THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC)

by

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APPROVAL

THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC)

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THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC)

I declare that this is my original work and has not been submitted to any other college or university for academic credit.

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<tr>
<td>KHSSP</td>
<td>Kenya Health Sector Strategic and Investment Plan</td>
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<tr>
<td>MOMS</td>
<td>Ministry of Medical Services</td>
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<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<td>MPPM</td>
<td>Makueni Public Participation Model</td>
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<td>MUHC</td>
<td>Makueni Universal Health Care</td>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<td>PC</td>
<td>Participatory Communication</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>SPHC</td>
<td>Selective Primary Health Care (SPHC)</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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ABSTRACT

The purpose of this study was to establish the effectiveness of participatory communication (PC) on the implementation of Makueni Universal Health Care (MUHC) program. Its objectives were to find out the PC avenues used in the implementation of the MUHC program, determine the level of PC used, and to establish how PC influenced the uptake MUHC. The study adopted a descriptive research design and its target population comprised the Makueni County development committee members. Purposive sampling technique was used to select a sample size of 100 respondents. Questionnaire, in-depth interview, and focus group discussions were used in data collection and the collected data was analyzed quantitatively and qualitatively using the statistical package for social sciences (SPSS) and thematic analysis approach respectively. The study found that all stakeholders had an equal opportunity in MUHC implementation since most of the categories of people were involved. Also, the study established that the Makueni County government dialogued with stakeholders during the MUHC implementation processes, although power to make final decisions was held by the government but the citizens aired their views. The study further found that PC had influenced the uptake of MUHC program, where 22(95.7%) of the development committee members asserted that it motivated the residents to register in the program. The study concluded that PC was not effective in the implementation of MUHC. The study recommends that PC structures should be strengthened and increased to empowerment level so as to make MUHC more effective to the people of Makueni.
CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

Participatory Communication (PC) can be defined as a model used by various development partners to share opinions and ideas geared towards empowering their lives and societies (Thomas & Mefalopulos, 2009). PC is not only sharing of opinions and information, but can also be an investigation and generation of original solutions to tackle conditions that require improvement in the society. PC tends to be associated with community-driven development, but it could be used at any level of decision making (local, national, international) regardless of the diversity of groups involved (Srampickal, 2006).

There is strong evidence and agreement that populations must be actively engaged in improving their well-being (World Health Organization (WHO), 2014). According to Draper, Hewitt, and Rifkin (2010), engaging the masses is believed to be integral in advancing health services delivery, equity as well as uptake, and has been, many times, endorsed in global charters and discussions (WHO, 2010; WHO, 2014). PC has been applied in several initiatives including Women, Healthy Lifestyles and Community Empowerment at Peru in 1998-2007 (Molyneux & Thomson, 2011). Minga Peru was established in 1998 as a non-profit, community-based organization working in Peru to solve problems of injustices in the society, gender impartiality, reproductive health issues as well as human rights.

Minga Peru initiative emphasized one-way methods in transmitting as well as disseminating significant information to the people, drawing on participating production
activities of radio program designing (Thomas & Mefalopulos, 2009). The Peru initiative resulted to women empowerment. The women became more confident and started to voice out their opinions and views in the public domain in matters of health. Further, the initiative led to better health care services and extensive and inclusive approach to health issues in the area.

In India, the National Center for Promotion of Employment for Disabled People (NCPEDP) successfully applied participatory communication strategies to pursue the rights of disabled people in 2006 (Hiranandani & Sonpal, 2010). NCPEDP applied ‘dharna’, an ancient culture in India of social mobilization. This form of social mobilization developed was very inclusive, open and participatory. The center sought to implement the plan (2007-2012 in the parliament that was to guide the country’s policy on disability. The outcome was impressive, and sense of ownership among advocates of persons with disability rights improved (Obregón & Waisbord, 2010).

Participatory communication was first incorporated in Makueni County in 2013 (Omolo, Macphail, & Wanjiru, 2018). It was first used during participatory budgeting process for 2013-2014 financial year, then it was integrated during the piloting phase of Makueni Universal Health care (MUHC) with the elderly persons of Makueni County (government of Makueni (GMC), 2018). Later on, MUHC was rebranded to MakueniCare which now covers every household that is registered.

According to Gathara (2018), Makueni County became a model to other counties since it is where PC was first incorporated in the implementation of MUHC, covering over 93% of health care needs in Makueni. Gathara further indicated that since it was initiated in September 2016, MakueniCare has adopted the principles of PC including dialogue
through public engagement. Additionally, a GMC (2018) study showed that Makueni County takes credit for involving her residents in adopting Makueni Care. The county claimed to have used consistent and indiscriminate dialogue and public engagement forums.

Although there is evidence to show that PC has benefits, Marston, Renedo, McGowan, and Portela (2013) observed that there is need to examine the activities, that is, avenues of PC as well as the extent or level of participation in interventions. They suggest that examination of both the avenues and extent of PC could probably provide the unavailable information on what makes PC interventions successful or unsuccessful.

**Background to the Study**

World Health Organization [WHO] (2019) defined universal health coverage (UHC) as a means where all people and communities around the world 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 them to financial hardship and strain. UHC overarching objective is the provision of equitable and quality health care services that are accessible to everyone.

The wellbeing of a population plays a key role in reducing levels of poverty making UHC one of the sustainable development goals (Freeman et al., 2016). In fact, health has been a fundamental concern of human beings throughout the history. Therefore, it should not be a shock that UHC has become a focal point of interest in most countries around the world, even to the ones that are still struggling to provide proper and affordable health care services to its citizens like Kenya (Sen, 2015).
On the other hand, openness and transparency centrally defines the processes, mediums and commitment a government chooses as the basis of how it shares information with its citizens (Molaodi, 2016). This process requires participatory communication which dictates that democracy should necessitate citizen participation (public participation), involvement and meaningful engagement such that a government is able to lay bare its operational activities for open scrutiny by the public (Gurría, 2018). At a global level, Article 4 of Alma-Ata declaration in 1978 portends that it is the right and responsibility of every person and communities to be engaged in matters concerning their well-being (Rifkin, 2003).

In Kenya, the promulgation of the 2010 constitution brought different ways of handling administrative and political operations. Some of the changes include devolution of healthcare (Wambua, 2014). According to Williamson and Mulaki (2015), devolution refers to the transfer of power and responsibilities from central government to lower level units for different variety of public functions which also encompass health care services. Decision making bodics were decentralized to the counties to make services easily accessible by local people, ease the process of making decisions and improve health services provision to Kenyans (Okech & Lelegwe, 2016).

Article 174c of the 2010 Kenyan constitution mandates that public participation is required for policy and legislative development initiatives. County governments are required to create mechanisms of engagements and coordinating the participation of communities and locations in governance (Ministry of Devolution and Planning & Council of Governors, 2016).
Vision 2030 and Health Bill of 2015 are among reports that acknowledged high standards of life is a strong foundation towards Kenya being one of the successful and competitive nations around the globe. These reports and concerns behooved the government to establish a legal model that ensures health care delivery system is participatory and easily accessible through devolution system of governance (GoK, 2010).

The Makueni Public Participation Model (MPPM)

According to Akindeke and Oluwadare (2012), PC should make use of appropriate structures and institutions to help citizens to articulate their issues, raise concerns, identify needs and come up with friendly solutions to meet those needs and concerns. Makueni county government has invested heavily in modeling participatory development processes using Participatory Rural Appraisal (PRA) tools and methods to facilitate people centered development, since financial year 2013/2014 (GMC, 2018).

The county-initiated PC model in during the preparation of budget (FY2013/14) and County Integrated Development Plan (CIDP) 2013-2017 (GMC, 2018). At the same, it also developed a public participation framework that has been adopted in the county planning, budgeting, project management, development and community reviews, civic education and vetting of county officers. The MPPM is a six-tier process which begins at the villages levels where 3,740 units convene meetings while at the top is the county forum as shown in the Figure 1.1.
Under the model, the county government and the community work in harmony to identify and implement projects. Periodic analysis and review are equally undertaken according to GMC (2018) through joint initiatives whose feedback is provided immediately.

Makueni Universal Health Care (MUHC)

The MUHC was launched in September 2016 where Governor Kivutha Kibwana announced that all residents were going to access free medical health services from facilities within the county (Gathara, 2018). Dr. Mulwa, the Executive Member for Health care services, announced during the launch that all bills incurred by patients shall be paid
by the county government and that all citizens of Makueni are eligible beneficiaries of the fund upon undergoing a registration process (Maundu, 2016).

At the launch, the process that involves registration of the principal beneficiary, their spouse(s) and direct dependents below the age of 18 and 24 for school going dependents was established. Makueni County residents were required to register annually at fee of Sh 500 which was to be paid to cover all members of a nuclear family. The plan covers most of the services offered within the county’s public health services. These include laboratory and radiological investigations, consultation services for in and outpatient services, theatre services, some specialized services including cancer screening, medical drugs, nutrition services, ambulance referral services, rehabilitative services like physiotherapy and mental services, dental services, family planning services. The program also covers mortuary fees for a period of up to ten days (Gathara, 2018).

The MUHC program was a scale up of the existing free healthcare program for the elderly citizens over 65 years in Makueni County. The equivalent for this cohort (the elderly) according to ministry of health was estimated to be 77,000 (Muasya, 2018). This category of people accounted for 50% of hospital visits (WHO, 2010). This, therefore, provided a suitable sample to test reliance of a health system. Since the inception of the program, the county has been able to register more than 78,000 households across the county by June 2018 (Gathara, 2018).
Overview of Makueni County

The county, one of the forty-seven in the country is located in the South Eastern side of Kenya, and lies on area of 8,000.7 square Kilometres (GMC, 2018). Makueni is basically dry characterized by droughts. It has six regions known as Makueni, Mbooni, Kibwezi East, Kibwezi West, Kaiti and Kilome usually referred as sub-counties. These regions additionally are divided into 30 wards and 60 sub-wards. (GMC, 2018).

According to the Kenya National Bureau of Statistics (KNBS), 2019), the population of Makueni County was 987,653, where 489,691 were males and 497,942 were females. Makueni County has a total of 333 health facilities compared to 221 at the start of devolution in 2013. Of these facilities, 235 (70%) are government owned. In-patient services are mainly in the sub-county hospitals with the level 3 and below providing the primary health care (PHC) services for free (GMC, 2018). The doctor-patient ratio in Makueni County is 1:25,436 while the nurses is 1:1779. The usual distance to the nearby health facility was 9 kilometers in 2013, but reduced to less than five kilometres in 2017 (GMC, 2018).

Statement of the Problem

There is a strong evidence and agreement that populations must be actively involved in improving their well-being (WHO, 2014). According to Draper, Hewitt, and Rifkin (2010), engaging the masses is believed to be integral in advancing health services delivery, equity as well as uptake, and has been, many times, endorsed in global charters and discussions (WHO, 2010; WHO, 2015).

Although there is an apparent agreement on the significance of PC, Marston, Renedo, McGowan, and Portela, (2013) observed that there is need to examine the avenues
of PC as well as the level of participation in interventions. They suggest that this could probably provide the unavailable information on what makes PC interventions effective or not.

Makueni County has been hailed by a number of studies including Omolo, Macphail, and Wanjiru (2018) as a PC model used in the implementation of UHC, covering over 93 per cent of the health needs of the county. The authors further noted that MUHC has adopted PC since its inception in September, 2016. Although the aforementioned shows that Makueni has incorporated PC in the implementation of MUHC, the county does not profile the avenues as well as the extent to which the people were involved to make the program a reality (Gathara, 2018). His findings show that MUHC has experienced very low uptake raising the question of the relationship of PC and uptake of the MUHC.

Therefore, this study sought to find out the effectiveness of PC used by Makueni county to roll out its universal health cover program on the residents. This could shed light on what contributes to the success or failure of a PC intervention as argued by Marston et al. (2013).

Purpose of the Study

The purpose of this study was to establish the effectiveness of PC on the implementation of Makueni Universal Health Care (MUHC) program.

Objectives of the Study

1. To find out the PC avenues used in the implementation of Makueni UHC program.
2. To determine the level of PC used in the implementation of MUHC program.

3. To establish how PC had influenced the uptake of MUHC program.

Research Questions

1. What were the PC avenues used by Makueni to implement its universal health care program?

2. What level of PC was used in the implementation of MUHC program?

3. How had PC influenced the uptake of MUHC program?

Justification for the Study

In the field of healthcare, equity and participatory approaches have progressively recognized as integral for health development (Rifkin, 2003). However, Halabi (2009) observed that though the element of health has been comprehensively advanced, the right to involvement as one of its mechanisms has continued to be basically unexplored.

Sen (2015) argued that though efforts to attempt universal health care fail due to poverty, he says that through adoption of social cohesion and people-centered policies, Rwanda was able to actualize a universal health coverage, making it the highest country with Community Based Health Insurance (CBHI) enrollment in the Sub-Saharan Africa (Chemouni, 2018). In Australia, Freeman et al. (2016) sought to investigate the case of an Aboriginal people-centered health cover. It revealed that the model was a favorable method to achieve the goal of universal cover.

This research therefore investigated the effectiveness of PC on the implementation of MUHC by finding out the avenues used as well as the extent to which PC was
incorporated. The findings could inform other devolved units how they can use public participation to avail affordable and effective health services closer to their constituents.

Significance of the Study

This study might be used as a subject of reference by different scholars for other studies or for identification of gaps to commission further studies. The study would be crucial to government legislators whom it may assist to come up with policies that support public participation towards implementation of universal health coverage. It could also provide crucial information to other counties and the country towards achieving the agenda of the universal health care.

The findings of the study could be used by Makueni County to strengthen and sustain its UHC program in the perspective of public participation. Finally, the study findings could be useful in creating awareness to the general public on the importance of UHC as enshrined in the Kenyan Constitution; as well as on their rights of participation in devolved programs.

Assumptions of the Study

This study assumed that the research assistants, who also worked as translators in bridging the language barrier were accurate and objective. The study also assumed that the respondents were honest in providing the information for the study.

Scope of the Study

This study specifically focused on Makueni County which had implemented a universal health care program to its people through a people-centered approach. The study
also focused on the Makueni Development Committee members who were the avenues of public participatory model in the county.

Limitations and Delimitations of the Study

The researcher is an employee of the county Government of Makueni that is rolling out the health care plan. Consequently, Adler and Adler (1987) warned that researchers might struggle with role conflict by being trapped between “loyalty tugs” and “behavioral claims” (Brannick & Coghan, 2007, p. 70). However, the researcher used research assistants to obtain objective and honest answers.

The research was limited to Makueni development committee members only and not the entire population of the county. To delimit this, the development committee members are usually selected through election by the residents following set requirements by the county government. As such, the committees were composed of males and females, the old and the young, faith-based leaders, professionals as well as people living with disabilities. This makes them to be a representation of the people. By interviewing them, the data collected represented the views of the residents.

Definition of Key Terms

Household: Include individuals living in shared habitation and sharing common facilities. In this study, everyone in a nuclear family is targeted (World Bank, 2014). In this study, household includes father, mother, and children.

Participatory communication (PC): According to Thomas and Mefalopoulos (2009), PC is an approach based on dialogue, which permits people (stakeholders) to share
information, perceptions, and ideas and thereby facilitates their empowerment. According to this study, PC is the process of involving the residents and their representatives to enable them to give out their concerns on how the UHC program should be operated.

Public participation: This refers to any process that directly engages the public in decision-making and gives full consideration to public input in making that decision (Wiggins et al., 2013). In this study, public participation is a constituent of participatory communication which is mostly used during public engagement forums in Makueni County.

Social Protection (SP): These are measures put in place to protect people from becoming trapped in poverty, to empower them to seize opportunities, to help workers to adjust to changes and to deal with unemployment and thus support productivity (United Nations, 2018). In this study, SP are policies employed by the government to mitigate extreme cases of poverty and healthcare risks among the vulnerable groups in the society.

Universal Health Care (UHC) is testimony to the continuing high-level political commitment to achievement of global health goals, an achievement that has the potential to transform health systems, especially for the poorest people (O'Connell, Rasanathan, & Chopra, 2014). In this study, UHC means that all individuals and communities registered under the MUHC program should receive the health services they need without suffering financial hardship.

Summary

This chapter has introduced the research topic of this study and given the background of participatory communication. It has explained the UHC situation in Kenya and then given an outline of the location of the study. The chapter has also explained the
purpose of the study, objectives of the study, the significance, scope, and assumptions of
the study. The chapter has further provided the limitations and delimitations of the study
and defined key terms.

CHAPTER TWO
LITERATURE REVIEW

Introduction

This chapter presents the theoretical framework comprising of theories on which
this study was grounded. The theories include the participatory communication and
stakeholder theories. The chapter also reviews the general literature on participatory
communication and universal healthcare followed by the empirical literature that is
relevant to participatory communication and the universal healthcare. In addition, the
conceptual framework illustrating the relationship between the key variables of this study
is presented in this chapter.

Theoretical Framework

Participatory Communication (PC) Theory

In the 1970s, scholars from Latin America began deconstructing the dominant
paradigm of communication for development and pointing to new directions for research
(Claridge, 2004). They began by examining the assertions that development efforts were
ideologically and materially related to neo-colonialism and the extension of capitalist
relations. This led to the development of participatory communication theory where
alternative directions for development efforts - including notions of praxis, dialogue, and communication process were introduced (Claridge, 2004). Among the reasons that led to this theory development is the acknowledgement of the importance of participation that grew out of the recognition that the worlds’ poorest have actually suffered as a result of development, and that everyone needs to be involved in development decisions, implementation and benefits (Claridge, 2004).

Consequently, the PC theory sought to involve people in the decision-making of the development process. It was intended to make communication something common through sharing meanings, perceptions, worldviews or knowledge in a community. In terms of its overall thrust, this theory takes an interactive and participatory approach and stresses the interrelationships that exist in practice among the main lines of action. Communication at the grassroots level, the exchange of information, two-way media, and non-formal education (Mefalopulos, 2008) are all forms of participatory communication approach.

Critiques of Participatory Communication Theory

Hardianto (2013) observed that the participatory method was mainly used in majority of development activities due to a myriad of strengths. Freire (1997) stated that these strengths can be crucial basis in people’s empowerment and growth. However, Waisbord (2001) and Hardianto (2013) noted that the model has received a number of criticisms. First, local people’s willingness to participate in activities with enthusiasm is considered to be one of the hitches. In some way, people are unwilling to take part in the activities that they have no specific concern or which are likely not to benefit them directly (Hardianto, 2013).
Furthermore, Waisbord (2001) noted that the model was not clear if communities needed to be involved for specific results to be achieved. Besides, Leeuwis (2000) added that the unavailability, among other resources, proficient scientific knowledge and access to socio-economic capitals, which they can use to raise and challenge certain rational prerogatives concerning truth, normative relevance and reality. This results to difficulty in influencing or inspiring knowledge production procedures.

Cooke and Kothari (2001) identified another challenge of the participatory model that it neglects the functions of group dynamics in a society, while Waisbord (2001) observed that it may favour the powerful and active members of the community and give them more participation opportunities at the expense of the entire community or the marginalized. This way, he further explains that it results in division, misunderstanding and distraction that do not to provide solutions to problems. However, advocates of participatory models admitted that conflicts and divisions could result. Waisbord (2001) proposed negotiation and resolution skills rather than choosing interventions that deprive people of their power in the name of building consensus.

Mosse (2001) as cited in Mubita, Libati, and Mulonda (2017) claimed that participation has lost the drastic meaning it had. This was echoed by studies by Cornwall (2007) and Leal (2007) which indicated that participation is tasteless with no meaning hence the desired results may not be achieved. Moreover, Mubita et al. (2017) in their study which sought to discuss the significance and challenges of engaging communities in empowerment programs concluded that participatory communication model has its weaknesses and strengths. However, PC must be considered as a platform that gives the
locals a voice on matters that concern them. They therefore urge that involvement needs to be part of inclusive development plan.

Application of Participatory Communication Theory to this Study

The PC theory was integrated in this study to establish how Makueni residents had been involved in the implementation of the Makueni UHC program. Kloppers and Fourie (2018) outlined the principles of participatory communication including participation, dialogue and cultural sensitivity that must be applied in any public participation initiatives. On the other hand, the 2010 Constitution of Kenya under Article 174c stipulates that measures should be taken to ensure public participation is done before any development initiatives is done. Members of the public must be incorporated to voice their views throughout the design, implementation and assessment of development agendas (including social protection policies like UHC) that directly affects them - to promote accountability, transparency and ownership of such initiatives.

Figure 2.1: Participatory Communication Model
Source: Claridge (2004)

Stakeholder Theory
Freeman (2010) posited that the stakeholder theory was first proposed in 1963 during the internal memorandum at the Standard Research Institute where stakeholders were defined as sets of individuals who support an organization into existence, meaning, and once their support stops the organization ceases to exist. This theory underwent more development by Edward Freeman in 1980 that further defined stakeholders as individuals, groups, or organizations that have entered into a contractual agreement based on ethical, financial, or political interest or stake to support the existence of an organization.

The stakeholder theory focuses on the relationship between an organization and other people in its internal and external environment. It moves further to examine how these links influence how a firm conducts its operations (Friedman, 2006). It defines what managers should do and how they ought to respond to the interests and claims of stakeholders in a proper way. The stakeholder theory focuses on two important questions; the purpose of the organization and the duty of the leaders.

First, the questioning of the purpose of the firm encourages organizational leaders to outline the values they create and share and give elements that bring their stakeholders together (Freeman, 2010). These elements drive the firm forward and allow it to produce great results, which are determined by its goals and its value in the marketplace. Secondly, questioning on the duty of leaders to stakeholders pushes the leaders to analyze how they intend to conduct business and the kinds of relationships they intend to create with their stakeholders to meet on their purpose (Freeman, 2010). Leaders need to cultivate relationships that motivate their stakeholders by creating an enabling environment such that everyone tries to give their best to meet the values of the firm. It is by managing these relationships effectively that firms will survive for long and perform better than firms that
do not manage their relationships. Shareholders are a key component and profits are important in this activity.

However, profit making is the outcome rather than the catalyst in value creation. According to this theory, stakeholders can come from the inside or outside of a firm. Stakeholders in the community include the government, chiefs, village elders, hospitals, dispensaries, doctors, nurses, pharmaceutical industries, health insurance programs, medical unions, local health authorities and the public (Freeman, 2010). As much as the stakeholder theory emphasizes on knowledge of stakeholders and making them a top priority and identifying the groups of people aligned to an organization, it does not provide a concrete basis for identifying who qualifies to be termed as a stakeholder in an organization. The concept of a stakeholder tends to vary, and it may not only include persons but also non-persons of which some may not have a direct relationship with the organization (Key, 1999).

A Critique of the Stakeholder Theory

The theory does not guide the directors on how to determine which group of stakeholders is more important than others. However, because of lack of clear guidance under the theory it is a challenge for directors to identify which stakeholders have a greater significance than the others (Key, 1999). However, Blattberg (2004) recommended conversation among stakeholders as way of solving conflicts among their various interests.

Stakeholder theory is applicable in the communication practice in that it provides a theoretical grounding for public relations practitioners to expand their understanding of how individuals, groups and external organizations impact their organizations. It seeks to identify and manage the diverse needs, values and interests of various stakeholders and the
potential communication tension between the groups (Freeman, 2010). The stakeholder theory was therefore applicable to my study because it supported the PC theory. This is because it moved further to identify the stakeholders who are a key aspect in Makueni and described their purpose and responsibility to the community. The stakeholders in the context of the study were to be understood because they formed a key population in the community. The stakeholders included the county government, opinion leaders, and the public.
General Literature Review
The Concept of Participatory Communication

Communication

Matteoli (2016) stated that communication is fundamental in participatory approaches. For stakeholders to be consulted and involved in development project decisions and processes, development experts must communicate with the affected parties. However, the author further argues that it is not possible to provide a specific plan on how communication should take place since it differs significantly for every development initiative, program or the purpose in which communication is set to achieve.

Moemeka (1994) observed that communication plays two roles in the development context. They include the transformation role which causes social change to improve the quality of life and the socialization role which upholds the ideologies within society that are harmonious with development. According to Moemeka, these roles work simultaneously. Matteoli (2016) further stated that communication should be multi-directional, inclusive, context- and content-oriented in order to enable participation. Besides communication, Ramirez and Quarry (2004) outlined other essential factors that facilitate participation. They include; creating institutional capacity, balancing of power relationships, ensuring fair processes and facilitating effective negotiation with a reliable and unbiased convener.

History of PC Model

PC model came about as a result of limitations associated with the way communication was used during the modern theory. In the new era, this model is seen as
different approach on development communication. The methodology indicates that involvement of people to actualize development is through downward communication. It stresses on higher comprehension of ideas and views to defeat labelled thoughts by giving respect to counterpart’s attitudes and embrace self-independence (Servaes, Jacobson & White, 1996). In 1970, Paolo Freire brought up the ideas of dialogue and United Nations Education, Scientific, and Cultural Organization’s (UNESCO’s) community engagement and self-management as models of participation. He recognized dialogue as a medium of information flow instead of emphasizing media like TV and radio, while UNESCO outlined participation, access and self-management as three major principles of PC. These features pinpoint availability of mass media to satisfy community needs in diverse services.

Servaes and Malikhao (2005) postulated that in the recent times, participatory model has been employed to give citizens control through reasoning and their values to alter and improve different areas of the community’s lives such as education, health and governance. Further, the authors emphasized that PC has been employed to boost development through exploring a people’s values and resources, informing and sensitizing them to be integral in causing change in the community.

Strengths of Participatory Communication

Cadiz (2005) pointed out that participatory model has a number of advantages that can be a basis of community’s empowerment. First, it stresses impartiality between the development stakeholders and change agents. Servaes et al. (1996) compared this with learner-teacher scenario where both are sources of information and knowledge. Secondly, PC enables vertical as well as horizontal flow of information. Vertically, the
communication process starts from the development agencies while horizontal aspect of PC enables partners to be equals and learn from each other (Kasongo, 1998).

Problem-posing is another advantage associated with use of PC. This concept focuses on the challenge rather than focusing on the solutions. Oakley and Clayton (2000) argued that this strength helps in individual examination and analysis of the problem. According to Oakley, self-examination arises from their interpretations about the condition surrounded by exploring the drawbacks and the importance of the issues.

Principles of Participatory Communication

Although there are other principles/tenets of participatory approaches from different authors’ point of view, this study adopted two main principles of the participatory approach as highlighted by Kloppers and Fourie (2018). They include dialogue and participation.

Dialogue

Dialogue is appreciated as the foundation of participatory communication and therefore its importance cannot be overlooked in the development and empowerment contexts (Kloppers & Fourie, 2018). Further, Ting-Toomey and Dorjee (2018) noted that in dialogue, all persons or groups involved must be heard equally without any of them controlling the process of communication. Therefore, mutual respect and listening are key component so as to dialogue meaningful to both parties. The parties involved in dialogue require to both understand the context of development as well as each other as stakeholders (Baumeister, Maranges, & Vohs, 2018).

Participation
Mubita et al. (2017) and Matteoli (2016) noted that the concept of participation is hard to define and implement because it has various meaning to people depending on the set up. This is due to its numerous sources and that it occurs at different levels and stages within development projects and programs. However, there seems to be an agreement among various scholars and organisations that participation is simply involvement (Mubita et al., 2017). It is about the poor being part of information sharing and being part of decision making in the outcome interventions. According to Matteoli (2016), true and efficient participation should be guided by principles of accountability and transparency such that all stakeholders participate freely and at all levels, embracing diversity to promote volunteerism and creation of ideas and solutions among stakeholders.

Mubita et al. (2017) argued that the masses should be fully engaged for participation benefits to be realized achieved. According to the Makueni Universal Health care program manual, the required preparatory activities for the project implementation included county and community sensitization, formation of local committees and resident’s identification process. This was to be followed by verification of national identity cards, marital status and residency details (GMC, 2018).

Levels of Public Participation

According to Arnstein (1969), public or citizen participation is anchored on tree-like ranking that doesn’t necessary mean advancement from one level to the next. These levels of public or citizen participation include information, consultation, involvement, collaboration, and empowerment. These levels are discussed here below.

Information
In view of public participation, knowledgeable citizenry forms the basis of programs or projects, hence preventing public conflicts. Here, the citizens are only given information so as to understand the project or decision arrived at. It is a one-way communication and as such, this level does not provide them with power to participate at all. According to Bothwell (2019), the people have not power to influence the results of a process but are rather manipulated to believe that they took apart in the process while the official decision carries the day. Therefore, the aim and the promise is to keep an informed public (Connor, 1985; Bothwell, 2019).

Consultation

This level of participation is the lowest point in which the people contribute to a decision (Lake, 1980). In simplest terms, it translates to asking. Bothwell (2019) noted that the marginalized are given the opportunity to air their views which eventually are not considered. Arnstein (1969) concluded that a lot of consultation happens here but the development agency has an already predetermined outcome. As observed by Bothwell (2019), consultation can happen through meetings, barazas, or surveys. It is a limited kind of participation which Arnstein (1969) refers to as window dressing.

Involvement

Besides consultation, the citizens in this level are included in the process (International Association for Public Participation ((IAPP), 2016). Further, they participate from the initial stage and are provided with various ways for their input as the process of decision-making advances. However, Bothwell (2019) observed that the largest chunk of power still held by the decision makers who are external forces. Therefore, the level of influence over the final decision is still low by the community.
Collaboration

This entails all levels of engagement, where the decision makers and the community work together (IAPP, 2016). Therefore, the citizens are involved openly in the process of making decisions. Bothwell (2019) added that at this level, partners frequently endeavor to have consensual solutions. However, he further says that the level of consensus to be sought and the degree of decision sharing must be made open. In the end, the agency will take all of the input received and make the decision. The aim of this level is to come up with a plan that permits operational partnership with the people on all phases of the final decision (Poppe, Weigelhofer, & Winkler, 2018).

Empowerment

Poppe et al. (2018) described empowerment as one of the highest levels of participation where the public has the full power to make decisions and sometimes implement programs. According to Bothwell (2019), the communities are in full control of their resources. The government agency implements what the people decide. However, Connor (1985) argued that there is no paramount plan to implement PC and that several methods can be used at the same time to meet the needs of a particular situation. This was echoed by Abelson and Gauvin (2006) who observed that participation is context-dependent in nature and therefore cannot be completely prescribed adding that a different form of participation may be applicable in every situation. Reed (2008) also added that no specific ‘tool-kit’ is applicable on how to apply participation in development context.

According to Reed (2008), it is recommended that participation with all relevant stakeholders starts at the early stages of a development activity so as to yield effective and sustainable decisions. This therefore means that the locals need to be incorporated at the
planning stage of a development intervention for participation to bear the intended results because here goals are determined. Benoliel and Somech (2010) and Bobekova (2015) noted that the level of stakeholder engagement is one of the key determinants of how effective participatory process in empowerment context. Therefore, the early the stakeholders are engaged, the better the results of the participatory process. However, Reed (2008) advised that stakeholder participation should be sustained throughout the stages of an intervention including the evaluation stage.

Participation and Uptake of Health Interventions

There is no doubt that participation has been viewed as greatly important in health intervention and improving outcomes (Weger, 2018; Rifkin, 2014). However, Rifkin (2014) further observed that the indicators that directly relates community involvement and improved health outcomes is weak. She adds that in situation-specific interventions, participation process can lead to public uptake, ownership of programs as well as sustainability. According to Weger (2018), desired outcomes from peoples’ engagement can be realized if the processes employed are involving, available and give voice to the locals. These can be achieved if the people are engaged early and power imbalances recognized and solved.

Cyril et al. (2015) suggested that participatory models can lead to better health and behaviors among the underprivileged residents. However, they emphasize on the process to be consultative and involving. Steyn et al. (2016) carried a review on participatory models involving the locals and healthcare providers in family planning in providing information and services. They analyzed 28 specific programs and a number of FP programs showed
increase in knowledge and uptake. However, absence of strong monitoring and evaluation mechanisms caused challenges in making candid recommendations.
Universal Health Care

Universal Health Care (UHC) is a system in which everyone in a society can get or seek the healthcare services they need without any financial hardship. This means that everyone in the population has unlimited and affordable access to appropriate promotive, preventive, curative and rehabilitative health care (Okech & Lelegwe, 2016). Universal health care thus implies equity of access and financial risk protection. It’s also based on the premise of equity in financing and therefore people contribute on their ability to pay rather than them being unable to pay. UHC involves evaluations about who the potential recipients are, the range of services to be offered and the quality of care they will receive (WHO, 2010).

The principles that guide the formation of a successful UHC include being universal and social solidarity. In this case, universality refers to the given right to access health services and have financial protection from the costs of the services bearing in mind that all services should have the same entitlements in relation to the quality of health services. The second principle which is social solidarity refers to the common responsibilities and interests within a given society United Nations Development Program (UNDP, 2009). In the context of healthcare, it relates to the need for cross subsidies in the overall health system through having both income cross subsidies from the haves to the marginalized where an individual contributes to financing the health services based on his or her ability to pay. It also means the need for risk cross-subsidies whereby individuals benefit from health services based on their need for services. The universal health coverage is illustrated in Figure 2.2.
Universal Health coverage brings the hope of better health and protection from poverty for hundreds of millions of people, especially those in the most vulnerable situations. Universal health coverage is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda as stipulated in the Alma-Ata declaration of 1978. There are four key elements that are identified by World Health Organization (WHO) which are key towards the realization of universal coverage. First is the need for a strong, efficient, well-run health system; secondly, a system for financing health services; thirdly, access to essential medicines and technologies; and finally, enough capacity of well-trained, motivated health workers (WHO, 2010).
History of Universal Health Care

UHC is about all people being able to access quality health services they need without exposure to financing hardships or burdens (Okech & Lelegwe, 2016). Therefore, everyone should be protected from the risk of financial implications that are associated with using health services. There are four key components to achieving UHC. They include financing, human resources, equipment, and infrastructure, capitalizing on synergies between sectors and involving all stakeholders and good governance.

Universal Health coverage can be traced from the 1978 Alma Ata declaration where member states unanimously agreed on the need through primary health care protect and promote health for all. Medcalf, Bhattacharya, Momen, Saavedra, & Jones (2015) narrated the journey towards achieving UHC. One year after the Alma Ata conference, its key message received resistance with many clients saying it was too expensive and impracticable. These disagreements caused divisions among earlier partners and officials within the international organizations. As a result, the United Nations Children’s Fund (UNICEF) developed a new approach called Selective Primary Health Care (SPHC) that concentrated on what seemed as smaller and more achievable activities. This strategy received support for being more quantifiable, quick and less risky compared to primary healthcare (PHC). However, SPHC did go through without resistance. PHC supporters criticized some aspects of SPHC that they threatened equitable access associated with PHC. They argued that it depended heavily on the use of technology; it was not people-centered thus lacking involvement of the people.

There was lengthy discussion in the global health between comprehensive, people-centered approach, top down, horizontal and vertical health interventions in the 1980s and
1990s. There has been a change from 2000 to integrate the strengths of the two approaches and employ selective initiatives to slowly provide more comprehensive care. The obligation to UHC now echoes this new agreement.

Thailand achieved UHC in 2002 using three public health insurance schemes to cover the entire population (Tangcharoensathien, Suphanchaimat, Thammatacharee & Patcharanarumol, 2012). However, Cotlear, Somil, Owen, Ajay, and Rafael (2015) while describing the experiences of 24 developing countries that used the bottom-up approach in UHC implementation argued that there are no specific paths towards achieving UHC. Cotlear et al. also argued that bottom-up approach is viable for developing countries that are willing to achieve UHC. This approach focuses on the poor and vulnerable then expanding to the other sub populations in a country.

Kenya is dedicated to achieving UHC by 2022 with some attempts having been made towards the same (Barasa, Rogo, Mwaura, & Chuma, 2018). This quest is envisaged in the big four agenda where health care to all is a priority (KEMRI, 2019). The government chose National Hospital Insurance Fund (NHIF) as the official path for effective execution of UHC in the country. Several reforms have been made by NHIF but according to Barasa et al. (2018), they are not adequate to achieve UHC but observe it is a good sign by the government. In December 2018, Kenya launched a pilot UHC scheme in Kisumu, Isiolo, Machakos, and Nyeri counties. The counties were selected because they experience a high frequency of communicable and non-communicable diseases, high population density, high maternal mortality, and high incidences of road traffic injuries (WHO, 2018).
Kenya’s Universal Health Care

As mentioned earlier, Kenya’s population has grown so fast to over 47 million in 2019, posing great challenges on health services resource allocations (Wamai, 2009). Most of its citizens reside in the rural set ups and rely on small scale farming as a source of their livelihoods (World Bank, 2014). This implies that the government needs to embrace strategies that will seek to solve the health dilemma facing the country due to financial hardships faced by the majority poor masses (WHO, 2010).

The country grapples with a high disease burden out of which the traditional diseases are a major cause (Ministry of Medical Services (MOMS) & Ministry of Public Health and Sanitation (MOPHS), 2012). In a study carried out by the Institute for health metrics and evaluation in 2010 on the global burden of disease, the study indicated that communicable diseases, maternal, neonatal and nutritional conditions remain the top ten leading causes of Disability Adjusted Life Years in Kenya. However, non-communicable diseases and injuries are increasingly becoming a big contributor to the disease burden.

Public, private, faith-based, and non-governmental organizations are the major providers of health services. The private and faith-based institutions are a mix of profit and not-for-profit agencies. The public sector operates the largest share of healthcare facilities in the country and it’s the major health service provider in the rural areas (Ministry of Health (MoH), 2009). The larger public health division has challenges of insufficient funds which are always mismanaged, few workers who not sufficiently competent, poor medical equipment, as well as insufficient medical essentials and supplies. This compromises the quality and general functioning of the health systems (Luoma et al., 2010).
The existence of policy strategies, and the National Hospital Insurance Fund (NHIF) shows that a lot has been done to improve accessibility and financial protection aspects of UHC. However, there are still major weaknesses in the health system that results in skewed access making it difficult for the rural and poorer populations. According to Ministry of Medical Services (MOMS) & Ministry of Public Health and Sanitation (MOPHS), (2012), a majority of Kenyans depend on their pockets to access the required health services. This results to high levels of poverty (Kitui, Lewis, & Davey, 2013). Such results show that there is need to invest totally in strategies that will help achieve universal coverage goals.

There is no proper UHC strategy enshrined in the country’s legislation. However, some UHC features have been captured in the present robust Kenya Health Policy 2012-2030(MOMS & MOPHS, 2012). In addition, Kenya has made major strides to address the high disease burden. The major plan has been the efforts to change, twice, the National Hospital Insurance Fund to become the main public health cover (Wamai, 2009). The main aim of the changes was to move the present health funding provisions to advance payment methods to curb out-of-pocket expenditure and mobilize additional financial resources into the well-being sector through individual contributions.

The success of the suggested universal coverage monitoring strategy lies on the operationalization of the sector’s information network which will be vital in creating effective and dependable information which can be a model in evaluating the coverage achievement (Abouzahr & Boerma, 2005). The present system has insufficient human, financial and infrastructural resources hence failing to qualify into the general and worldwide reporting strategies (Republic of Kenya, 2018). Although the state ministry of
health is spearheading the universal coverage, its efforts are limited by lack of capacity to
uninterruptedly influence fund allocations to stir the entire impact anticipated from
achieving UHC (Wamai, 2009).

According to Republic of Kenya (2018), worldwide deliberations on universal
coverage are ongoing. However, the central focus should be around creation of the proper
information by developing countries in related contexts. The organizers should incorporate
plans to support poor countries on funding and capacity building of researchers of the
framework. The report further recommends WHO and World Bank to offer their support in
the right infrastructural development.

Lastly, the roll out of the universal coverage monitoring strategy will facilitate the
country’s ability to monitor ad evaluate the success. All in all, inclusive efforts will push
for local planning and outlaying for the measures unavailable in Kenya. The country will
need to match up in putting in place strategies on UHC expansion to how to satisfy its
needs. The tracking and evaluation of the entire system will be key in achieving Kenya’s
health goal (WHO, 2010).

Empirical Literature Review

Despite the significance of participatory communication, previous research has
greatly ignored participatory communication and implementation of universal healthcare in
Kenya. Further, PC has enjoyed a wide exposure in the literature, with various writers and
a school of thought arguing from different angles to understand aspects of participatory
communication and universal healthcare (Bassette, 2004).

Odugleh-Kolev and Parrish-Sprowl (2018) noted that for health systems to achieve
UHC and sustainable development goals, the downward curative method that is people
centered need to be adopted. Experiences from successful countries in UHC like Thailand is a good indicator that community empowerment is the most important pre-requisite for establishing UHC (Joarder & Sarker 2014). By community empowerment, they refer to the means by which relatively powerless people in the community work collectively to have control over the situations that affect their lives.

A study carried out by Joarder and Sarker (2014) gave examples of some health programs that have been successful due to the involvement of the communities. The health programs include immunization program, directly observed treatment short-course program, and community clinic approach. In each case, the locals were empowered and success achieved. They therefore argued that the proactive attitude of the locals is a good signal for policy makers to embrace the good message of UHC which could be an answer to the high out of pocket payment by citizens in the country.

Allotey, Tan, Kirby, and Tan (2019) carried out a study on community engagement in support of moving towards Universal Health Care. The study sought to establish the methods of involving the locals and improving the health structures towards sustaining growth towards universal coverage. Findings of the study revealed that effective public involvement can empower people to make decisions making what and how services are implemented. This will ensure accountability and sustainability of the health interventions. The study then concluded that community engagement can be efficient in making sure that health services are accessible by everyone, and more so to the poor. However, they note that the process should recognize that UHC is a fundamental right and a shared responsibility for it to be effective.
Freeman (2016) in their study of an Aboriginal community-controlled health service in Australia partnered with six health services on comprehensive health care including one Aboriginal community-controlled health service for a period of five years. They found out that the Aboriginal community-controlled health service emerged as a promising form for the implementation of UHC vision compared to the others which were state-managed and non-governmental ones. They further observed that besides other strengths, the Aboriginal community-controlled service provided multiple avenues for community participation. They included structural participation evident in the service’s board, taking community members to external forums to provide a voice for the local community, consulting community members about new programs, employing local Aboriginal health practitioners, and having cultural advisory committees which provided advice and guidance on cultural protocols.

Cotlear et al. (2015) analyzed the experiences of 24 developing countries which had embarked on UHC following a bottom-up approach. They sought to document how those countries implemented UHC using people-centered approach. They noted that UHC priority enabled people to access health care services without experiencing financial burden. They also argued that UHC is a process which cannot be achieved in a day. However, they observed that the starting point matters for the immediate road ahead. The path towards UHC uses steppingstones, meaning that a country may initiate UHC programs targeting a group and later expand them to cover other sub populations. The study further revealed that implementation of the bottom-up approach is a feasible alternative for developing countries and countries that are focused on pursuing a progressive path to expand health coverage should consider it. The approach, they further
say, involve the use of various methodologies to reach out to different cadres of populations and more so the poor and the vulnerable.

Another study was carried out in Ghana by Assan, Takian, Aikins, and Akbarisari (2019). The study sought to find out the drawbacks of attaining UHC using an inclusive implementation strategy. The findings revealed that a community-based health planning and service (CHPS) initiative was founded to enhance the realization of UHC through improved health services. The health services were majorly preventive, promotive, and handlings of minor illnesses, nearer to the doorstep of the local people, especially those at the rural areas. Under the program, community health professionals supported by community volunteers, were trained to provide healthcare in a CHPS area.

Conceptual Framework

Figure 2.3 illustrates the conceptual framework for the study.
Figure 2.3: Conceptual Framework
Source: Author (2020)
Discussion

Creswell (2009) defined a dependent variable as those that depend on independent variables. Independent variables are further defined as those variables that (probably) cause, influence or affect outcomes while intervening variables are defined as those variables that stand between the independent and the dependent variables and they mediate effects of the independent variable or the dependent variable (Creswell, 2009). The study aimed at finding out the Influence of participatory communication on the implementation of Makueni Universal Healthcare.

Summary

This chapter has presented the concept of PC which includes dialogue, participation and how PC links to universal healthcare at the grass root. Further, the information explored relevant theories like the PC theory and stakeholder theory under which the study was grounded. Although there is no specific method of stakeholder participation that produces the best results, stakeholders should be involved throughout the lifecycle of a development program. Literature review has showed that PC has positive influence on the outcomes of health programs. Additionally, this chapter has presented a discussion on the empirical literature and conceptual frameworks of the study. The empirical literature has highlighted studies that have been done in relation to the subject of study, whereas the conceptual framework has illustrated the dependent and the independent variables and how they relate to each other.
CHAPTER THREE
RESEARCH AND METHODOLOGY

Introduction

This chapter discusses research methods that were used in the study. It describes the research design used, the population studied, the sample selected, the sampling method used, the data collection procedures, data analysis plan and the ethical principles observed.

Research Design

A research design describes how data collection and analysis are structured to meet research objectives (Chandran, 2004). It refers to the structure and procedures of an enquiry which ensures that the evidence obtained answers the research questions as unambiguously as possible (Creswell, 2008). The study adopted a mixed qualitative and quantitative descriptive design to profile Makueni County development committees (the avenue for the people’s participation) and the county health policy makers for comprehensive information (Mugenda & Mugenda, 2012). This study used in-depth interviews, focus group discussions, and questionnaires. According to Mugenda and Mugenda (2012), in-depth interviews and questionnaires help to establish the depth of the topic under study.

Population

The study population included the people of Makueni County residing across all the six sub-counties of the county including Makueni, Mbooni, Kibwezi East, Kibwezi West, Kaiti, and Kilome. According to the Kenya National Bureau of Statistics (KNBS, 2019), the county had a population of 987,653, where 489,691 were males and 497,942 females.
Target Population

The target population of the study included the Makueni County development committee members, which is the avenue of public participation in the county. According to GMC (2019), the committees fall into six levels, namely, area, cluster, village, ward, sub-county, and county levels. The area, cluster, and village committees consisted of 12 members comprising women, men, youth, and representative of persons living with disabilities. This is because, the entire development committees represent the public in development matters and ensure transparency, accountability, and sustainability of county development programs and projects. On the other hand, the ward, sub-county and county levels have membership of 15, with 3 members co-opted from faith-based organization, civil society, and professionals. The total number of the development committee members across the county was 50,871.

Sample Size

The sample size for this study was drawn from the committee members who possessed the necessary information related to the goals of this research (Mugenda & Mugenda, 2003). The sample size was calculated using Yamane’s formula which was preferred based on the recommendation by Gbegi and Adebisi (2015) that it is suitable when dealing with a predetermined population.
\[ n = \frac{N}{1 + N \cdot (e)^2} \]

Where,

\( n = \) the sample size

\( N = \) the size of population (50,871)

\( e = \) the acceptable margin of error (10%)

95% confidence level and \( p = 0.5 \) are assumed

Given the target population (\( N \)) as 50,871 and assuming an error margin of 10%, and a confidence level of 95% the resulting sample size (\( n \)) is computed as:

\[ n = \frac{50,871}{1 + 50,871 \cdot (0.1)^2} = \frac{50,871}{1 + 0.1^2} = 100 \]

This study used 72 elected development committee members at the six sub-counties level and 5 members of county committee executive. They included the president, the secretary, youth, persons living with disabilities, and women representatives. The 21 co-opted members of the two levels of development committees was also incorporated. Two officials, that is, the health executive committee member, and the county assembly health committee chairperson were integrated in the population sample due to the policy formulation roles they played in the Makueni health matters. Therefore, the researcher worked with a sampled population of 100 respondents.
Sampling Techniques

Purposive sampling technique was used in this study. The technique was preferred as it ensured that the sample composition was relevant to the proposed study (Gravetter & Forzano, 2012). In deciding the total sample for this study, consideration for all the representatives of all the six sub-counties committees was most important so as to ensure a representative sample. The researcher sought assistance from Makueni County leadership to get lists of all the county committee representatives.

Data Collection Instruments

The study adopted focus group discussions, the questionnaire, and in-depth interviews for data collection. The FGDs were guided by a series of questions, the questionnaires had both open and closed-ended questions, while the in-depth interviews were guided by semi-structured questions that gave the researcher a room for probing.

Focus Group Discussions

Focus Group Discussions (FGDs) are mostly associated with gathering of qualitative data and explores various issues. Chandran (2004) and Gilner et al. (2011) stated that the FGDs have two approaches, namely, participation observation and individual interviews. Seventy-two elected sub-counties development committee members formed six FGD’s of 12 members each (Mugenda & Mugenda, 2012). These members had rich information on the Makueni participatory model hence the choice for discussion groups.

The discussions were moderated by the researcher and two research assistants. Each FGD lasted for approximately forty-five minutes and the discussions were recorded
after acquiring consent. The research assistants took notes, recorded the proceedings, and later assisted in the translation, where necessary, besides ensuring other logistical arrangements. Trained in data collection, the assistants assisted in the compiling and sorting of raw data through identifying themes. The data obtained from the discussions was highly secured to ensure confidentiality.

Questionnaires

Questionnaires were administered to twenty-one co-opted members of the six sub-counties and the county committees. The five executive members of the county committee, that is, the president, assistant president, women, youth, and representatives of people living with disabilities in the county committee were incorporated. The co-opted categories were members from the civil society, faith-based organizations, and professionals. These are sensitive members of the community who have influence over the people and such they may seek anonymity or privacy. According to Mugenda and Mugenda (2012), questionnaires can be responded in privacy or anonymity, therefore a suitable data collection tool for this category of participants.

In-depth Interviews

According to Paradis, O'Brien, Nimmon, Bandiera, and Martimianakis (2016), an interview schedule guide is a data collection tool that is made up of a list of questions with structured answers to guide the interviewer, researcher or investigator. It is also known as a plan or guide for investigation. The interviews were conducted in the offices of the interviewees. The people interviewed were the county health executive member and the chairperson to the Health Committee in Makueni assembly. These were managers who
dealt with crucial health issues such as policy formulation and county health projects and programs. As such, through in-depth interviews, the researcher was able collect complete information with greater understanding hence higher response (Kombo & Tromp, 2014).

Pretesting

According to Vallabhaneni (2005), pretesting allows researchers to assess if they are asking the right group of respondents the right question. Pretesting the questions before the study therefore enabled the researcher to obtain some assessment of the questions’ validity and the likely reliability of the data to be collected. Pretests are therefore conducted with a small set of respondents from the population that will eventually be considered for full scale study. This makes it possible to discover whether a research instrument is adequately prepared. For the purpose of this research, the questionnaires and the FGD questions were pre-tested for reliability and validity on the 15 members drawn from Wote Ward development committee. The questionnaire and FGD questions were then revised to correct areas of misunderstanding. Questions discovered in the pretest to be difficult and misunderstood were edited to make the tool yield desired data.

Data Collection Procedures

Once the researcher received approvals from Makueni County, Daystar University, and the National Commission for Science, Technology and Innovation (NACOSTI), research assistants were recruited and briefed on the purpose of the study. The research assistants were residents of Makueni, conversant with English, Kiswahili and Kamba languages. This enabled them to work as translators to help bridge language barrier. The researcher held a session to ensure that intended meaning in the tools, the data collection method and confidentiality and privacy of respondents were well captured.
Questionnaires were printed and distributed to the 21 co-opted members and 5 county committee executive members. They were informed the purpose of study, that their participation was voluntary, that they were at liberty not to write their names or any form of identification on the research tool, and that their responses were to be kept confidential. The filled in questionnaires were collected by the assistants and handed to the researcher for safe keeping.

Focus Group Discussions (FGDs) were conducted with the 72 elected sub-counties development committee members from the six sub-counties. The FGD’s members were volunteers while the in-depth interviews were conducted with the two top health representatives. Data collection for this study happened at a time when the country was facing the Coronavirus pandemic. As such, adherence to social distancing, use of face masks, washing and sanitizing of hands was done to ensure safety of both the researcher and the respondents.

Data Analysis Plan

According to Yin (2009), data analysis refers to the process of examining, categorizing, tabulating, testing, or otherwise recombining evidence to draw empirically based conclusions. Data analysis involves the cleaning, coding, computerization, and analyzing the collected data such that it is transformed from a raw form to the one that allowed statistical techniques to be applied.

The Statistical Package for Social Science (SPSS) version 20.0 was used to analyze quantitative data collected through questionnaires. The summarized data was organized into descriptive statistics, classified, tabulated, and analyzed and presented using bar graphs and pie charts. On the other hand, qualitative data obtained from interviews and
focused discussions was grouped into themes, summarised, and reported in narrative form based on the variables of the study.

Ethical Considerations

The proposal was submitted to the Daystar University Ethics Review Board (ERB) to ensure that the rights of the respondents were respected. The researcher also obtained approval from NACOSTI and the informed consent was obtained from the participants. They were requested to give an oral or written consent. They were also informed of the purpose of the study and there was an option of not indicating real names in the questionnaires for confidentiality. The researcher and assistants explained to the respondents about the research and clarified that this study was for academic purposes only. In addition, the researcher made it clear to the respondents that they had the right to ask questions or seek clarifications during any point of the study and that their privacy was to be respected.

The researcher and the assistants ensured anonymity during data collection. As recommended by Kumar (2019), the researcher and assistants disassociated the names of the participants from the responses given during recording and coding of responses. The researcher informed the respondents that their contribution was voluntary. As recommended by Schutt (2018), respondents in a study were not coerced into participation. The researcher ensured that any information gathered during this study was not made available to anyone who was not part of this study. The researcher also ensured that any data related to this study was kept safely.
Summary

This chapter has presented a detailed methodology of the research method that was used to conduct the study. It has also provided a detailed presentation on the populated under study, sample selection methods, data collection instruments, data analysis plan and the ethical concerns that guided this study. The chapter also has explained how the questionnaires and FGDs, which were the data collection tools for this study, were pretested for reliability and validity and data collection procedures. The chapter has also described how the data from the study was sorted, coded, and analyzed with the help of SPSS to generate accurate findings.
CHAPTER FOUR
DATA ANALYSIS, PRESENTATION AND INTERPRETATION

Introduction

This chapter presented qualitative and quantitative data analysis, findings and their interpretations. The findings of the study are presented in form of frequencies and percentages in tables and descriptive responses from in-depth interviews and FGDs. The chapter begins by presenting the response rate, followed by demographic data then findings in regard to the participatory communication avenues used in MUHC program implementation, the level of participatory communication used and how participatory communication had influenced the uptake of MUHC program.

Analysis and Interpretation

Response Rate

The researcher administered 26 questionnaires, carried out two in-depth interviews and conducted 6 FGDs. Out of the 26 administered questionnaires, 23 were duly filled and returned, resulting in a response rate of 88.5%. Similarly, all the focus group discussions and the two in-depth interviews were successfully carried out, implying a 100% response rate. Mugenda and Mugenda (2012) noted that a response rate of 50% in a descriptive research is adequate for analysis and reporting, 60% is good and 70% or more is excellent. Therefore, this study’s response rate was excellent.
Demographic Characteristics

Gender of Respondents

The study sought to establish the gender distribution of the respondents. The findings were as presented in Figure 4.1.

Figure 4.1: Gender of Respondents

Figure 4.1 indicates that 15(65.2%) of the respondents among the members of development committees in MUHC program were males and 8(34.8%) were females. This implies that both genders were involved in participatory communication on the implementation of Makueni Universal Health Care.

Respondents’ Age Bracket

Respondents in the development committees were asked to indicate their age bracket and the findings are presented in Table 4.1.
Table 4.1: Age Distribution of Development Committee Members

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-28 years</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>29-39 years</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td>40-49 years</td>
<td>10</td>
<td>43.5</td>
</tr>
<tr>
<td>50-59 years</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Above 60 years</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

The findings revealed that 1(4.3%) were aged 18-28 years, 8(34.8%) were aged 29-39 years, 10(43.5%) were aged 40-49 years and 4(17.4%) were aged 50-59 years. These findings imply that stakeholders and residents of different ages participated in the implementation of the MUHC Program. It is also noteworthy that the development committee did not have members that were over 60 years, implying that the committee members were young enough to be productive in executing their MUHC mandate.

Place of Residence

The researcher asked the respondents to indicate the sub-counties from which they hailed, findings of which are presented in Table 4.2.

Table 4.2: Respondents’ Place of Residence

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Makueni</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Mbooni</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Kibwezi East</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Kibwezi West</td>
<td>3</td>
<td>13.0</td>
</tr>
<tr>
<td>Kaiti</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Kilome</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

Findings in Table 4.2 revealed that respondents for the study came from Makueni, Mbooni, Kibwezi East, Kaiti and Kilome sub-counties at 4(17.4%) each, while 3(13%) came from Kibwezi West sub-county. This implies that the development committees drew
its membership from all the sub-counties in Makueni County and therefore the public participation for MUHC program was well represented across the county, hence making the study inclusive.

The respondents were also asked to indicate if they were recipients of MUHC program. The results are indicated in Figure 4.2.

![Figure 4.2: Whether Respondents Received the Universal Healthcare](image)

Findings in Figure 4.2 showed that 23(100%) of the respondents who were members of development committees were recipients of Makueni Universal Healthcare services. This probably implied that the respondents were involved by the County Government of Makueni in the implementation of the program. It also indicated that the program had been running and was offering service to the residents of the county. These findings were supported by the County Health Executive Committee Member who indicated that:

*The MUHC is a program that is a small component of Makueni healthcare system which started in 2016 where we picked people with 65 years and above and when they came to our facilities, government pays their bills*
after treatment in terms of reimbursing the hospitals for the bills in their cards. It essentially means that a household in Makueni County with people below 65 years only needs to pay 500 per annum and the household is covered and are able to access all the services that are within public health domain.

The County Assembly Health Committee Chairperson who was also interviewed stated that:

*It is about 4 years roughly; I guess the program was launched in 2016. MUHC targets categories of people. Many were not able to afford pay for their health that that necessitated the government to start universal health care targeting those families and the elderly from the age of 65 years and above and also people living with disabilities. Under the program, the basic things are covered for example if it is out-patient, it is covered with lab, X-rays and even operations.*

Findings from the two in-depth interviews indicated that the reason that fueled the commencement of the program was to lift up the burden of medical expenses by removing the financial barrier which hindered many people from seeking health services in the health facilities. The County Health Committee Member indicated that:

*Essentially the UHC program is meant to remove the financial barrier that many people were encountering and hindering them from seeking health services in the facilities since the health expenditure was catastrophic which will push them deeper into poverty levels. This is the reason why the government of Makueni care fundamentally thought of establishing this Makueni care program to improve on access, remove the financial barrier which leads to catastrophic health expenditure so that the health-seeking behavior of people would improve.*

The Focus Group Discussions also indicated that the respondents were aware of the program. For example, some respondents in the FGD from Makueni Sub-County stated as follows:
I am aware of it and I liken it to NHIF whereby upon payment, one is able to receive free services upon visiting health facilities. So we understand it as our Makueni NHIF. We register with sh 500 and register your nuclear family. The dependent children should be below 18 years (Participant 7).

“Yes, I am aware. For one to qualify, they have to be residents of Makueni and have passport size photos for all the dependents and should be below 18 years.” (Participant 3).

“It lasts for one year whereby you have to renew with sh 500 for continued services. One cannot register more than one wife. Any extra wife is treated as another independent family which has to register.” (Participant 5).

Another respondent in FGD from Mbooni Sub-County stated that they were aware of MUHC program, what it is and why it was incepted.

Yes, it is a plan by the county government to treat residents for free. One registers by paying Sh 500 upon which a nuclear family is covered. It was launched in September 2016 where most of us were present and we got an opportunity to give our views concerning the program (Participant 4).

In the FGD from Kaiti Sub-County, three respondents from the development committee acknowledged that they were aware of the program, how it came into existence and why it was incepted.

This is a card we call Makueni Universal Health Care whereby citizens who have registered are able to access free health services within Makueni County facilities. It covers a nuclear family whose children are below 18 not unless they are school going who can verify through school IDs or a letter from the institution during registration. According to my knowledge, it started through a research by the County Minister for health services. The initiative was informed by high levels of poverty in the county. People accumulated huge hospital bills and that is how the government came up with UHC to provide solution (Participant 1).

MUHC is a government initiative which falls under headquarters projects which do not come from the residents’ request. At some point, which is now during the launch, we were involved and were told about it and its
advantages and how to enroll into the program. Afterwards, we started to sensitize the residents about the UHC (Participant 2).

Yes. I am aware of MUHC. I got to know about it through the county government administrators and officials. However, I got to know about it when it had already started. One registers by paying Sh 500 to cover a nuclear family (Participant 5).

Respondents from Kilome FGD as well indicated that they were aware of the program:

MUHC started in 2016 and it is a plan by the government to help the residents to access free health services. It involves a registration process whereby when the principal member pays Sh 500, he or she is allowed to cover their nuclear family but the dependent children should not be more than 5. The children also should not be above 18 years not unless they are students who need to verify that by availing institution letter during the registration process. It began because of high levels of poverty where people could accumulate huge hospital bills and especially the elderly. It covers in-patient services, outpatient and others (Participant 7).

In the Kibwezi-East FGD, the respondents were also aware of the program, how it was initiated and its functionality.

The initiative started because of us the community because of high levels of poverty that we experience. This is because when we used to go to hospitals for health services, the prescribed medicine was very expensive. We had just shifted from the central to the county governments and so the hospitals didn’t have enough medical supplies and essentials. It is out of that challenge that we engaged our county government so that they can take up the issue and make the services free. But because we also wanted to feel part of the program, we felt that it was good to contribute something small like Ksh 500 for registration. This way we also had ownership of the program. That’s how the MUHC was born. So after paying the 500, we could access services like mortuary services for 10 days and our families of husband, wife and children below 18 years are treated for free. But children above 18 years and are school going are qualified to be included (Participant 1).

This program is also called Makueni care and we register with Sh 500. But for the elderly, the ones who are above 65 years, they are given the card without paying the registration fee and are treated for free. It started mostly
because of the burden by the elderly when they get sick and have no people to take care of them (Participant 5).

PC Avenues Used to Implement MUHC Program

To achieve the objective of finding out the PC avenues used in implementation of the MUHC program, the researcher sought to establish how the respondent knew about the program. Findings of the respondents from the development committee members are indicated in Table 4.3.

Table 4.3: Mechanisms Used in Involving and Communicating about MUHC Program

<table>
<thead>
<tr>
<th>How did you know about MUHC</th>
<th>Responses</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>6</td>
<td>15.00%</td>
<td>26.10%</td>
</tr>
<tr>
<td>County government forums</td>
<td>23</td>
<td>57.50%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Faith based gatherings (church, mosque, temple)</td>
<td>4</td>
<td>10.00%</td>
<td>17.40%</td>
</tr>
<tr>
<td>Public Baraza's/chiefs</td>
<td>6</td>
<td>15.00%</td>
<td>26.10%</td>
</tr>
<tr>
<td>Other means(phone texts and WhatsApp)</td>
<td>1</td>
<td>2.50%</td>
<td>4.30%</td>
</tr>
</tbody>
</table>

Findings in Table 4.3 indicated that 23(100%) of the development committee members knew about Makueni Universal Healthcare through county government forums, 6(26.1%) knew about the program through radio, another 6(26.1%) knew through Public/Chiefs Barazas, 4(17.4%) knew about it through Faith based gatherings such as church, mosque and temple and 1(4.3%) knew through other means such as phone texts and WhatsApp. This indicated that the county government of Makueni had put in place structures that were the major mechanisms of involving its residents in development matters like health programs.

The chairperson of the County Assembly Health Committee in the in-depth interviews also stated that:
We have had Barazas and public participation meetings where we call them at cluster levels with administration devolution organization. We tell them and engage them for their opinions specifically about universal health care. In public participation we have to meet with the people, enlightening them through the radio.

As the residents of Makueni County got to know about the program, there was a tremendous increase in enrolment of households into the program. This was stated by the county executive member for health services who stated that: “Makueni County has approximately 200,000 households and currently we have about 90,000 households that are registered which would be translated to 45%”. On the other hand, the County Assembly Health Committee chairperson indicated that: “To the best of my knowledge, it is about 100,000 households.”

Stakeholders Involvement in MUHC Implementation

To investigate if the stakeholders in MUHC program were involved in its implementation, members in the development committees were asked if they thought all stakeholders had equal opportunities in MUHC implementation. Table 4.4 captures the findings.

Table 4.4: Whether all Stakeholders had Equal Opportunities in MUHC Implementation

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, because public participation in the MUHC was not enough</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>No, because PWDs are not considered and highly cost of medicine</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>No, lack of information</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Yes, because most of the categories were involved e.g youth, PWD, women,</td>
<td>20</td>
<td>87.1</td>
</tr>
<tr>
<td>FBOs/children, business people and the civil societies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>
From the findings, 20(87.1%) of the respondents indicated that all stakeholders had equal opportunities in MUHC since most of the categories of people were involved. These categories comprised of the youth, persons living with disabilities, women, children, business people and the civil societies. However, those who thought that all stakeholders had no equal opportunities in MUHC implementation had varied reasons including; they thought that public participation in the MUHC was not enough at 1(4.3%), PWDs were not considered and the cost of medicine was high at 1(4.3%), and there was lack of information at 1(4.3%). This could imply that although the respondents were involved in the implementation of the program, they were not fully involved at all levels of implementation. There is also a possibility that not all the information was conveyed to them.

In a similar manner, respondents in FGDs were asked to give their views in regard to whether they thought they were involved in the implementation of MUHC and if public participation was done. Respondents in FGD from Makueni sub-county acknowledged that they were involved but not from the beginning:

"In my view, I was involved though later when the program had already kicked off. The County assembly came to the ground to explain about it and also to get our views so that they can include them in a universal health care bill" (Participant 1).

"I say yes but I would say the involvement was very low because we didn’t start from the beginning the way we do following our Makueni Participatory Model. I heard about it when it was already being rolled out. Also our people have not enrolled so much because they feel they were not sufficiently involved in decision making (Participant 2).

"At the beginning, I was not involved but later it improved. The county government even brought the cards at our villages after they considered it as our input” (Participant 3).
One respondent in FGD from Mbooni Sub-County acknowledged that they were involved in implementation of MUHC but later after the program had kicked off:

“In my view, I was involved though at a later stage after the program had kicked off. The government organized forums where they explained to us about MUHC. We also gave our views on the same” (Participant 4).

From FGD in Kaiti sub-county, respondents stated that they were involved though at not at the beginning:

“In my view, I was involved though not at the beginning. I got an opportunity as the chairperson of the PWDs in Kaiti and proposed if we can have the PWDs if they can be excluded from paying the registration fee” (Participant 6).

Respondents in FGD from Kilome sub-county acknowledged that they were involved because they were asked for their views to be included in the Universal Health care Bill. They added that all the stakeholders were involved.

Yes, I was involved because we were called by the county government administrators where they explained to us about MUHC. Again, the county assembly came to us to get views from us to be included in the Universal Health care Bill. So I would confidently say that we have been involved in the implementation of the program. And actually women, PWDs, youth, men, Civil society, faith-based organizations and other stakeholders were also present (Participant 4).

In Kibwezi-East sub-county, respondents in the FGD had many views concerning public participation and involvement in MUHC program.

For sure, the program began because we were involved and we saw it a good initiative. Most of the stakeholders actually saw it very good. the county government also came to the villages to inform and sensitize us about MUHC. Initially, the registration used to happen at the sub county level facilities but we requested them to be brought to the villages which was done. We raised some issues on the limitation of the number of children to be covered from 3 and proposed 5. This one excited me most because it was considered (Participant 4).
We proposed devolvement of the registration process to be brought to the villages. The county government heard our cry. We wanted everyone to access the cards because at the start we used to travel to the sub county Kibwezi hospital. The government officials even slotted days for mass registration at the villages (Participant 7).

I also support 80% because most our views and opinions were included into the final decision like increment of children who are dependents, the cards registration process was brought to our doorsteps. The government also included mortuary services which were not covered initially (Participant 9).

Use of Dialogue with Stakeholders During MUHC Implementation Processes

Dialogue is the primary component of public participation in any development implementation program (Fourie, 2018). The researcher sought to understand if the County government of Makueni dialogued with stakeholders in the implementation of MUHC program. Findings are presented in Figure 4.3.

![Figure 4.3: Use of Dialogue with Stakeholders During MUHC Implementation Processes](image)

Findings in Figure 4.3 showed that 15(65.2%) of the members in development committees strongly agreed that the government used dialogue with stakeholders during implementation of MUHC and 8(34.8%) agreed on same. This could be the reason as to
why the program was sustainable since it was initiated in 2016 because in dialogue all groups of persons are involved and mutual respect and listening for all parties are embraced.

As observed from the in-depth interviews, the sustainability of the program relied on dialogue with the stakeholders before adjustment of the services in the program such as registration fees and views concerning the implementation of the program. This clearly indicated that the government had embraced dialogue for the sustainability of the program as stated by the executive member for health:

_The county government Act demands that all county government programs before implementation, we must be able to get the participation of the people, so including all other programs there is heavy participation of people for example improving the physical access is very important so that we achieve universal healthcare. The physical facilities put up in place is not the county government or the department who decides but it is the citizens who demand for those facilities to be put up and mostly they are justified. The wishes of people are respected in such a way that technically they are comprehensible for example in issues of drugs, services received and this is possible through suggestion boxes and call centers._

The Extent by Which Participatory Communication was Used in the Implementation of MUHC Program

The researcher sought to determine the level of participatory communication used in implementation of MUHC program. The respondents were asked to state to what extent (level) they thought they had been involved in implementation of the program. The results of the findings are indicated in Figure 4.4.
The findings from the members of development committees indicated that 15(65.2%) stated that they had been involved in implementation of MUHC program in which they aired their views which were not included in the process. However, they felt that government still held lot of power and their level of influence over the final decision on MUHC was low. Further, 5(21.8%) of the respondents stated that they were collaborated in decision making and worked with the government on all the phases of final decisions about MUHC. Equally, 3(13%) of the respondents indicated they were consulted where they only aired their opinions which were not considered in making final decisions about MUHC.

### Influence of PC on the Uptake of MUHC Program

The researcher asked respondents to indicate whether their participation in MUHC implementation motivated them to register the program. The findings are indicated in Figure 4.5.

---

**Figure 4.4: Extent of Involvement in MUHC Implementation**

<table>
<thead>
<tr>
<th>Level</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation level (given a platform to air my opinions which were not considered in making final decision about MUHC)</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Involvement level (Aired my views but were not included in the final process)</td>
<td>15</td>
<td>65.2%</td>
</tr>
<tr>
<td>Collaboration level (I was involved openly in the process of making decisions)</td>
<td>5</td>
<td>21.8%</td>
</tr>
</tbody>
</table>
Findings in Figure 4.5 show that 22 (95.7%) of the respondents agreed that their participation in MUHC implementation motivated them to register to the program, while 1 (4.3%) didn’t respond to the question. This implies that participation in MUHC program was the main motivation that drove respondents to register. This could be attributed to better understanding of the program and its associated benefits in health care.

Motivation to uptake of MUHC program due to public participation was also echoed by the health executive member in an In-depth interview who stated that:

*During the participatory forums, when for example you ask how many people in the meeting have registered for Makueni care you find a good number of them positively saying they have registered and they are given an opportunity to talk and let others know what are the benefits of Makueni care, and by the time the who have not registered are leaving that meeting they are saying they did not know these benefits. This encourages more people to take it up.*

Benefits Gained by Enrolling in MUHC Program

In any development program, there are benefits that are associated to it. In view of the MUHC program, the respondents were asked if there were any benefits they gained by

Figure 4.5: Participation in MUHC Implementation and Registration in MUHC
enrolling in the program. Findings for members of development committees were as indicated in Table 4.5.

*Table 4.5: Benefits Gained by Enrolling In MUHC Program*

<table>
<thead>
<tr>
<th>Benefits of enrolling for MUHC program</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free medical services</td>
<td>16</td>
<td>24.20%</td>
</tr>
<tr>
<td>Positively changed health behavior</td>
<td>5</td>
<td>7.60%</td>
</tr>
<tr>
<td>Reduced cost of medication</td>
<td>5</td>
<td>7.60%</td>
</tr>
<tr>
<td>Increased frequency of check-ups</td>
<td>5</td>
<td>7.60%</td>
</tr>
<tr>
<td>Helped in obtaining health information</td>
<td>4</td>
<td>6.10%</td>
</tr>
<tr>
<td>Improved health seeking behavior</td>
<td>15</td>
<td>22.70%</td>
</tr>
<tr>
<td>Free ambulance services</td>
<td>1</td>
<td>1.50%</td>
</tr>
<tr>
<td>Extension of medical services to family members</td>
<td>4</td>
<td>6.10%</td>
</tr>
<tr>
<td>Affordable registration fee</td>
<td>1</td>
<td>1.50%</td>
</tr>
<tr>
<td>Free admission and mortuary services for 10 days</td>
<td>3</td>
<td>4.50%</td>
</tr>
<tr>
<td>Poverty index reduction by saving cash that would have spent on medication</td>
<td>7</td>
<td>10.60%</td>
</tr>
</tbody>
</table>

The results indicated that 16(72.7%) of the respondents enjoyed the benefit of free medical services, 15(68.2%) had improved in health seeking behavior, those whose health behavior had changed positively, enjoyed the benefit of reduced costs of medication and increased frequency of check-ups had a tie at 5(22.7%), 7(31.8%) stated that the program had led to poverty index reduction by saving cash that would have spent on medication, obtaining health information and extension of medical services to family members had a tie at 4(18.2%), 3(13.6%) enjoyed free admission and mortuary services for 10 days and free ambulance services and affordable registration fee had a tie at 1(4.5%). It was evident that the residents were benefiting from the program through its intensive services in health for the betterment of the society. Similarly, for the respondents to have cited the benefits is indicative of their uptake of the program.
In the FGDs, the same benefits were stated. Respondents from Makueni sub-county FGD stated the following benefits:

‘I think it came to make people equal in terms of acquiring health services. Both the rich and the poor can access same health services at no cost.’ (Participant 4).

“We are able to access free health services despite the health condition. We no longer sell our properties to cater for medical bills” (Participant 9).

Respondents from Mbooni sub-County as well stated the following benefits:

“We are able to develop ourselves more using the money that would have been used for paying hospital bills. Our health has improved because we can now seek services frequently because we don’t need to pay” (Participant 7).

The following were the outstanding benefits of MUHC program among the respondents from Kaiti Sub-County.

“One of the benefits is that we are able to get treated for free. One of my friends was suffering from cancer but through UHC she was able to get her bills catered for” (Participant 7).

“I support the benefit of free services because for me I seek medical services because I have a condition and I don’t pay at all” (Participant 8).

“I also want to support the benefit of free services that x-rays are free. We used to pay for them huge bills. With the card it is free” (Participant 2).

“Upon registration, you start using the card as soon as possible. It doesn’t require time for activation or maturity” (Participant 3).

Respondents in the FGD at Kilome stated the following benefits.

“We have been able to access free health services which would have otherwise been expensive for us to pay like mortuary bills, admission fees, ambulance services during referrals” (Participant 7).

“I just want to concur with P7 that our family health bills have been catered for through this MUHC” (Participant 8).
‘MUHC has helped us to fight poverty because once the government pays for your hospital bills, you are able to concentrate on the development issues in your family’ (Participant 4).

In the Kibwezi-East FGD, the following benefits of MUHC program were stated:

‘One of the benefits is that the elderly people are treated free without even the sh 500 and it has eased that burden’ (Participant 5).

‘The card doesn’t need a specified period for activation. You can register when you fall sick and use it at that moment. You don’t need to wait for a month or days for it to be operational’ (Participant 8).

‘Improvement of our livelihoods because the money that would have otherwise gone for paying in hospitals has been used to do other development activities at our homes’ (Participant 10).

Similar benefits were stated among the respondents from Kibwezi-west.

‘We are able to access free health services any time. We don’t bother the community through fund drives anymore’ (Participant 1).

‘Besides free treatment, when one dies, the government caters for mortuary services up to 10 days’ (Participant 6).

‘It has helped us better our lives in that the money we used for hospital bills is now channelled to other family activities’ (Participant 3).

Influence of MUHC Program in Seeking Health Services

The researcher sought to understand whether MUHC program influenced how often the respondents sought health services. Figure 4.6 shows the findings.
Findings in Figure 4.6 indicated that 22(95.7\%) of the respondents affirmed that MUHC program influenced how often they sought health services. This is well explained by the associated benefits of MUHC with the major being equity of access and financial risk protection. The respondents moreover gave the reasons as to why and how MUHC program had influenced how often they sought health services. Table 4.6 shows the findings.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Changed my health seeking behavior</td>
<td>15</td>
<td>65.2</td>
</tr>
<tr>
<td>It has improved health status</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>Health facilities have been devolved in almost every cluster</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td>It has encouraged change of attitude towards the services</td>
<td>1</td>
<td>4.3</td>
</tr>
</tbody>
</table>
It has helped to seek health information from the health facilities 1 4.3
It has reduced the expenses involved in catering for health care services. 3 13.3
Total 23 100

MUHC program had influenced how often the respondents sought health services by changing their health seeking behavior at 15(65.2%), reduction of the expenses involved in catering for health services at 3(13.3%) and improvement of health status, devolved health services, change of attitude towards health services and health information in the health facilities had a tie at 1(4.3%). These findings could be as a result of the MUHC plan which addressed the interests and needs of the residents by involving them, hence led to the uptake of the program.

Description of MUHC Services

The researcher sought to understand the how the MUHC program services were to the recipients. This was obtained by asking the respondents how they could describe the services. Findings were indicated in Table 4.7
Table 4.7: Description of MUHC Services

<table>
<thead>
<tr>
<th>MUHC Services</th>
<th>Responses</th>
<th>Percent of Cases</th>
<th>Reasons</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>15</td>
<td>40.50% 68.20%</td>
<td>Services are nearer 2 8.6</td>
<td>Operations are always available 2 8.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Free services 4 17.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessible</td>
<td>18</td>
<td>48.60% 81.80%</td>
<td>Services are devolved to village levels 4 17.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Open day and night 4 17.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dispensaries are near 2 8.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Services are reached by mwananchi 1 4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficient (Quality)</td>
<td>4</td>
<td>10.80% 18.20%</td>
<td>trained health workers who are ready to serve 1 4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>best services offered once enrolled 1 4.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>lack of adequate personnel, enough medicines and limited coverage in terms of range of diseases covered by MUHC has reduced efficiency 1 4.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Findings in Table 4.7 revealed that 18(81.8%) of the respondents described the MUHC program services as accessible with the reasons being that services are devolved to village levels, the facilities were open day and night, dispensaries were nearer and that the service were reachable by the common Mwananchi. Further, 15(68.2%) of the respondents described the services as available, they are free, operations are always available and services are nearer, while 4(18.20%) of the respondents described the services as efficient because of trained health workers who were ready to serve and best services offered once enrolled. Although MUHC was efficient, the respondents, however, felt there were
challenges encountered including lack of adequate personnel, limited equipment and services in terms of range of diseases covered by MUHC had reduced its efficiency.

Role of Makueni County in Overseeing PC During MUHC Implementation

The respondents were asked to state what the role of Makueni County was in overseeing the participatory communication in the implementation of MUHC program. Findings are indicated in Table 4.8.

<table>
<thead>
<tr>
<th>Role</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enlightening through forums</td>
<td>2</td>
<td>7.10%</td>
</tr>
<tr>
<td>Creating awareness through media</td>
<td>14</td>
<td>50.00%</td>
</tr>
<tr>
<td>Training development committee members</td>
<td>1</td>
<td>3.60%</td>
</tr>
<tr>
<td>Identifying and addressing MUHC challenges</td>
<td>1</td>
<td>3.60%</td>
</tr>
<tr>
<td>Providing relevant information</td>
<td>6</td>
<td>21.40%</td>
</tr>
<tr>
<td>Decentralizing MUHC cards and enrolment</td>
<td>4</td>
<td>14.30%</td>
</tr>
</tbody>
</table>

From the findings, 14(77.8%) of the respondents stated that the role of Makueni County was to create awareness through media, 6(33.3%) stated that their role was to provide relevant information, 4(22.2%) acknowledged that the County was involved in decentralizing MUHC cards and enrolment, 2(11.2%) indicated that they conducted awareness creation through forums, while 1(5.6%) indicated that their role was to train development committee members and addressing MUHC challenges at 1(5.6%) respectively. These findings imply that the county government provided structures for participatory communication.

Respondents in the FGDs also had roles to play in MUHC program implementation as they were part of the stakeholders’ representatives in the government. Respondents in FGD from Makueni Sub-County in their sentiments echoed the following roles:
“One role is that we take part in creating awareness about UHC so that people can enroll for the program. In my case, I have sensitized people in churches. We act as medium between the county government and the people” (Participant 3).

“I took part in registering people to the program. I took that opportunity to also educate people about MUHC” (Participant 5).

One respondent in FGD from Mbooni Sub-County stated the following roles:

We do mobilize people to sensitize them about the program. Actually, most of the residents have registered for MUHC through these efforts. We take advantages of religious gatherings, barazas and other social events to explain to the locals about the program (Participant 8).

In the Kaiti FGD, two respondents stated the following roles:

“One is that we go to the ground sensitizing people to enroll to the program, especially the PWDs” (Participant 6).

“We are facilitated by the government to traverse across our sub-county to create awareness about UHC so that people can register” (Participant 5).

Similar roles were stated in the Kilome FGD in the following sentiments:

We create awareness to the people about MUHC through barazas (Participant 4).

“We also sensitize people about the benefits of MUHC in the churches” (Participant 2).

I specifically remember that we also did public participation for children in schools on MUHC. The children aired their views concerning the MUHC and it is at this point where the children asked for the oral vaccines to be taken to their schools and it was done. We also reached out to our Makueni people living in Nairobi and Mombasa, we call them diaspora, and they gave their views (Participant 7).

“We also took part in the registration process. We worked as clerks to capture and enter data for people during registration” (Participant 9).

Respondents in the FGDs in Kibwezi-East and Kibwezi- West stated that their role was to act as public participation platforms to mobilize and sensitizing residents on the benefits of the program, to gather peoples’ opinions concerning the challenges and above
all to act as a link between the residents and the government in development matters as stated in the following statements from Kibwezi- East and Kibwezi-West FGDs respectively:

*Our role as development committee members is that we are used as public participation platforms. In this case of MUHC, we mobilize them and explain the goodness and benefits of the program and how to enroll. They also give us their opinions and views like if were the registration is done is far, we talk to the government on their behalf to solve some of the challenges. We are the link between the residents and the government in matters development* (Participant 12).

“*We sensitize the residents about MUHC so that they can enroll and many have registered for the card. We are used as channels of public participation by the residents*” (Participant 4).

Challenges of the MUHC Program in Terms of Public Participation and Services, Infrastructure and Human Resource

The researcher sought to understand the challenges faced when running the program in terms of public participation, infrastructure, human resource and services offered. In terms of public participation, findings from the in-depth interviews indicated that there was less citizen empowerment through civic education so as their participation was not to be in vain. This was echoed in the sentiments of the health executive committee member who stated that:

*The citizens need to be empowered more through civic education so that as they participate, they are guided so as their participation is not in vain. They need to know their rights as citizens, what to demand, what is sustainable, what is good for the community.*

In terms of running the program, among the challenges observed included influx of people in the health facilities and the human resource was not optimized. This resulted to
overstretching of the workforce and the drugs run off so fast. Also, majority of the people rely on curative measures of managing diseases which makes it a challenge to re-strategize to preventive health care. This was evident from the following sentiments from the interview:

One of the main issues that I would say is that advance selection; most residents want to register when they have their loved ones sick or themselves. This has been an issue because our program does not put some weight in period before the cover is active, it is instantaneous. The other issue is the numbers because there are so many people who are locked out of accessing health care services because of the financial factor. Now we have removed that financial, it means that everyone who ordinarily would stay home because they don’t have money now they have access. So the numbers that are able to visit our facilities have doubled but if you look at the workforce, it is not possible for us to be doubled it because there are many restrictions put by the National treasury in terms of percentages of the salaries you ought to have for total current expenditure and so we are not optimized in staff to handle the number of people who are coming. The other is that traditionally most African countries Kenya included have been relying on a heavily curative system of managing disease and that is not sustainable, so we want to re-strategize to preventive health care.”

The county assembly health committee chairperson indicated that:

With the universal health care system, many people are coming, the staffs are overworked and always the drugs will be getting off so quickly. Money is not enough, drugs sometimes delay at KEMSA, our budget cannot have everything the patients want and some services like cancer treatment are not available because we have not established cancer treatment centers also people of accidents because of implants which are expensive.

From the FGDs, varied challenges were stated. In the Makueni FGD, the following challenges were observed as shown in the following sentiments:

“Some services like implants are not free. We have to buy the metallic plates and they are very expensive. Also, some prescriptions are not available and one has to buy them from chemists.” (Participant 1).
Similar challenges were observed as indicated in the following statements:

“The card does not cover for treatment outside Makueni county health facilities. In this case one has to pay for them. Also, services are also not available. And these could be the most expensive ones.” (Participant 9).

There is a challenge of low and late involvement into the implementation of the card. We were involved when the program had already started and couldn’t have our inputs considered. We have also not gotten opportunity to give our feedback concerning the card (Participant 12).

Challenges such as regional functionality, inadequate machines and some services not covered by the card among others were indicated in the following statements for respondents from Kaiti FGD.

“Challenge of regional functionality. One cannot be treated in case they fall sick outside Makueni health facilities” (Participant 7).

“There is challenge of overcrowding of patients in the facilities making the services slow” (Participant 11).

The expiry date is uniform to all despite the time of registration therefore some end up having shorter time of coverage before the one-year period ends. The card expires after one year so if some register at September, they only seek services for 3 months compared to some who had registered in January.” (Participant 4).

“Sometimes the prescribed medicines are not available therefore you end up buying them from chemists. Most of these medicines are the expensive one like the ones for treating ulcers.” (Participant 8).

For Kilome sub-county FGD, the following challenges were observed:

“Some services are not covered by the MUHC like implants” (Participant 3).

“Some prescribed medicines are most of the times not available so we are forced to buy them from chemists. The one unavailable are the most expensive ones” (Participant 5).

“There is a lot of congestion making services to take long. You can take a whole day without being attended” (Participant 4).
There is an aspect of corruption in that if a patient comes and their mode of payment is cash, the ones using the card are put aside to be attended first. This is discrimination. There is a challenge of PWDS being more pressed by the sh 500. I am one of the PWDs and I feel that our interests have not been catered for (Participant 10).

“I also wish to add another challenge that is affecting the PWDs. The facilities lack specialists to attend to their special services. So at the end of the day they end up going out to seek these services so they use cash. Even their medication is not available” (Participant 6).

Also, similar challenges were observed from the FGD in Kibwezi-East sub-county:

“The card expires after one year for all despite the time the time registration. For example, if a resident register in July, they will be served only for 5 months. The services cannot be pushed to July the following year” (Participant 12).

“Sometimes the medicine one is prescribed is not stocked and end up buying them from chemists. Some of these medicines are the most expensive ones” (Participant 4).

“It only caters for nuclear family members only so if one has grandchildren who are dependents, you have to register them as a separate family or use out of pocket to cater for their health services” (Participant 3).

“Some services are not covered by the UHC card. For example, bone replacement services, we have to buy the “metal” which is expensive” (Participant 10).

“Public participation on the implementation is not satisfactorily in that most of our views concerning the program have not been taken into considerations” (Participant 13).

System failures when running MUHC program and inadequate medical supplies were the other challenges observed among the respondents in the FGD from Kibwezi-West sub-County.

“There is challenge of system failure where one can fail to be traced in the county records. In such a case, one ends up paying the registration fee twice” (Participant 7).
‘Some vital services are not catered by the MUHC program like bone replacement’ (Participant 8).

‘Some common medical supplies sometimes lack like medicines, bandages. When this happens, we are forced to buy them form the chemists’ (Participant 9).

‘This program doesn’t cater for payments of services sought outside Makueni County health facilities. The card is only used within Makueni County’ (Participant 3).

However, infrastructure was not a major challenge as the county health executive Member stated that program is well off. He acknowledged that the health facilities are well equipped since there are good maternity wings, theaters running and people are operated free but acknowledged that budget has never been enough for health services.

Yes, we have and this is a process, you start from low and progress and our hospitals are well equipped. They have got very good maternity wings, we have theatres that are running and people are operated free. In the human resource there is a challenge because the numbers of people have increased and from our neighboring counties, they are all coming here. Due to this influx of people, our staffs are over-stretched. The budget has never been enough for health services.

In summary, the challenges faced in running MUHC program included influx of people in the health facilities and the human resource not optimized resulting to overstretching of the workforce and the drugs running off so fast, advance selection where most residents want to register when they have their loved ones sick or themselves, money is not enough, budget not covering everything the patients want and some services like cancer treatment are not available, residents who are covered by NHIF cannot register under MUHC, the card does not cover for treatment outside Makueni county health facilities, low and late involvement into the implementation of the program, prescribed medicines are not available , aspect of corruption in that if a patient comes and their mode
of payment is cash, the ones using the card are put aside to be attended first the card only
caters for nuclear family members, public participation on the implementation is not
satisfactorily in that most of the citizens’ views concerning the program have not been
taken into considerations and challenge of system failure where one can fail to be traced in
the county records.

Future Suggestions on the MUHC Program

The respondents suggested that for the program to run effectively and sustainably, some
actions need to be taken into consideration. The findings from the members of the
development committees’ suggestions are presented in Table 4.9.

<table>
<thead>
<tr>
<th>Suggestions to county government</th>
<th>Responses</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening public participation structures and increasing public participation</td>
<td>21</td>
<td>55.30%</td>
<td></td>
</tr>
<tr>
<td>Increasing budgetary allocation for MUHC</td>
<td>4</td>
<td>10.50%</td>
<td></td>
</tr>
<tr>
<td>Devolving the program to other counties</td>
<td>2</td>
<td>5.30%</td>
<td></td>
</tr>
<tr>
<td>Employ more staff</td>
<td>3</td>
<td>7.90%</td>
<td></td>
</tr>
<tr>
<td>Increasing range of services like diseases covered and availability of medicine</td>
<td>2</td>
<td>5.30%</td>
<td></td>
</tr>
<tr>
<td>Continuous registration and creation of awareness at ground level</td>
<td>2</td>
<td>5.30%</td>
<td></td>
</tr>
<tr>
<td>Waiving annual renewal subscription fee yearly and free UHC to PWDs</td>
<td>4</td>
<td>10.50%</td>
<td></td>
</tr>
</tbody>
</table>

Findings in Table 4.9 indicated that 21(91.3%) of the members in the development
committees suggested that the county government should strengthen public participation
structures and increase public participation, those suggested that the county government
should increase budgetary allocations for MUHC and waiving annual renewal subscription
fee and free UHC to PWDs had a tie at 4(17.4%), 3(13.0%) suggested that the county
government should employ more staff and those suggested that the county government should devolve the program to other counties, increase range of services of the disease covered and availability of medicine, continue registering and creating awareness at the ground level had a tie at 2(8.7%). This could imply that effective public participation can lead to successful implementation of the MUHC.

This therefore means that the locals need to be incorporated at the planning stage of a development intervention for participation to bear the intended results because here goals are determined. This was also indicated by the respondents from FGDs in various sub-counties. In Makueni sub-county FGD, the following suggestions were echoed in the following sentiments:

“I recommend the registration fee of sh 500 to be excluded so that it becomes free.” (Participant 2).

“I recommend the registration process to be open throughout the year.” (Participant 3).

In Mbooni Sub-County the following suggestions were made to the county government for the sustainability of MUHC program.

“I recommend the card to be reviewed such that it can be used in any part of the country not just within Makueni. The governor can start by collaborating with Machakos and Kitui Counties because they have similar program.” (Participant 10).

“I recommend the government to engage us more so that we have our inputs considered especially on the problems that are facing the MUHC. We need inclusion from the beginning and throughout the running of the initiative.” (Participant 3).

“We recommend for more budgetary allocation so that the services that are not covered are included and also make sure that the hospitals don’t run short of medical essentials and supplies.” (Participant 1).
Respondents in the Kaiti sub-county FGD also recommended the following to the county government.

“I recommend the card to be reviewed such that we can use it even outside Makueni County. And also to cover all the services.” (Participant 2).

“I recommend residents to be fully included and especially before it starts so that we can air our challenges concerning the MUHC. Our issues have not been well addressed in the MUHC.” (Participant 1).

In Kilome Sub-County FGD, the respondents who were the members of the development committee recommended the following for the implementation of MUHC program.

“I recommend increment of health workers to ease the congestion at the health facilities.” (Participant 4).

“I also support the recommendation of increasing the human resource at the facilities. It is a major challenge.” (Participant 6).

“I recommend that people living with disabilities to be exempted from paying the registration fee of Sh 500 just like the elderly people.” (Participant 10).

I advise the government to increase the level of our participation in the MUHC program. As much as we are aware and are recipients of the program, our decisions and concerns have not been captured. No wonder we feel so many gaps and challenges in the program (Participant 1).

For the Kibwezi-East sub-county, the following recommendations were made by the respondents in the FGD.

“The government should engage the residents fully in the implementation of the UHC. This will help to solve most of the challenges that we feel are very key in making the cover better for us.” (Participant 1).

The development committees as public participation avenues should be empowered so that they can adequately reach out to the residents for example budgetary allocation and full engagement by the government in UHC program (Participant 4).
Similar recommendations were also observed in the Kibwezi-West Sub-County FGD from the respondents in the following statements.
“I recommend all health services to be covered by the program.” (Participant 10).

“We recommend the government to engage us fully so that we say the challenges concerning these cards. There are issues we wish could be reviewed to make it better.” (Participant 6).

Summary of Key Findings

The study made the following key findings:

1. All the respondents who were members of the development committees (100%) knew about MUHC and the avenues of PC used included county government forums, the radio, Public Barazas/Chief’s, Faith based gatherings such as church, mosque and temple and also phone texts and WhatsApp.

2. Stakeholders had an equal opportunity in MUHC because most of the categories of people were involved. These categories comprised of the youth, persons living with disabilities, women, children, business people and the civil societies. However, those who thought that all stakeholders had no equal opportunities in MUHC implementation had varied reasons: they thought that public participation in the MUHC was not enough, PWDs are not considered and highly cost of medicine and lack of information.

3. Majority 15(65.2%) of the members in development committees strongly agreed that the government had used dialogue with stakeholders during implementation of MUHC implementation processes, where they aired their views which were then included in the process but they felt that a lot of power was still held by government and their level of influence over the final decision on MUHC was low.

4. In regard to how participatory communication had influenced the uptake of MUHC program, 22(95.7%) of the development committee members asserted that it
motivated the residents to register to the program. This was equally echoed by the health executive member in an in-depth interview, who indicated that participation on public forums motivates the uptake of the program. By enrolling on the MUHC program, 16(72.7%) of the respondents indicated that they were able to enjoy the benefit of free medical services. Other benefits included poverty index reduction by saving cash that would have spent on medication, access to health information and extension of medical services to family members, free admission and mortuary services for 10 days and free ambulance services and affordable registration.

5. Further, 15(65.2%) of the respondents indicated that the MUHC program influenced how often the respondents sought health services by improving their health seeking behavior, reduction of the expenses involved in catering for health services at 3(13.3%) and improvement of health status, devolved health services, change of attitude towards health services and health information in the health facilities all at 1(4.3%).

6. Majority of the respondents, 18(81.8%) described the MUHC program services as accessible with the reasons being that services are devolved to village levels, the facilities are open day and night, dispensaries are nearer and that the service reached by common citizen. 15(68.2%) described the services as available they are free, operations are always available and services are nearer, and 4(18.20%) described the services as efficient because of trained health workers who are ready to serve and best services offered once enrolled. Although MUHC are efficient, they however felt that there is lack of adequate personnel, limited machine and
coverage in terms of range of diseases covered by MUHC had reduced its efficiency.

7. The major functions of the County government in implementation of MUHC program were to create awareness through media, providing relevant information, decentralizing MUHC cards and enrolment, enlightening through forums and those stated training development committee members and identifying and addressing MUHC challenges.

Summary

This chapter has given the research findings in details as the respondents provided, summarizing and presenting the data in a manner that can be understood. Data was organized and presented in tables and figures in accordance to the study objectives. The analyzed data forms the basis on which chapter five will be presented providing discussions, conclusions and recommendations including areas for future research.
CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

This chapter provides discussion of key findings, conclusions and recommendations. The study sought to establish the effectiveness of participatory communication on the implementation of Makueni Universal Health Care (MUHC) program. Its objectives were to find out the PC avenues used in the implementation of MUHC program, to determine the level of PC used and to establish how PC influenced the uptake of MUHC program.

Discussions

Participatory Communication avenues used in MUHC implementation

PC is a model used by various development partners to share opinions and ideas geared towards empowering their lives and societies (Thomas & Mefalopulos, 2009). PC is about sharing of opinions and information and it is associated with community-driven development and helps in decision making (Srampickal, 2006).

The first objective aimed at finding out the PC avenues used in implementation of MUHC program. The findings indicated that all the respondents knew about MUHC and the avenues of PC used included county government forums, the radio, Public Barazas/Chief’s, Faith based gatherings such as church, mosque and temple and also phone texts and WhatsApp. Also, every hospital that offered MUHC had customer care services, suggestions boxes for feedback and the department at the headquarter level had a call center where people also called and they were able to give their complements and criticism. This implies that the communication avenues served to create awareness on the
MUHC services, provide relevant information, and also helped in identifying and addressing MUHC challenges.

Involvement of households in the implementation of the program’s changes was highly embraced. This was evident in an in-depth interview where the County health executive committee member stated, “We are also looking at the household themselves, their contributions, we are popularizing the plan so that each and every household in Makueni are able to register which will give us about one hundred million shillings in a year. Also, the public participation we can have those who want to remain at Ksh 500 but also introduce another package which is superior like a multilayered program where if one wants something else can add another Ksh 500 to get other advantages”. This indicates that for any amendments in the program, people’s views were sought first through the aforementioned avenues before implementation. This is consistent with Moemeka (1994) who indicated that in any development program, communication is employed in transformation to improve the quality of life and socialization and to uphold the ideologies within society that are harmonious with development.

Dialogue which is the foundation of PC was employed by the government as 15(65.2%) of the members in development committees strongly agreed that the government had used dialogue with stakeholders during implementation of MUHC. Findings from Focus Group Discussions indicated that all the stakeholders who represented all the categories of people in the society were involved in the implementation of the program and heard equally without any of them controlling the process of communication implying that mutual respect, listening and understanding the context of
development as well as each other as stakeholders were embraced as advocated for by Baumeister et al. (2018).

These study findings concur with those of Freeman (2016) who found that structural participation was evident in health service provision where hospital boards took community members to external forums where they aired their opinions, consulted community members about new programs, employed local health practitioners and had cultural advisory committees that provided advice and guidance on cultural protocols. This kind of inclusivity was evident in this study where residents were incorporated through radio, county government forums and development committees. According to WHO (2011), there is a strong evidence and agreement that populations must be actively engaged in improving their well-being. Further, Draper et al. (2010) stated that involving the masses is integral in advancing health services delivery, equity as well as uptake. Matteoli (2016) stated that communication is fundamental in participatory approaches. For stakeholders to be consulted and involved in development project decisions and processes, development experts must communicate with the affected parties.

Levels of PC Used in MUHC Implementation.

The second objective of the study was to determine the level of PC used in the implementation of MUHC program. Findings indicated that stakeholders had an equal opportunity to participate in the implementation of MUHC because most of the categories of people were involved. These categories comprised of the youth, persons living with disabilities, women, children, business people and the civil societies. However, findings indicated that the citizens’ engagement into the implementation of MUHC was low at the involvement level. This was according to the majority of the development committee
members (65.2%). In this level, the residents aired their views concerning the MUHC program which were not included in the program. They felt that the government still held a lot of power and their level of influence over the final decision on MUHC was low (Bothwell, 2019). This could explain the challenges faced by the MUHC as pinpointed by the residents. Major challenges ranged from lack of major health services to limitation to the county health facilities.

Influence of Participatory Communication in the MUHC Uptake

The third objective of the study was to establish how PC influenced the uptake of MUHC program. The results indicated that participation in MUHC implementation motivated the residents to register to the program as reported by 22 (95.7%) of the members of the development committees. This was equally echoed by the health executive member in an in-depth interview, who indicated that participation on public forums motivates(d) the uptake of the program. By enrolling to the MUHC program, 16 (72.7%) of the respondents indicated that they were able to enjoy the benefit of free medical services. Other benefits included poverty index reduction by saving cash that would have spent on medication, access to health information and extension of medical services to family members, free admission and mortuary services for 10 days and free ambulance services and affordable registration.

Further, 15 (65.2%) of the respondents indicated that PC influenced how often the respondents sought health services and also improved their health seeking behavior, reduced the expenses involved in catering for health services at 3 (13.3%) and improved the health status and changed the attitude of the residents towards MUHC health services and health information in the health facilities.
The County health executive committee member involved in the In-depth interviews acknowledged that participation on public forums motivates the uptake of the program. He stated:

*Yes, because in those forums for example when you ask how many people in the meeting have registered for Makuenicare you find a good number of them positively saying they have registered and they are given an opportunity to talk and let the others know what are the benefits of Makuenicare, and by the time those who have not registered are leaving that meeting they are saying they did not know these benefits. This encourages more people to take it up.*

Through the different roles played by both members of development committees and the government through the avenues of public participation, residents were able to understand more about the program. Some of the roles played included creation of awareness through media, provision of relevant information, decentralization of MUHC cards and enrolment, enlightening citizens through public forums and training development committee members and identifying and addressing MUHC challenges.

Members of the development committees acted as the platforms for public participation for the people in Makueni by mobilizing the people to attend public participation forums, monitoring and evaluation of projects by accessing the progress of the project, identify development projects that are forwarded to the government for implementation and also conducting civic education to enlighten the people on their rights and playing oversight roles on the development projects during implementation by making sure it is done according to the Bill of Quantities. This brought about transparency and accountability within the stakeholders and the government which eventually motivates the residents to uptake the program.

Through PC, the community members get to understand the benefits of the program including free medical services, improved health seeking behavior, reduced costs of
medication, reduced poverty index through saving cash that would have spent on medication, access to health information.

The findings concur with Cyril et al. (2015) who posited that PC model leads to better health seeking behaviors among the underprivileged residents, increase in knowledge and uptake of health services. Further, Assan et al. (2019) observed that participatory approaches enhanced the realization of UHC by providing improved health services and dealings of minor illnesses, nearer to the doorstep of the local people, especially to those at the rural areas. It also empowers community members through provision of healthcare information.

The study findings further concur with those of Allotey et al. (2019) who established that PC helped to educate communities and improved their understanding of health structures and sustained growth towards universal coverage. The study also revealed that effective PC empowered the people to be integral in decision making and helped them to understand what and how services are implemented. This is similar to the MUHC program where the residents were empowered through civic education to know their rights and responsibilities and the benefits associated with development projects which motivates them to uptake the development projects in large numbers. Also, participatory communication ensures accountability and sustainability of the health interventions which result to efficiency in making sure that health services are accessible by everyone, and more so to the poor (Cotlear et al., 2015). Moemeka (1994) observed that participatory communication plays transformation role which causes social change to improve the quality of life and the socialization role which upholds the ideologies within society that are harmonious with development.
Conclusion

Based on the study findings, the following conclusions were made:

1. In implementing the MUHC program, Makueni County employed a variety of PC avenues including county government forums, the radio, Public Barazas/Chief’s, Faith based gatherings like the church, mosque and temple, phone texts and WhatsApp. Therefore, it can be concluded that Makueni residents were involved in the implementation of the MUHC and this influenced its uptake.

2. The county government of Makueni used the involvement level of participatory communication in MUHC implementation. In this level, citizens participate from the initial stage and are provided with various ways for their input as the process of decision-making advances (IAP2, 2016). However, the largest chunk of power is still held by the decision makers who are external forces. Therefore, the level of influence over the final decision is still low by the community (Bothwell, 2019).

3. Dialogue is the foundation of participatory communication where all the stakeholders who represent all the categories of people in the society are involved in the implementation of the program and heard equally without any of them controlling the process of communication and mutual respect, listening and understanding the context of development are vital. It is in dialogue that people have an equal chance in giving their views, desires and needs and this opens the opportunity to identify a development project which can be of benefit to members of the society.

4. For PC to be effective, stakeholders and community involvement should be included from the initial level of project development (Information level) to the last
level (Empowerment level). This makes it significant as the members own the project and contribute to it positively. For public participation to be effective, stakeholders and community involvement should be included from the start to the end of a development intervention. This makes it significant and beneficial as the members own the project and contribute to it positively.

5. Civic education for members of the society in terms of their constitutional rights in development project identification and knowing their rights in project development positively contribute to sustainability and success of any development project as transparency and responsibilities are upheld.

6. Public participation through forums accessible to the members of the society results to information reaching many people which in return influences them to uptake the program.

Recommendations

From the study findings, the following recommendations were made:

1. Participatory Communication structures need to be strengthened and increased to allow every member of the society to contribute to the implementation of the development project, particularly the PLWDs who indicated that participation in the MUHC was not enough and that they were not considered and lacked MUHC information and special services.

2. Budgetary allocations for MUHC program need to be increased for the program to expand its services in terms of availing medicine and equipment, infrastructural advancement, and employment of more staff.
3. The development committee members and the citizens generally need to be empowered through civic education to be able to understand the process of PC and its impact on development.

4. Government institutions and development agencies need to incorporate beneficiaries in development programs for maximum benefit, sustainability and ownership.

Recommendation for Further Research

1. This study investigated the effectiveness of PC in the public health domain in Makueni County. A similar study needs to be done to ascertain the effectiveness of PC on other development projects.

2. Another study needs to be conducted to establish the role of political goodwill on the adoption and the sustainability of development programs.
REFERENCES


World Health Organization. (2019). We are called the et cetera: Experiences of the poor with health financing reforms that target them in Kenya. *International Journal for Equity in Health*, 18(1), 98-100.


APPENDICES

Appendix A: Questionnaire

Dear Respondent,

I am Jane Muthoki Mason, a post graduate student at Daystar University under the School of Communication. Currently, I am carrying out a research on examining the influence of participatory communication in the Implementation of Makueni Universal Healthcare. The goal of this study is to advance understanding of how participatory communication as stipulated in the constitution has been incorporated in the implementation of the Makueni Universal healthcare program. I therefore request you to truthfully answer the following questions; this will help me in carrying out an accurate study. This study is purely for academic purposes and all information received will be treated with utmost confidentiality.

Kindly read the questions carefully and give your honest answer. Carefully follow the instructions in each question. Please do not write your name on this questionnaire or indicate any form of identification.

If you have understood the purpose of this study and its benefits and you are willing to participate kindly sign here

Thank you.

Part A: General information

Please tick (☐) the one that best describes you.

1) Gender: a) Male ☐  b) Female ☐

2) Age? Below 18 years ☐  18-28 years ☐  29-39 years ☐  40-49 years ☐  50-59 years ☐  60 years and above ☐

3) Where do you stay? Makueni ☐  Mbooni ☐  Kibwezi East ☐
4) Are you a recipient of Makueni Universal Healthcare?

Yes ☐   No ☐

(i)  

Part B: The participatory communication processes used in the implementation of MUHC

5) How did you know about the Makueni Universal Healthcare? (You can tick more than one)

a) Radio ☐

b) County government forum ☐

c) Faith based gatherings (church, mosque, temple) ☐

d) Public Baraza’s/chiefs ☐

e) Others

means_________________________________________________

6) Do you think all stakeholders have equal opportunities in the implementation of the MUHC? Yes, or No? Why? __________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

_
7) On a scale of 1 to 5 please indicate the extent to which you agree or disagree with the following statement (1. strongly disagree, 2. Disagree, 3. Neutral, 4. Agree, 5. Strongly agree). Please tick one per statement

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(ii) Part C: The Extent by which Participatory Communication was used in the implementation of MUHC

8) In your view, to what extent (level) do you think you have been involved in the implementation of MUHC program? (Tick what best describes your level of participation.)

a) Information Level  
(Only given information about MUHC)  

b) Consultation Level  
(Given a platform to air my opinions which were not considered in making final decision about MUHC)  

c) Involvement Level  
(Aired my views and was included in the process. However, a lot of power was still held by the government. My level of influence over the final decision on MUHC was low)  

d) Collaboration Level  
(I was involved openly in the process of making decisions. I worked together with the government on all the phases of final decision about MUHC)  

e) Empowerment Level  
(It is one of the highest levels of participation where people are in full control. The government implements only what the people want.)
9) (iii) Part D: To establish how PC has influenced the uptake of MUHC

a) Did your Participation in MUHC implementation motivate you to register to the program? □ Yes □ No

b) What benefits have you gained by enrolling in MUHC program?

_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

10) (a) Has MUHC program influenced how often you seek health services?

Yes □ No □

(b) Explain your answer in question 10(a)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

11) How can you describe the MUHC services? (You can tick more than one)

a) Accessible □ b) Available □

C) Efficient (Quality) □
Explain your choice(s)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

12) What has been the role of Makueni County in overseeing of the participatory communication in the implementation of MUHC program?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

13). What suggestions would you give on the MUHC program in future?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Thank you
Appendix B: Interview Schedule

Date of Interview: _____________________________________________

Name of the Key Informant (optional) _____________________________

Title: ________________________________________________________

Gender: _______________________________________________________

1. For how long has the MUHC program been running?
2. What motivated you to start the UHC program? The gap
3. What mechanisms did you use to involve and communicate to the people about the program?
4. What is the current enrollment for the MUHC in the county?
5. Do you think you have the capacity (infrastructural, human resource, budgetary) to run the MUHC program? Explain how
6. What challenges do you encounter when running the program?
7. Do you have any challenge in terms of how you have involved the people in the program?
Appendix C: Focus Group Discussion Guide

1. What are your roles as development committee members?

2. Are you aware of MUHC program?

3. What do you think are the benefits of the MUHC program?

4. In your view do you think you were involved in the implementation of MUHC?

5. What are your roles in the uptake of MUHC program?

6. What are the challenges of the MUHC program?

7. What are your recommendations/advice for the MUHC program implementation?
Appendix D: Ethical Clearance

VERDICT – APPROVAL WITH COMMENTS
Daystar University Ethics Review Board

Our Ref: DU-ERB/21/07/2020/000436

Date: 21st July 2020

To: Jane Muthoki Mason

Dear Jane,

RE: THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC)

Reference is made to your ERB application reference no. 180620-01 dated 18th June 2020 in which you requested for ethical approval of your proposal by Daystar University Ethics Review Board.

We are pleased to inform you that ethical review has been done and the verdict is to revise to the satisfaction of your Supervisors and Head of Department before proceeding to the next stage. As guidance, ensure that the attached comments are addressed. Please be advised that it is an offence to proceed to collect data without addressing the concerns of Ethics Review Board. Your application approval number is DU-ERB-000436. The approval period for the research is between 21st July 2020 to 20th July 2021 after which the ethical approval lapses. Should you wish to continue with the research after the lapse you will be required to apply for an extension from DU-ERB at half the review charges.

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 Daystar University Ethics Review Board.

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 Daystar University Ethics Review Board within 72 hours of notification.

iv. Any changes anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to Daystar University Ethics Review Board 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 a signed one-page executive summary report and a closure report within 90 days upon completion of the study to Daystar University Ethics Review Board via email [duerbs@daystar.ac.ke].

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

Yours sincerely,

Mrs. Purity Kiambi,
Secretary, Daystar University Ethics Review Board

Encl. Review Report

[Signature]
Appendix E: Research Permit

![Research Permit Image]

This is to certify that Ms. Jane Muthoki Muses of Daystar University, has been licensed to conduct research in Makueni on the topic: THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC) for the period ending: 05/August/2023.

License No: NACOSTEP/296916

834812

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION

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Appendix F: Plagiarism Report

THE EFFECTIVENESS OF PARTICIPATORY COMMUNICATION ON THE IMPLEMENTATION OF MAKUENI UNIVERSAL HEALTH CARE (MUHC)

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