

## **An analysis of universal health coverage(UHC) policy through the multiple streams framework in Makueni County, Kenya**

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### **ABSTRACT**

Universal health coverage(UHC) ensures that all people can access the health services they need, without being exposed to financial hardship. This calls on governments and health stakeholders to build on the political commitment that health is a good investment and reduce the number of people who pay out of pocket for healthcare. This can be said to true of the Makueni UHC policy. In Makueni county, UHC became a reality with the rest of Kenya playing catch up and learning from their journey. While a policy's entrance onto the political agenda is not random, Makueni county has been able to provide UHC since 2016 dubbed, 'Makueni care'. The quest to achieve UHC is explicitly a political process with a variety of strategies to shape organizational change that accompanies health systems reform capitalize on political windows of opportunity. Political change makes it more possible prepare and identify such political windows and pursue policy and legislation change to underpin the health system reforms. This paper uses Kingdon's (1995) Multiple Streams Framework (MSF) to critically analyze the Makueni county UHC policy. First, it will describe the Makueni county UHC policy. Second, is to evaluate and apply Kingdon's MSF to analyze how the UHC policy came to be constructed as a problem and to consider the proposed policy solutions, as well as the surrounding political forces in Makueni county. Third, is to identify the possible notions of policy entrepreneurs and policy windows in the UHC policy in Makueni county. This is a qualitative case study through extensive document review and semi-structured interviews with key informants. Purposeful sampling was used to have the county executive committee member for health, chief officer health, three directors of health, county health records officer and county health administrative officer provide a deeper understanding on how UHC was identified as a problem, what was involved in policy making and the political process.

**KEYWORDS;** Universal health coverage (UHC), multiple streams framework, Makueni care, windows of opportunity

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### **I. INTRODUCTION**

Universal health coverage(UHC) ensures that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This continues to attract the attention of many stakeholders and governments. This is because it embodies; equity in access to health services-those who need the services should get them, not only those who can pay for them; that the quality of health services is good enough to improve the health of those receiving services; and finally financial risk protection which aims at ensuring that the cost of using care does not put people at risk of financial hardship (Okech & Lelegwe, 2016).

Achieving UHC in Africa is a tall order as more than half of Africa's population currently lacks access to essential health services, and the continent's population is expected to double by 2050 with the United Nations Economic Commission for Africa (UNECA) estimating a financing gap of \$66 billion per year. It on this reality that the African Health Forum (2019) brought African politicians, donor agencies, activists and private sector representatives together to discuss how to achieve UHC in Africa and launch an initiative to increase spending on health (Nordling, 2021).

The intention is to build on the political commitment that health is a good investment and reduce the number of people who pay out of pocket for healthcare. Over the past few decades healthcare in Africa has been very disease-specific leading to vertical programmes with significant inefficiencies. The focus is to promote people-centered healthcare by not only focusing on disease but the whole person (Nordling, 2021). Further, the State of UHC in Africa report (2021) takes stock of Africa's progress in fulfilling commitments made by African leaders, such as the Abuja Declaration (2001), the Africa Health Strategy (2007-2015, 2016-2030) and

the Addis Ababa Call to Action on UHC (2019) and noted that Africa's health systems are poorly attuned to meet the health care needs of the poor, the disabled and other vulnerable groups, with coverage of essential health care services in Africa being decidedly low: only 48 per cent of the population (approximately 615 million people) receives the health care services they need (Africa health agenda international conference commission, 2021).

A policy's entrance onto the political agenda is not random and there are competing theories on how issues work their way onto the agenda. This can be said to true of the Makueni UHC policy. In Makueni county, UHC became a reality with the rest of Kenya playing catch up and learning from their journey. Makueni Governor Prof. Kivutha Kibwana observes that when he took over in 2013, they realized that 40 per cent of Makueni people would sell land and assets to settle medical bills hence jeopardizing their livelihood. With the fact that healthcare in dispensaries and health centres was met by the national government and accessed for free by the people, the county government figured out if it could augment its budgetary allocation for health with household contribution then it could have UHC, which was adopted and called Makueni care (Gathara, 2021).

While in developed countries UHC has moved from an aspiration to reality it remains dream in most of the developing world. The quest to achieve UHC has been explicitly a political process. An analysis of the progress towards UHC reveals that among the factors that are important are windows of opportunity. A variety of strategies to shape organizational change that accompanies health systems reform capitalize on political windows of opportunity. Political change makes it more possible prepare and identify such political windows and pursue policy and legislation change to underpin the health system reforms (Berman, Azhar, & Osborn, 2019; McKee, Balabanova, Basu, Ricciardi, & Stuckler, 2013).

Health system governance is ensuring strategic policy frameworks to protect and promote the health of the people. It serves a critical role in unifying concepts such as health for all, basic health needs, the Alma-Ata declaration, sustainable development goal 3 (good health and well-being) and Africa agenda 2063 which urges African states to prioritize social protection key being healthcare. Governance is widely recognized as central to improving health sector performance and achieving UHC. However, it is political, the result of interactions, coordination and decision-making among different actors in the face of multiple views and interests (World health organization, 2021).

Decentralization that enables responsiveness to local needs and values has been identified as a key governance mechanism for influencing health outcomes. Reforms, such as devolution bring expectations for improved service delivery, increased responsiveness to community demands, increased accountability and greater efficiency, equity and expansion of UHC. Community health services have an important role to play in attaining UHC by involving and empowering communities to improve knowledge, change health-related beliefs, behaviors and improve access and uptake of health services. Community health services could therefore be expected to form the backbone for health service provision and community engagement following devolution ( McCollum, Limato, Otiso, Theobald, & Taegtmeier, 2018).

This paper will use Kingdon's (1995) Multiple Streams Framework (MSF) to critically analyze the policymaking process of the UHC in Makueni county, Kenya. The aim of the paper is threefold. First, it will describe the UHC policy in Makueni county. Second, is to evaluate and apply Kingdon's MSF to analyze how the UHC policy came to be constructed as a problem and to consider the proposed policy solutions, as well as the surrounding political forces in Makueni county. Third, is to identify the possible notions of policy entrepreneurs and policy windows in the UHC policy process in Makueni county.

## **II. METHODOLOGY**

The first stage involved conducting a documentary analysis and defining key words related to UHC and multiple streams framework. The search paid attention to UHC policy understanding and analysis from the MSF. The attention was given to UHC at decentralized and devolved settings where the healthcare function is share at several levels.

The second stage was to review key documents on the practice and policy of UHC in Makueni County, Kenya. A review of policy process and implementation of UHC in Makueni county was carried out. Further, a review of how UHC happens nationally, regionally and globally was done. The historical background to this study looked at the evolution of healthcare system in Kenya from a centralized to a devolved and shared function.

The research used the Tangaza University OPAC bibliographical search engines for the most important collections and databases. Mendeley reference manager and JSTOR provided the main online bibliographical documentation work. The online search engines connected with Sage Publications, Taylor & Francis Online Journals, SpringerLink, Wiley Online Library, Directory of Open Access Journals (DOAJ), Emerald Journals (Emerald Group Publishing), Oxford Journals (Oxford University Press), Cambridge Journals (Cambridge University Press). The Google Scholar and Google Books guided in accessing current empirical data. After making an extensive review of these materials, there was a careful selection of those documents that deal

specifically with UHC policy making through the MSF and what scholars have written on the subject. The compilation and analysis focused only that information which was relevant to the aims of the research. The headings that guided the literature selection and review were as follows: understanding the MSF, UHC policy in Makueni and application of the MSF to Makueni care.

### **III. FINDINGS FROM LITERATURE REVIEW**

#### **Understanding the Multiple -Streams Framework**

Policymakers do not always know where policies come from, including those in healthcare sector. John Kingdon presented the Multiple Streams Framework in his book *Agendas, Alternatives and Public Policies* where he focuses on how ideas become solutions to policy problems through understanding public policy agenda setting based upon first-hand and secondary examinations of agenda processes within a political system. Policymaker aims and policy problems are ambiguous and interested actors struggle to research issues and produce viable solutions quickly. Sometimes people wait for the right time to present their pet solutions. Sometimes policymakers just want to look busy and decisive. So, problem identification, solution production, and choice are 'relatively independent streams'. The streams are; problem stream, policy stream and political stream. Kingdon argued that three separate 'streams' must come together at the same time and they must do so during a brief 'window of opportunity' for policy to change markedly (Cairney & Jones, 2016).

The problem stream is filled with perceptions of problems that are seen as "public" in the sense that government action is needed to resolve them. These problems usually reach the awareness of policy makers because of dramatic events such as crises or through feedback from existing programmes that attract public attention. People come to view a situation as a "problem" based upon its variance with their understanding of some desired state of affairs. The policy stream is filled with the output of experts and analysts who examine problems and propose solutions. In this stream, the myriad possibilities for policy action and inaction are identified, assessed, and narrowed down to a subset of ostensibly feasible options. Finally, the political stream comprises factors that influence the body politic, such as swings in national mood, executive or legislative turnover, and interest group advocacy campaigns (Béland & Howlett, 2016).

These three streams flow along different channels and remain more or less independently of one another until, at a specific point in time, a policy window opens. Only then do the streams cross. Policy windows can be used by particular actors in a policy subsystem in order to advance the engagement of the issues they care about. Kingdon viewed agenda setting where the separate streams of problems, policies, and politics come together at certain critical times. Solutions become joined to problems, and both of them are joined to favourable political forces. Only then does an issue become a recognized problem on the official (or institutional) agenda and the public policy process starts addressing it (Chow, 2014).

Kingdon suggested that window openings could sometimes be triggered by apparently unrelated external focusing events, such as crises, accidents, or the presence or absence of "policy entrepreneurs" both within and outside of governments. At other times, these windows are opened by institutionalized events such as periodic elections or budget deadlines. Policy entrepreneurs play an important role in shaping the course of the three streams and their intersection by linking or "coupling" policy problems and policy solutions together with political opportunities. Policy entrepreneurs are people who are willing to invest their resources in pushing their pet proposals or problems, are responsible not only for prompting important people to pay attention, but also for coupling solutions to problems and for coupling both problems and solutions to politics (Guldbrandsson & Fossum, 2009).

#### **The Makueni county UHC policy Kenya's UHC journey**

Kenya has since 1963 initiated policy reforms and strategies earmarked towards UHC. These have culminated into various policy documents including Kenya Health Policy (2014–2030), various health Sector policies and strategic plans, Vision 2030, the Constitution 2010, and the 'Big four' agenda. The government recognized a high quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation. Kenya's 2010 constitution provides an overarching legal framework for a rights-based approach to health and from this foundation successive health policies and strategies have focused investment on provision of services across six levels of the health system and trying to ensure geographical proximity to services for patients (Okech & Lelegwe, 2016).

The Constitution of Kenya 2010 introduced a devolved system of government, which is unique for Kenya and provides for one (1) national government and forty-seven (47) county governments. The governments at the national and county levels are "distinct and interdependent," and are expected to undertake their relations through "consultation and cooperation. The specific healthcare functions assigned to the two levels of governments, are as follows: national government: leadership of health policy development; management of national referral health facilities; capacity building and technical assistance to counties; and

consumer protection, including the development of norms, standards and guidelines; county governments: responsible for county health services, including county health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food to the public; cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps, and solid waste disposal (Government of Kenya, 2010).

In the implementation of the health policy, the health sector will embrace the following principles: equity in distribution of health services and interventions; public participation, in which a people-centred approach and social accountability in planning and implementation shall be encouraged, in addition to the multisectoral approach in the overall development planning; efficiency in application of health technologies; and mutual consultation and cooperation between the national and county governments and among county governments (Ministry of Health, 2014).

In 2013 user fees were abolished at primary health care facility level to encourage uptake of services but challenges remain. Out of pocket expenses still account for around 26.1% of total health spending nationally, which has implications for the willingness of patients to take up services or seek care. In 2016, the County Government of Makueni launched Makueni Care, a UHC program. The target population of Makueni Care are residents of Makueni county. Households pay an annual registration fee of KES 500 to register for the program. Typically, households are comprised of the principal member, spouse and, on average, three dependants; however, there is no limit on the number of people who can register from a household. Children over 18 years of age are considered independent and are supposed to pay the annual registration fee, unless they are attending school and are under 24 years of age. People over 65 years old are not required to pay the annual fee unless they have dependants. Once registered, each household receives a unique identification number and a single card, on which all the names of the beneficiaries are listed. Makueni Care covers at least 93 per cent of the county's healthcare needs. It is built on a platform of ensuring adequate provision of primary care by increasing facilities, improving services and ensuring that medicines are available. (Makueni care brief, 2019; Kenya Vision 2030, 2021).

In 2018, President Uhuru Kenyatta declared Universal Health Coverage (UHC) to be a national priority in Kenya, as part of 'Big Four Agenda' for national sustainable development. Under this initiative, the Government of Kenya has committed to make strategic investments in health to ensure that all residents of Kenya can access the essential health services they require by 2022. This led to piloting of UHC programme in four out of 47 counties, easing access to health services for millions of people registered (Union for international cancer control, 2021; World health organization, 2021).

Historically, the Kenyan government has underfunded the health sector and has been reliant on donor funds and out-of-pocket (OOP) expenditure. OOP is the highest contributor of the largest share of total health expenditure as the Kenyan government has continually allocated less than the 15% required by the 2001 Abuja Declaration on Roll Back Malaria in Africa. The current government's spending priorities are in four broad areas, one of which is implementing UHC and improving the NHIF to adequately care for the vulnerable, such as the elderly and disabled. The government aims to achieve UHC through reforms in governance of private insurance companies; restructuring NHIF including expanding its coverage and benefits; scaling up the support of plans geared towards the provision of specialized medical equipment; increasing the total number of health facilities; scaling up the Linda Mama programme; and strengthening health research. The UHC pilot phase was rolled out in 2018 in Nyeri, Isiolo, Kisumu and Machakos counties with the aim of providing medication and medical equipment, improving the infrastructure of hospitals and addressing human resource concerns. Though Makueni county was not a national pilot county it had two-year experience with UHC. (Owino, Wangong'u, Were, & Maleche, 2020).

### **Makueni UHC journey**

When the county government came into being, it was realized that most of the people of Makueni would sell land and exchange family income to pay medical bills for relatives. Given that medical services in dispensaries and health centres were already free and paid for by the national government, the county government figured out that if it doubled the 100 million shillings county and sub county hospitals were collecting in user fees, it would offer free services across the board to its residents. Under the Makueni Care, the hospitals provide care and bill the county government which also supplies them as well as the primary health care facilities with drugs, equipment, staff and continuous improvement of infrastructure (Government of Makueni county, 2020).

The government of Makueni County prioritizes health as part of her key development agenda. From 1<sup>st</sup> of May 2016, the government piloted a universal health coverage program for her population aged 65 years and above. The pilot ran for six months. It is from this pilot that key lessons were learned that helped the County Government to design a population-wide universal health coverage scheme that enables all eligible citizens of Makueni to access secondary level care without incurring out of pocket expenditure at the point of care in all

public hospitals within the county. The scheme runs two sub-programs where those households headed by persons below the age of 65 pay a renewable annual registration fee of Ksh 500 while the elderly access services without any payment. Before initiation of the policy, different stakeholders such as health care providers, health managers and the community were involved to give their inputs. The stakeholders were receptive to introduction of the scheme (Government of Makueni county, 2020).

### **Applying policy streams approach to Makueni care**

#### ***The problem stream***

This section presents the health issues which were prevalent before devolution and after devolution, and who was presenting these issues. The purpose of doing this is to understand why inadequate access to health services was considered a major public problem that deserved attention. As of 2014, 48% of Kenyans did not have essential healthcare services and were susceptible to financial hardship due to health costs. When the county government took over healthcare in 2013 healthcare was expensive since it was cost shared by the government and individuals. The high poverty rate coupled with food insecurity and perennial droughts aggravated the affordability of healthcare by the people. Since the county government embraced public participation in need identification and resource allocation, the persistent theme of affordable healthcare was evident. According to the Government of Makueni county through public participation reports from 2014-2016 the people of Makueni continuously raised concern about the challenges of meeting costs of healthcare out of pocket. This made the government realize that the people were either having to fundraise or selling off assets to meet these costs (Government of Makueni county, 2013). This defined the path towards the strategic direction and policy to respond to the problem through adoption of UHC. Makueni care took two years to plan and was preceded and piloted by a program offering free healthcare to those over 65 years without the requirement for registration (Gathara, 2021).

This marked the transition of the healthcare issue from a private problem to the county government being involved in fixing it. The issue was defined as a problem by the public when their current condition does not match the values and perception of their ideal state. In Kingdon's theory a problem changes from a private problem to a public problem when an indicator shows a change in the state of a system. In this case the indicator was the price of healthcare service people find essential becoming unaffordable in the private sector (Atupem, 2017).

A study on priority-setting, undertaken across 10 counties in Kenya with the lens of health equity and community-based primary care, underscored key concerns with priority-setting after the transfer of functions to county governments. While most of the respondents in this qualitative study appreciated the need for devolution to decentralize decision-making for health, many recognized that decentralization had not led to community involvement in decision-making. Key concerns include:(a) The process in how priorities are made and weighted against each other remains unclear. (b) There is limited technical community capacity for county priority-setting. (c) Mistrust between actors at both levels has resulted in the national government playing a limited role in providing guidance. (d) Barriers faced by marginalized groups in engaging in the process were not addressed or even considered. (e) Most counties within the study did not seek to improve understanding of citizens on health holistically and thus there was preference for curative aspects of health. (f) Most of the community engagement processes were donor-dependent and would be dropped once funding was unavailable. (g) In many instances the process was captured by a "political elite" and prioritization reflected political and power interests, often favouring decisions around curative health that could gain political mileage. The study found that while devolution addressed equity between counties, it has failed to address equity within counties and the gaps within the priority-setting process were illustrative of this (Owino, Wangong'u, Were, & Maleche, 2020).

#### ***The policy stream***

This section looks at the policy alternatives which were proposed by various actors to address the issues that were prevalent in the health sector around the time of the UHC adoption. The policy stream involves various policy proposals and alternative solutions that are considered before a certain policy direction is adopted.

In a study aimed to investigate how Health in All Policies (HiAP) rose to the agenda-setting level and its adoption in Kenya using the Kingdon framework HiAP has received the highest political commitment globally, with the various WHO secretary generals endorsing it. South Sudan, Namibia and Zambia have high political commitment for HiAP with heads of state acting as one of the policy entrepreneurs and officially committing to implementing HiAP in their countries. In Kenya, HiAP is in the policy document, but Ministers of Health after Hon. Charity Ngilu did not propagate HiAP as an agenda with the same focus and tenacity. The lack of commitment at the highest level – beyond the Ministry of Health – did not secure the HiAP approach as a political priority. Policies addressing HIV in Kenya represent a good example – once the president had declared it a national disaster, there was conscious action on it from all the other ministries. Establishing a

‘super department’ or ‘super committee’ with a HiAP strategy is essential. Currently, there is an intergovernmental committee in Kenya, called the Apex, of which all ministers and governors are members and the president is chair; this can potentially be considered a super department. A potential window of opportunity would be the budgeting process when there can be a chance to evaluate each other’s policy objectives and can be an entry point for health considerations in the various policies. County health directors and the finance departments at county level should also be able to consider HiAP in their budgeting process (Mauti, et al., 2019).

Kyama in a study of Makueni county established that strategic leadership in policy availed opportunities for strategic decisions, conflict solving, human resource management and optimal operation translating to positive health outcomes (Kyama, 2020).

In their study, Oraro & Wyss found that Kenyan stakeholders recognize UHC as a major goal in the country’s health policy and priority-setting landscape. While the robust dialogue within Kenya’s health policy circles signals intentionality to create a path towards UHC, their findings suggest that the country lacks a centralized, systematic and inclusive process through which this agenda can be driven. As a result, a highly dynamic policy environment has emerged where actors differ substantively in their interpretations of the country’s UHC values and priorities. This suggest that county and national government stakeholders prioritize short-term health maximization as their main UHC policy goal in Kenya, ostensibly due to their proximity to elected government officials. Conversely, technical experts seem to value the legitimacy of their policy decisions, pushing for objectives that, in their view, optimize technical feasibility and sustainability. Development partners, on the other hand, leverage their fiduciary obligation to funders when participating in priority-setting activities (Oraro-Lawrence & Wyss, 2020).

### ***The political stream***

It is a political victory that UHC is discussed at all, and still more so that it has any veneer of consensus. UHC is a highly political concept. In the world of global health governance, it is part of an ongoing debate about the relative importance of “vertical” priorities such as disease eradication and broader “horizontal” system-strengthening proposals. UHC is expensive and redistributive; that is enough to make it contentious. As if that were not enough, UHC also builds in additional contentious goals such as efficiency or access and medicines. It is unwise to assume that UHC goals are entrenched in the countries that have broadly achieved them, to overstate the influence of health ministries or advocates committed to UHC, or to overstate the degree of consensus among governments that have adopted them on paper. If any generalization about UHC holds, it is that democratization promotes it. Middle-income countries can broadly afford to aim for UHC, but they are most likely to enact access expansions when they have governments that are accountable to the population. The effects of widespread democratization from the 1970s to the late 1990s help to explain the expansion of UHC in middle-income countries. Democracy and partisanship do not automatically produce UHC; UHC still needs organized support and faces organized opposition. Unorganized voters are unlikely to have their preferences reflected in any political system. The complexities of organization, political coalitions, and parties, a long-standing issue in comparative politics, therefore demand attention; and part of the reason is the interaction between politics and governance (Greer & Méndez, 2015).

Findings in both Indonesia and Kenya on a study on health system governance after devolution found that nepotism was widely described, highlighting potential opportunity for change. Politicians are often motivated to provide services that will appeal to their electorate, consolidate political support and maximize their voter base in their pursuit of re-election. In both countries, the provision of health (and other services) was already politically motivated prior to devolution. This continued politicization has in some instances brought positive results towards improving access to health services, with UHC recognized as an ‘electoral asset’ in Indonesia, with popular health schemes felt to contribute towards electoral success. In Kenya several years into devolution, some politicians are beginning to appreciate the potential political benefits associated with expanding community health service. In both Indonesia and Kenya, in the absence of a clear process and adequate capacity for determining guiding values and priorities, changing power dynamics following devolution became more important, with priorities being selected in line with the degree of ‘power over’ the decision-making process and values held by key decision-making actors ( McCollum, Limato, Otiso, Theobald, & Taegtmeier, 2018).

The Kenya UHC conference in 2018 concurred that the greatest threat to healthcare governance is corruption as it undermines policy setting and implementation. To mitigate this threat it was agreed that collaboration from national and county governments, private entities, universities and other stakeholders was necessary. It was acknowledged that for healthcare leaders to be held accountable then investments in management and governance of UHC have to be done and especially to extend the capacity of health workers (Government of Makueni County, 2018).

Further Mccollum et. al study in Kenya highlighted the vital importance of strong leadership capacity following reforms, providing examples of subcounty level managers having innovated and demonstrated flexibility to ensure essential services continue, despite uncertainty during the period immediately following devolution. Capacity of local officials has widely been acknowledged as critical to the success of devolution reforms ( McCollum, Limato, Otiso, Theobald, & Taegtmeier, 2018).

***Possible notions of policy entrepreneurs and policy windows.***

A problem broker is a role in which actors frame conditions as public problems and work to make policy-makers accept these frames. Problem brokers thus define conditions as problems. One aspect is especially important in this definition – that framing a condition as a public problem is done with the purpose of making policy-makers accept it and in the end do something about it. Problem brokering is thereby a strategic act. A range of actors could play the role of problem broker, from those inside government, to those on the outside. One advantage of seeing the problem broker as a role that can be enacted is that focus is placed on what actors do rather than on who these actors are. Policy entrepreneurs define conditions as public problems a process understood as framing. All problem frames, to some extent, include elements of knowledge, values, and emotions. They incorporate some form of knowledge of what the problem is about. Further, they allude to values that tell us why we should care. Finally, they also include elements that steer emotions. The emotional element sets the tone for how the problem should be understood (Knaggård, 2015).

Policy entrepreneurs could be in or out of government, in elected or appointed positions, in interest groups or research organizations. But their defining characteristic, much as in the case of a business entrepreneur, is their willingness to invest their resources—time, energy, reputation, and sometimes money—in the hope of a future return. In any given instance of policy change, it is usually possible to locate an individual or a small team that appears to have been a driving force for action. Policy entrepreneurs can be identified by their efforts to promote significant policy change. Their motivations might be diverse (Knaggård, 2015).

Given their goal of promoting change policy entrepreneurs actions follow certain patterns; change agents must display high levels of social acuity, or perceptiveness, in understanding others and engaging in policy conversations. Policy entrepreneurs display social acuity in two key ways. First, they make good use of policy networks by promoting change through acquired relevant knowledge from elsewhere. The second way that policy entrepreneurs display social acuity is by understanding the ideas, motives, and concerns of others in their local policy context and responding effectively. Policy actors who get along well with others and who are well connected in the local policy context tend to achieve more success in securing policy change than do others.

Problem definition; problems in the policy realm invariably come with multiple attributes. How those problems get defined—or what attributes are made salient in policy discussions—can determine what individuals and groups will pay attention to them. Problem definition, then, affects how people relate specific problems to their own interests. Viewed in this way, definition of policy problems is always a political act. Effective problem definition requires the combination of social acuity with skills in conflict management and negotiation.

Building teams; Like their counterparts in business, policy entrepreneurs are team players. Individuals are often the instigators of change, but their strength does not come from the force of their ideas alone, or from their embodiment of superhuman qualities. Rather, their real strength comes through their ability to work effectively with others. The team-building activities of policy entrepreneurs can take several forms. First, it is common to find policy entrepreneurs operating within a tight-knit team composed of individuals with different knowledge and skills, who are able to offer mutual support in the pursuit of change. Second, as noted in our discussion of social acuity, policy entrepreneurs make use of their personal and professional networks—both inside and outside the jurisdictions where they seek to promote policy change. Policy entrepreneurs understand that their networks of contacts represent repositories of skill and knowledge that they can draw upon to support their initiatives. Finally, policy entrepreneurs recognize the importance of developing and working with coalitions to promote policy change.

Leading by example; Risk aversion among decision makers presents a major challenge for actors seeking to promote significant policy change. Policy entrepreneurs often take actions intended to reduce the perception of risk among decision makers. A common strategy involves engaging with others to clearly demonstrate the workability of a policy proposal. When they lead by example—taking an idea and turning it into action themselves—agents of change signal their genuine commitment to improved social outcomes. This can do a lot to win credibility with others and, hence, build momentum for change (Mintrom & Norman, 2009).

#### **IV. DISCUSSION**

The Africa Health Agenda International Conference 2021 highlighted weak governance and accountability of health systems as a huge challenge in UHC policy. The challenges include inadequate legal and policy frameworks for UHC, weak management of the political dynamics of UHC reforms, poor leadership and management of the health sector, weak multi-sectoral coordination and health priority setting, poor public-private coordination, under-prioritization of primary healthcare and quality of care, the scourge of corruption, and inadequate community engagement and accountability systems. They indicate solutions focused on political commitments to UHC need to be utilized to advocate for more investments in UHC-related reforms and for more African countries to enact UHC policies and legislations not centered on health insurance reforms alone (Africa health agenda international conference commission, 2021).

Good governance in the health sector refers to the making of pro-health legislation and frameworks for the implementation of strategic policies combined with effective regulation, monitoring, system design and social accountability. Governance shapes the likelihood that UHC will be adopted and actually implemented for three reasons. First, it is a prerequisite for some policies. Just as policies for UHC can cost too much for a given state, they can also demand a level of expertise, accountability, and good public administration that is not always available. In particular, elaborate public--private, market based, and personal insurance schemes can overwhelm the capacity to design, regulate, and operate them. Second, governance, particularly political institutions, can shape the likelihood of pro-UHC forces winning in politics. Third, governance affects the likelihood that programs will be entrenched by affording programs greater or lesser real effectiveness and greater or lesser political defenses (Greer & Méndez, 2015).

Governments can lock in UHC achievements by making the systems transparent and accountable to affected groups who will in the future be able to ward off efforts to reduce government commitments or undermine achievements. A well-crafted policy includes governance changes that promote its own political survival by biasing policymaking toward groups who defend UHC. UHC advocates should pay attention to ways they can create institutional safeguards for a right to health. "Policies create politics," after all (Greer & Méndez, 2015).

UHC2030 advocates for increasing political commitment to UHC and facilitates accountability and knowledge sharing. It frames emerging priorities, identifies bottlenecks and proposes collective recommendations to accelerate progress towards UHC. UHC2030 is a movement that fosters political will to achieve UHC and is a platform for multiple stakeholders to exchange knowledge and act collectively to strengthen health systems. UHC is an inherently political agenda, and political will is essential to secure and sustain investment in health and drive appropriate health system reforms. That's why UHC2030 aims to build political momentum around healthy systems for UHC (World Health Organization, 2018).

UHC will be sustained through fostering citizens' platforms and people's voice mechanisms. This is through the introduction of mechanisms of voice and community empowerment in health service delivery, and establish citizens' platforms to formulate and review national health policies, strategies and plans as well as priority setting and decisions on resource allocation.

To consolidate the lessons and gains on UHC there is need to promote freedom of information and expanded use of quality data. This will be by ensuring citizens' access data and information on UHC freely and adopt a core set of indicators formally to monitor UHC progress and incorporate them in national monitoring and evaluation systems.

It is also important to adopt legal frameworks supporting access to quality health services. Governments have to provide and enforce fair, transparent and effective regulatory frameworks and accreditation systems to maximize the reach, affordability and quality of health services for all.

It is crucial to develop policy dialogue platforms with a whole-of-government approach. This will allow for multi sectoral plans, mechanisms for community mobilization and co-ordination across ministries and other stakeholders, and engagement with the private sectors effectively to address health risks and promote health for multi-sectoral action.

The promotion of regional and global mechanisms for collective action and partnership is necessary to have a united front on UHC. This will include to initiate, organize and finance collective action on research, tool development, norms and standards, and mutual learning and sharing of experiences on health system strengthening across countries regardless of development status. It enables achieving UHC for all a closer reality.

UHC will require the strengthening of research and development. This will entail the delivery of relevant products with an effective interaction of R&D between public and private sectors, and strengthen regulatory systems and a skilled workforce to use technology transfer effectively including technology transfer mechanisms.

Supporting UHC requires policies and systems that respond to the voices and needs of the people and protect the human right to health. UHC is first and foremost a social contract. By prioritizing investments in



health equity, countries can foster stronger economies and more just societies (World Health Organization, 2018).

Governments may use a variety of strategies to shape organizational change that accompanies health systems reform. These include: 1. Establish a high-level interministerial team to create political commitment to UHC-related reforms as a countervailing force to bureaucratic resistance to change. Particularly in countries where an MOH may be perceived as a ministry with relatively lower power and influence, an interministerial platform, with technical guidance from the MOH, could envision the future health system and alleviate institutional barriers to organizational changes in MOH or other agencies. 2. Establish a 'change team' in the MOH responsible for translating the strategic systems-level decisions into implementable steps for internal organizational change. A change team may enable change in the domain of individuals and teams, by accessing different parts of the organization and developing a roadmap to navigate and sequence potentially disruptive changes within the bureaucratic structure. 3. Pursue legislation to modify the institutional environment to enable the changes needed in the domain of organisations. When Poland, Chile and Thailand set up third-party purchasers, legislation served to define the functions of new entities and the separation of powers from the MOH. Legislation can preserve key reform components through future political fluctuations. 4. Capitalise on political 'windows of opportunity' when political change makes it more possible to successfully introduce health reforms and accompanying organizational change. Although this is a more difficult mechanism, it is arguably more successful because comprehensive government reform packages reflect political commitment. Ideally, a change team in MOH would prepare for and identify such political windows and pursue a legislation change to underpin the health system reforms (Berman, Azhar, & Osborn, 2019).

## V. CONCLUSION

Health systems do not operate in isolation from the broader social context in which they are located. Relationships between the social protection programmes and health system actors, those within the health system and those with the population they serve, are determined and modified by the socioeconomic environment, values, social norms and standards. Understanding of the contextual factors along with a conducive health system governance and political commitment are deemed to be among the determinants of better health and the key to improve health protection performance. Good governance is explicitly mentioned in SDG 16 that points to the need to 'develop effective, accountable and inclusive institutions'. However, the relationship between governance and health is multifaceted, including broader governance environment, public policies and those specific to the health sector, and the effectiveness of institutions or organizations. Governance encompasses multiple aspects, such as systems of representation and engagement for citizens, accountability mechanisms, power and institutional authority, ownership, political stability, transparency and the rule of law. It is related to how policies are formulated and implemented and how regulation is generated and exercised, as well as to the accountability mechanisms of all stakeholders. Governance is thus related to how political, economic and administrative leadership and authority are exercised within a health system. Governance should be improved to support progress towards UHC.

There is need to create better linkages and joint governance between UHC policies, focused on access to health services and to the direct expenses incurred by citizens for purchasing these services and medical products, and systems that address the full economic consequences of ill health. In fact, the social and economic burden of ill health is often much larger than that related to high out of pocket payments for medical services and products. It includes non-medical direct expenses (for travelling, food, accommodation, etc.) incurred when accessing health services, and income losses due to unpaid sick leave, disability or restrictions to the workplace due, for instance, to the risks of transmission of infection. Health crises such as the current COVID-19 pandemic cause economic disruptions that, if not addressed, will lead to long-term increases in poverty.

Weak social protection systems make people less resilient to health shocks, less able to seek care when needed, less able to follow preventive advice and more prone to economic hardship related to healthcare use (especially long hospitalization), disability and quarantine. Poor integration (service delivery and funding streams) of health and social services (especially for the elderly) hampers implementation of pandemic/public health responses. UHC policies should, thus, be coordinated with social protection systems providing social safety nets, and coordinated governance is required across health and social sectors. This is a major challenge that requires system-wide social and health policies breaking the boundaries of traditionally fragmented welfare systems and global health programmes (Tediosi, Lönnroth, Pablos-Méndez, & Ravigione, 2020).

## REFERENCES

- [1]. Africa health agenda international conference commission. (2021). The state of universal health coverage in Africa.

- [2]. Atupem, G. (2017). Applying John Kingdon's three stream model to the policy idea of universal preschool. BSU honors program theses and projects. Item 245. Available at: [http://vc.bridgew.edu/honors\\_proj/245](http://vc.bridgew.edu/honors_proj/245), 1-13.
- [3]. Béland, D., & Howlett, M. (2016). The role and impact of the multiple-streams approach in comparative policy analysis. *Journal of comparative policy analysis: research and practice*; 18:3; DOI: 10.1080/13876988.2016.1174410, 221-227.
- [4]. Berman, P., Azhar, A., & Osborn, E. J. (2019). Towards universal health coverage:governance and organisational change in ministries of health. *BMJ Global Health* ;4:e001735. doi:10.1136/bmjgh-2019-001735, 1-7.
- [5]. Cairney, P., & Jones, M. D. (2016). Kingdon's multiple streams approach: what is the empirical impact of this universal theory? *Policy Studies Journal*, 44; doi: 10.1111/psj.12111, 37-58.
- [6]. Chow, A. (2014). Understanding policy change: multiple streams and national education curriculum policy in Hong Kong. *Journal of Public Administration and Governance* , 4; 2; doi:10.5296/jpag.v4i2.5184, 49-64.
- [7]. Gathara, P. (2021, 04 17). Devolved healthcare: Makueni's trailblazing experiment in providing universal healthcare. Retrieved from <https://www.theelephant.info/features/2018/01/11>
- [8]. Government of Kenya. (2010). Constitution of Kenya. Nairobi: Government printer.
- [9]. Government of Makueni county. (2013). First county integrated development plan 2013-2017. Wote: Government of Makueni county.
- [10]. Government of Makueni County. (2018). Conference proceedings report on universal healthcare. Meeting Kenya's universal healthcare challenge (pp. 44-45). Makueni: Government of Makueni County.
- [11]. Government of Makueni county. (2020). Universal healthcare policy. Wote: Government press.
- [12]. Greer, S. L., & Méndez, C. A. (2015). Universal Health Coverage: A Political Struggle and Governance Challenge. *American journal of Public Health* ;105,s5; doi:10.2105/AJPH.2015.302733, 637-639.
- [13]. Guldbrandsson, K., & Fossum, B. (2009). An exploration of the theoretical concepts policy windows and policy entrepreneurs at the Swedish public health arena. *Health Promotion International*, Vol24; 4;doi:10.1093/heapro/dap033, 434-444.
- [14]. Kenya Vision 2030. (2021, 03 01). Retrieved from [vision2030@go.ke](http://vision2030.go.ke): <http://vision2030.go.ke/county-governments-at-the-centre-of-achieving-universal-health-care/>
- [15]. Knaggård, Å. (2015). The Multiple Streams Framework and the Problem Broker. *International Conference on Public Policy, Milano*, 1-3 July 2015 (pp. 1-19). Milano: Lund university.
- [16]. Kyama, B. M. (2020). Adoption of quality healthcare strategies on universal healthcare at Makueni county referral hospital. Nairobi: University of nairobi.
- [17]. (2019). Makueni care brief. Nairobi: Thinkwell.global.
- [18]. Mauti, J., Gautier, L., Neve, J.-W. D., Beiersmann, C., Tosun, J., & Jahn, A. (2019). Kenya's Health in All Policies strategy: a policy analysis using Kingdon's multiple streams. *Health Research Policy and Systems* 17:15; doi.org/10.1186/s12961-019-0416-3, 1-12.
- [19]. McKee, M., Balabanova, D., Basu, S., Ricciardi, W., & Stuckler, D. (2013). Universal health coverage: a quest for all countries but under threat in some. *Elsevier; value in health*; 16; doi.org/10.1016/j.jval.2012.10.001, S39-45.
- [20]. McCollum, R., Limato, R., Otiso, L., Theobald, S., & Taegtmeier, M. (2018). Health system governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia. *BMJ Glob Health* ;3:e000939. doi:10.1136/bmjgh-2018-000939, 1-11.
- [21]. Ministry of Health. (2014). Kenya health policy 2014-2030. Nairobi: Ministry of health.
- [22]. Mintrom, M., & Norman, P. (2009). Policy Entrepreneurship and Policy Change. *The Policy Studies Journal*, 37; 4, 649-667.
- [23]. Nordling, L. (2021, 04 11). Achieving universal health coverage in Africa. Retrieved from Africa portal: <https://www.africaportal.org/features/q-achieving-universal-health-coverage-africa/>
- [24]. Okech, T. C., & Lelegwe, S. L. (2016). Analysis of Universal Health Coverage and Equity on Health Care in Kenya. *Global Journal of Health Science*; Vol. 8, No. 7; doi:10.5539/gjhs.v8n7p218, 1-10.
- [25]. Oraro-Lawrence, T., & Wyss, K. (2020). Policy levers and priority-setting in universal health coverage: a qualitative analysis of healthcare financing agenda setting in Kenya. *BMC Health Services Research* 20:182; doi.org/10.1186/s12913-020-5041-x, 1-11.
- [26]. Owino, L., Wangong'u, A., Were, N., & Maleche, A. (2020). The missing link in Kenya's universal health coverage experiment: a preventive and promotive approach to SRHR. *Sexual and Reproductive Health Matters*, 28:2, 1851347, DOI:10.1080/26410397.2020.1851347, 89-105.
- [27]. Tediosi, F., Lönnroth, K., Pablos-Méndez, A., & Raviglione, M. (2020). Build back stronger universal health coverage systems after the COVID-19 pandemic: the need for better governance and linkage with universal social protection. *BMJ Global Health* ;5:e004020. doi:10.1136/bmjgh-2020-004020, 1-4.

- [28]. Union for international cancer control. (2021, 04 11). Retrieved from Kicking off UHC in Kenya; building a people-centred health system: <https://www.uicc.org/case-studies/kicking-uhc-kenya>
- [29]. World Health Organization. (2018). Universal health coverage advocacy guide. New york: WHO.
- [30]. World health organization. (2021, 04 11). Retrieved from Keeping to the universal health coverage path in Kenya: <https://www.afro.who.int/news/keeping-universal-health-coverage-path-kenya>

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