at assessing how institutional capacity influences the implementation of Universal Health Care (UHC) in Kenya, focusing on the Social Health Authority (SHA). Your responses will remain confidential and will be used strictly for academic purposes. Kindly respond to each of the following statements based on your level of agreement. Use the scale below to indicate your response: 1 = Strongly Disagree | 2 = Disagree | 3 = Not Sure | 4 = Agree | 5 = Strongly Agree.

SECTION A: Background information

1. What is your age group?

- Below 25 years
- 25 – 34 years
- 35 – 44 years
- 45 – 54 years
- Above 55 years

2. What is your highest level of education?

- Primary Level
- Secondary Level
- Diploma Level
- Bachelor's Degree
- Master's Degree or above

How many years of experience do you have in your current field?

- Less than 1 year
- 1 – 3 years
- 4 – 6 years
- More than 6 years

SECTION B: Human Resource Capacity

This section seeks to understand how human resource-related factors influence the implementation of UHC. Please indicate the extent to which you agree with the following statements. (Scale: 1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree).

statements	1	2	3	4	5
The current number of health personnel is sufficient to implement UHC programs.					
Staff are regularly trained to meet emerging UHC implementation needs.					
There are clear recruitment policies to attract qualified staff.					
The retention of experienced healthcare staff is well managed.					
Staff distribution across departments supports efficient UHC delivery.					

statements	1	2	3	4	5
Performance management systems exist for continuous staff appraisal.					
Human resource capacity challenges have affected UHC implementation timelines.					

SECTION C: Financial Capacity

This section seeks to understand how Financial Capacity influence the implementation of UHC. Please indicate the extent to which you agree with the following statements. (Scale: 1=Strongly Disagree, 2=Disagree, 3-Neutral, 4=Agree, 5=Strongly Agree).

Statements	1	2	3	4	5
The Social Health Authority receives adequate financial resources for UHC programs.					
Budget allocations are timely and aligned with UHC priorities.					
There is transparency in fund utilization for UHC activities.					
Financial management systems in place ensure accountability.					
Financial constraints hinder the effective rollout of UHC.					
External donor support supplements government funding for UHC implementation.					
The financial sustainability of UHC programs is well monitored.					

SECTION D: Healthcare Infrastructure

This section seeks to understand how Healthcare Infrastructure influence the implementation of UHC. Please indicate the extent to which you agree with the following statements. (Scale: 1=Strongly Disagree, 2=Disagree, 3-Neutral, 4=Agree, 5=Strongly Agree).

Statements	1	2	3	4	5
Health facilities under SHA are adequately equipped for UHC service delivery.					
Infrastructure supports equitable access to services across all regions.					
ICT systems (e.g., digital records) support efficient service delivery.					
Maintenance and upgrading of infrastructure are regularly conducted.					
Facility space is sufficient for handling UHC-related activities.					
Procurement processes for medical equipment are efficient and timely.					
Infrastructure limitations have delayed UHC implementation in some areas.					

SECTION E: Policy and Governance

This section seeks to understand how Policy and Governance influence the implementation of UHC. Please indicate the extent to which you agree with the following statements. (Scale: 1=Strongly Disagree, 2=Disagree, 3-Neutral, 4=Agree, 5=Strongly Agree).

Statements	1	2	3	4	5
There is a clear policy framework guiding UHC implementation.					
Governance roles between national and county actors are well					

Statements	1	2	3	4	5
defined.					
Decision-making processes are inclusive and participatory.					
Inter-agency coordination enhances UHC implementation.					
Oversight bodies actively monitor UHC implementation progress.					
The SHA leadership is committed to achieving UHC objectives.					
Weak governance structures are a key barrier to effective UHC implementation.					

SECTION F: Implementation of Universal Health Care

This section focuses on evaluating the perceived status and effectiveness of Universal Health Care implementation in Kenya as carried out by the Social Health Authority. (Scale: 1=Strongly Disagree, 2=Disagree, 3-Neutral, 4=Agree, 5=Strongly Agree).

Statements	1	2	3	4	5
UHC has increased access to essential health services in Kenya.					
The affordability of healthcare services has improved under UHC.					
Health services are now more equitably distributed across regions.					
UHC has reduced the financial burden on households.					
Healthcare service availability has improved since UHC implementation began.					
Community members are increasingly satisfied with UHC services.					
The implementation of UHC has been effective in meeting public health needs.					

THANK YOU

Appendix IV: ERC Letter



REF: MKU/ISERC/5108
TO: ALOISE KINYANJUI KURIA

Date: 21 May 2025

REG: MPAM/2023/42442

Dear Sir/Madam,

RE: INFLUENCE OF INSTITUTIONAL CAPACITY ON IMPLEMENTATION OF THE UNIVERSAL HEALTH CARE IN KENYA: CASE OF SOCIAL HEALTH AUTHORITY

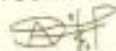
This is to inform you that **Mount Kenya University** has reviewed and approved your above research proposal. Your application approval number is **3830**. The approval period is **21/05/2025 - 20/05/2026**.

This approval is subject to compliance with the following requirements:

- i. Only approved documents including informed consents, study instruments, MTA will be used
- ii. All changes including amendments, deviations and violations are submitted for review and approval by **Mount Kenya University**
- iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **Mount Kenya University** within 72 hours of notification
- iv. Any changes, anticipated or otherwise that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to **Mount Kenya University** within 72 hours
- v. Clearance for export of biological specimens must be obtained from relevant institutions
- vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal
- vii. Submission of an executive summary report within 90 days upon completion of the study to **Mount Kenya University**

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke> and also obtain other clearances needed.


Yours sincerely,



Dr. Alfred Owino, PhD
Chairman, Mount Kenya University ISERC



Appendix V: Introduction Letter



Mount Kenya University

DIRECTORATE OF GRADUATE STUDIES

MPAM/2023/42442

21st May, 2025

*National Commission for Science Technology & Innovation (NACOSTI)
Off Waiyaki Way, Upper Kabete,
P.O Box 30623- 00100
NAIROBI, KENYA*

Dear Sir/Madam,


RE: ALOISE KINYANJIU KURIA - REGISTRATION NO. MPAM/2023/42442

The purpose of this letter is to introduce the above named student who is pursuing **Master of Arts in Public Administration and Management** in the department of **Management** in the school of **Business and Economics**

The title of the research is **"Influence of Institutional Capacity on Implementation of the Universal Health Care in Kenya: Case of Social Health Authority."** It has been cleared by the University's Ethics Review Committee (Certificate attached) and now has to proceed to the field to collect data between **May, 2025 and July, 2025.**

Any assistance accorded to the student will be highly appreciated.


Thank you.


Dr. Samuel M. Karenga, Ph.D.
Director, Graduate Studies
Enc.


Mount Kenya University
Office of the Director, Graduate Studies

Main Campus, General Kago Road, P.O. Box 342-01000 Thika.
Cell: +254 709 153 000 | +254 709 153 200
Email: info@mku.ac.ke, Web: www.mku.ac.ke
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Unlocking Infinite Possibilities

Appendix VI: NACOSTI Authorization




REPUBLIC OF KENYA
National Commission for Science, Technology and Innovation



**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION**

RESEARCH LICENSE




This is to Certify that Mr. ALOISE KURIA KINYANJUI of Mount Kenya University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: INFLUENCE OF INSTITUTIONAL CAPACITY ON IMPLEMENTATION OF THE UNIVERSAL HEALTH CARE IN KENYA: CASE OF SOCIAL HEALTH AUTHORITY for the period ending : 10/June/2026.

License No: NACOSTIP/25/4174699

515310
Applicant Identification Number

(Signature)
Deputy Director
**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION**

Verification QR Code



NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

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Appendix VII: Field Authorization

NAIROBI CITY COUNTY

Telephone: +254 20 2224281
Email: info@nairobi.go.ke
Web: Nairobi.go.ke



City Hall,
P. O. Box 30075-00100,
NAIROBI, KENYA.

OUR REF: NCC/BHO/COC/S/VXI

Date: 10th June, 2025

Whomsoever is concerned.

RE: RESEARCH AUTHORIZATION

The bearer of this letter, **Aloise Kinyanjui Kuria** is a student at **Mount Kenya University** studying **Master of Science Degree in Project Planning and Management**.

He has written to this office seeking authority to collect data for his research proposal.

Consent has been given, and he is hence introduced to carry out the research titled: *"Influence of Institutional Capacity On Implementation of the Universal Health Care in Kenya: Case of Social Health Authority"*.

The research should comply with any other conditions as may be required at the specific data collection sites.

Kindly accord him the necessary support.



NAIROBI CITY COUNTY
Chief Officer Cooperatives
10th JUN 2025
P.O. BOX 30075-00100,
NAIROBI

George Mutiso Musembi
Chief Officer Cooperatives

For:
County Executive
Business and Hustler Opportunities
Nairobi County


LET'S MAKE NAIROBI WORK

TELEPHONE: +254 725 624 489; +254 738 041 292 | EMAIL: INFO@NAIROBI.GO.KE

Appendix VIII: Similarity Index

ALOISE KINYANJUI KURIA

**INFLUENCE OF INSTITUTIONAL CAPACITY ON
IMPLEMENTATION OF THE UNIVERSAL HEALTH CARE IN KE...**

 MBA 2025
 MASTERS
 Mount Kenya University

Document Details

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142,942 Characters



Page 1 of 122 - Cover Page

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Mount Kenya

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