"BRIDGING THE HEALTH DIVIDE: ACHIEVING EQUITY AND ACCESS IN KENYA'S HEALTHCARE SYSTEM"

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Abstract

This paper provides a detailed analysis of healthcare access and equity in Kenya by providing historical context, current status, and critical disparities experienced in health services. It looks at the urban-rural divide, important court cases, healthcare infrastructure, public health, and the quest for Universal Health Coverage. Best practices emerge for Kenya through comparative analysis with countries like Rwanda, Ghana, and Thailand. These are all-inclusive policy recommendations, community engagement strategies, public-private partnerships, technological innovations, and capacity-building initiatives. The article concludes: "We envision a future where every Kenyan has access to the health care needed. We hope this vision inspires readers."

Introduction

In a small village in rural Kenya, a mother clutches her ill child, anxiously awaiting the weekly doctor's visit to the closest health clinic. Many 50 kilometers away, in Nairobi, another family can reach several state-of-the-art hospitals within minutes. What seemingly is the sharp geographical contrast is but a symptom of a far-more-deeply-rooted systemic problem. However, in a country where 70% of the population resides in rural areas, such inequality in health care is more than a mere statistic matter of life and death.

The instance of Kenya is one of the evolutions of the health care system since colonial times. To start with, a small urban elite was catered to in the created healthcare infrastructure while leaving the rural majority of the people deprived. Since independence, many reforms and schemes have been implemented to create a more equitable structure. However, even today, vestiges of that unequal structure continue to haunt us. Today, Kenya boasts some of the best medical professionals and facilities in Africa, yet these are unequally distributed, creating considerable healthcare access and quality disparities.

To address this, the government and past administration have initiated several projects to enhance the healthcare system. For instance, the Vision 2030 development plan lists health as

one of the four pillars encompassing national development. The entire National Health Insurance Fund has been overhauled to expand its coverage, and numerous public health campaigns have been waged against everything from maternal health to infectious diseases. But the thing is that for many Kenyans, access to quality healthcare remains out of reach.

The management of healthcare disparities in Kenya is, therefore, essential. Much needs to be done concerning those issues that have contributed to inequalities in healthcare so that healthcare equity can be achieved, such as those that deal with infrastructure, policy, legal framework, and innovations, among others.

This paper presents these aspects in great detail, as well as an analysis and practical recommendations to help close the gap in healthcare access and quality. This paper lays the background of the healthcare situation in Kenya by establishing gaps in accessing quality services, including the state of healthcare infrastructure and public health programs, assessing the progress gained, and identifying the challenges facing the achievement of UHC. The paper will also discuss related legal framework, human rights implications, and comparative presentations with other countries". Finally, the article concludes with evidence by giving recommendations to policymakers, community leaders, and other stakeholders, along with guidelines on informed policy evidence and recommended actions towards closing the disparities and moving towards equity in health in Kenya.

1.0 Historical Context and Current Landscape

1.1 Historical Context

1.1.1 Colonial Legacy

Like most of its infrastructure, the healthcare system in Kenya was deeply marked by its colonial history. Great Britain's colonial rule ensured that most healthcare services were planned for the colonial administrators and settlers.[1] Such a system served urban areas and regions where most economic activities benefited the colonizers, like the highlands and port cities.[2] Thus, the health facilities in the rural and less economically strategic places were poor or did not even exist.[3]The

[1] Rebecca Martin, 'Edited, with Additional Research and Writing a Report on the Colonial History of The' (London School and Lioba Hirsch , 2022) https://researchonline.lshtm.ac.uk/id/eprint/4666958/1/Hirsch_Martin_2022_LSHTM-and-colonialism-a-report.pdf.
[2] Ibid, n(1)
[3] Ibid, n(1)

period of colonialism was also responsible for institutionalizing racism and socioeconomic inequalities in health policies. Hospitals, as well as clinics, were segregated, with the provision of better services extended to Europeans and, to a lesser extent, to Asians than to Africans, who were treated much worse and given inferior treatment most of the time.[4]

Colosso's view is that this slice of healthcare spending was channeled chiefly to address the health problems of those elements within the workforce that contributed to the colonial economy, which, apart from general Malaria and incidents of Tuberculosis, had the potential to impact and limit the workforce's productivity.[5] This unequal distribution of health resources formed the ground for continuing disparities. Inadequate infrastructure was left to the rural areas where the bulk of the indigenous population resided, which haunts the nation even to this very day.[6] The legacy of these is evident in the current urban-rural divide in healthcare regarding access and quality, where urban centers like Nairobi and Mombasa have several well-equipped facilities. In contrast, many rural areas have little basic medical service.

1.1.2 Post-Independence Reforms

Kenya inherited a fragmented and inequitably distributed system at independence in the years 1963: it was at this point that there was a creation of political will with due recognition that it needed to be an all-inclusive approach. The new government started to undertake several reforms to ensure coverage for all citizens.[7] The literature reports that one of the early significant steps was the establishment of the Ministry of Health, which zeroed in on creating a national health policy framework.[8] In the years after, the government set in place various initiatives focused on better health care delivery. With the increased healthcare infrastructure in rural areas, there came more training for healthcare workers and more access to affordable healthcare. For instance, the Community Health Strategy of the 1970s decentralized the delivery of healthcare services and

[4] Stephen Onyango Ouma, '*What Is Ailing Africa? — Practical Philosophy in Reinventing Africa'* (BRILL 2024) https://books.google.com/books?hl=en&lr=&id=TmQNEQAAQBAJ&oi=fnd&pg=PR7&dq=e+period+of+colonialism+was+also+responsible+for+institutionalizing+racism+and+socio-economic+inequalities+in+health+policies.+Hospitals (accessed 13 June 2024).

[5] Joel C Ogbodo and others, '*Effect of HIV/AIDS on Labour Productivity and the Moderating Role of Literacy Rate: A Panel Study of Africa and Its Sub-Regions'* (The International journal of health planning and management, 2024)

[6] Ibid, (5)

[7] Juma Omondi, '*THE INTERPLAY between HORIZONTAL INEQUALITIES and INTRACTABLE ETHNIC CONFLICTS in UASIN GISHU COUNTY, KENYA'* (2023) http://41.89.195.24:8080/bitstream/handle/123456789/2714/James%20Omondi.pdf?sequence=1&isAllowed=y (accessed 13 June 2024).

[8] Benjamin Tsofa and others, 'Political Economy Analysis of Sub-National Health Sector Planning and Budgeting: A Case Study of Three Counties in Kenya' (3 PLOS Global Public Health, 2023)

empowered community action through training for community health workers to offer essential health services and health education.[9]

The turning point in the search for universal health coverage came with the establishing of the NHIF in 1966.[10] Initially, it was meant for the governmental workforce, which extended its arms to cover the informal sector, thus widening the safety net of the citizens in health expenditure.[11] The coverage and benefits of NHIF have undergone reviews over the years to incorporate the diversity in the needs of the Kenyan population. However, real progress has not been compared with so much rhetoric in this field. Political instability, economic problems, and corruption often prevent effective health policy implementation. A growing HIV/AIDS epidemic in the 1980s and 1990s further tormented the ailing healthcare system, requiring immediate public health interventions and international aid. Recent COVID-19 pandemic is the recent ailment in the healthcare proving just how the system is unequal.

The government of Kenya reiterated in its Vision 2030 its promise of improving healthcare as one of the main pillars of national development.[12] It is a strategic plan to transform Kenya, which is envisioned as a globally competitive and prosperous nation that will ensure that a high quality of life is guaranteed to its citizens.[13] The Vision 2030 initiatives target the healthcare infrastructure, service delivery, and Universal Health Coverage.[14] There have been significant strides since independence, but old differences that characterized healthcare access and delivery remain in rural areas and marginalized communities. Such inequalities further require an equitable distribution of resources, practical policy implementations within the health policy, and innovative interventions bridging the difference between urban versus rural healthcare services.

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[9] Stephen Hodgins and others, 'Community Health Workers at the Dawn of a New Era: 1. Introduction: Tensions Confronting Large-Scale CHW Programmes' (2021) 19 Health Research Policy and Systems.

[10] Susan E Nungo, Jonathan Filippon and Giuliano Russo, 'Social Health Insurance for Universal Health Coverage in LMICs: A Policy Analysis of the Attainments, Setbacks, and Equity Implications of Kenya's National Health Insurance Fund' [2023] Social Health Insurance for Universal Health Coverage in LMICs: A Policy Analysis of the Attainments, Setbacks, and Equity Implications of Kenya's National Health Insurance Fund <https://www.researchsquare.com/article/rs-3123732/latest.pdf> (accessed 13 June 2024.)

[11] Ibid, n(10)

[12] Stephen Okumu Ombere and others, 'Local Perspectives on Policy Implementation of Free Maternity Health Services in Kenya: Implications for Universal Health Coverage.' (2023) 27 PubMed 71.

[13] Ibid, n(12)

[14] Ibid, n(12)

1.2 Current Landscape

1.2.1 Statistics and Data

The healthcare situation in Kenya is a mixed bag—some things are perfect, while others are bad; above all, there are considerable disparities in access and outcomes. Data from recognized bodies like the WHO and the Ministry of Health give many insights into the present state of healthcare.

The WHO gives some explanation of how, over decades, Kenya has achieved some improvement in a few health indicators. For example, about the infant, the mortality rate has decreased from 61 deaths for 1,000 live births to 36 deaths for every 1,000 live births in 2019. Maternal mortality has also waned from 510 deaths per 100,000 in 1990 to approximately 342 in 2019.

However, as much as all these have been attained, Kenya still rides on the waves of glaring health inequalities and disparities affecting access and quality provision of healthcare. The primary division is between the urban and rural areas; the metropolitan areas have a concentration and centralization of healthcare structures and resources, especially in major cities such as Nairobi and Mombasa. On the other side, the rural areas that house most of the population still wallow in severe inadequacies in medical infrastructure and personnel. Besides, access to essential medical services varied by socioeconomic status: the rich in urban areas could afford the private health facilities that offered good-quality services, while the less fortunate had to satisfy themselves with the overcrowded public hospitals and clinics with lessened resources in rural or poor urban areas.

1.2.2 Key Disparities

The disparities in access and quality of healthcare are so pronounced among different regions and demographic groups in Kenya.[15] A good example is the service area of maternal health. However, antenatal care attendance by the national coverage is impressive; with 62% of women attending at least one session during pregnancy, access to skilled birth attendants is low.[16] This is in the rural areas, making the situation alarming and increasing maternal mortality. In equally marginalized areas like Turkana and Mandera, their health infrastructure is the worst, and it runs short of hospitals, clinics, and qualified health professionals. It necessitates that remote

[15]Ismail Adow Ahmed and others, 'Health Systems' Capacity in Availability of Human Resource for Health towards Implementation of Universal Health Coverage in Kenya' (2024) 19 PLOS ONE.
[16] Ibid,n(15)

communities in those parts cover long distances through rugged parts before receiving one of the most basic forms of treatment. This results in cases of late treatment of easily curable diseases and, in a sense, high mortality rates.

Moreover, other barriers to accessing health services are experienced among the most underprivileged segments of society, such as women, children, and other people with disabilities.[17] There are even gender inequalities in the pattern of healthcare use, and due to cultural and economic reasons, females are significantly less likely to become users of medical services. Resultantly, poverty and unwholesome health are found among the children of the poor through malnutrition and infectious diseases.

2.0 Access to Quality Services: Urban vs. Rural Divide

2.1 Disparities

The rural-urban divide in health care is among Kenya's most significant challenges in realizing equitable access to quality services.[18] In urban areas, there are vast concentrations of healthcare facilities, specialized medical services, and well-trained healthcare providers.[19] On the other hand, rural areas face a problem with low infrastructure and scarce personnel in health care, which leads to poor accessibility of medical supplies.

A characteristic of access to healthcare in urban locations is proximity to several facilities that offer various services.[20] Recent introductions such as Nairobi and Mombasa have modern hospitals with high medical technology and specialized departments offering many medical solutions.[21] Meanwhile, personalized care at a fee can also be acquired via many private clinics and specialist practices; unfortunately, there are no developed healthcare structures and staff to serve in these structures for the rural population. In most remote villages, even basic healthcare facilities are unavailable, forcing the residents to travel long distances to get medication. In addition, most of the already available health facilities have limited medical equipment, medication, and qualified healthcare workers. Under such situations, most of the delays

[17] Supra,n(15)
[18] Peter M Macharia, Eda Mumo and Emelda A Okiro, 'Modelling Geographical Accessibility to Urban Centres in Kenya in 2019' (2021) 16 PLOS ONE.
[19] Ibid, n(18)
[20] Pauline Bakibinga and others, 'Demand and Supply-Side Barriers and Opportunities to Enhance Access to Healthcare for Urban Poor Populations in Kenya: A Qualitative Study' (2022) 12 BMJ Open.
[21] Ibid, n(20)

experienced by rural residents usually result in deteriorating health conditions and, in some cases, increased mortality rates.

3.0 Case Studies

3.1 Case Study: Nairobi (Urban)

Capital, Nairobi, is just a drop in the ocean regarding access to urban health care. The over 4 million potential patients provide for the existence, up to date, of a range of hospitals, clinics, and specialist centers in need of diversified medical care.[22] For instance, Kenyatta National Hospital—the largest referral hospital in the East Africa region— boasts a vast medical portfolio including cardiology, oncology, and neurology.[23] Private ones like Aga Khan University Hospital care for whoever can afford their services, often using modern medical technology and staff who received training abroad.

3.2 Case Study: Turkana (Rural)

On the other hand, Turkana County presents a more significant challenge than anywhere else to rural dwellers in accessing adequate health facilities. Turkana County is well known for its dry landscape, low population, and poor infrastructure in the northern parts of the country.[24] There are minimal health structures; indeed, some of the village establishments are such that not even an entry-level clinic exists. For instance, the deep hinterland, the village of Lokori, comprises thousands of people, yet it has only one tiny health center.

To put these numbers into perspective, the doctor-population ratio stands at about 1 to 500, while in Nairobi, in Turkana, the trend stands at about 1 to 25,000. Equally telling are the numbers that represent the density of hospitals and clinics: in Nairobi, there is, on average, one healthcare facility per square kilometers, but in Turkana County, the average plummets to one in 10,000 square kilometers.

Such disparities have genuine outcomes that can be linked to the health of the residents. In Nairobi, diseases are diagnosed early and well-treated because of the well-established medical

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[22] Ismail Adow Ahmed and others, 'Health Systems' Capacity in Availability of Human Resource for Health towards Implementation of Universal Health Coverage in Kenya' (2024) 19 PLOS ONE.

[23] Anita Babra, 'Profiles and Management of Adult Cancer Patients with Neutropenia Using Granulocyte Colony Stimulating Factors at Kenyatta National Hospital' (*erepository.uonbi.ac.ke*2021) <http://erepository.uonbi.ac.ke/handle/11295/160168> accessed 14 June 2024.

[24] Gregory Akall, 'Effects of Development Interventions on Pastoral Livelihoods in Turkana County, Kenya' (2021) 11 Pastoralism.

facilities, reducing morbidity and mortality rates. In contrast, most of the life-threatening diseases go untreated in Turkana mainly because of a lack of medical facilities and trained personnel, thus leading to very high rates of morbidity and mortality.

The urban-rural healthcare divide in Kenya colors the need for focused interventions to address disparities in access to quality services. While most of the health options and resources are available in urban setups like Nairobi, most of the challenges are to be found in rural setups like Turkana, marked by poor infrastructure and acute personnel shortages. There is a need for this gap to be bridged through priority investments by policymakers in rural healthcare infrastructure that addresses hiring and retaining health professionals working in underserved areas so that the population is up to innovative solutions for its needs.

3.0 Healthcare Infrastructure

3.1 Distribution of Facilities

The distribution in Kenya's health facilities has significant disparities, and their spread remains uneven for most people when quality is an issue. This includes clinics and hospitals with the urban centers' best facility and equipment standards. At the same time, the rural and remote areas remain far removed from even basic health facilities.

Within the urban settings of Nairobi, Mombasa, and Kisumu, there are pretty endowed health facilities with various hospitals, clinics, and specialist centers.[25] Thus, they are entirely dedicated to the medical care of the urban populace. These areas within the country have more investment in the realization of improved health care, and, therefore, they happen to be overstaffed with better professionals. Disparities continue to exist within the metropolitan areas since more investment is made only in the up-class neighborhoods rather than the facilities in the lower-income areas.

Contrarily, inadequacies in health care delivery in rural and marginalized regions accompany this.[26] In most outlying villages, there may not be a simple health care center, or the residents have to travel many miles to reach the nearest health care provider. Other challenges facing the

[25] John Kobia Rimberia, 'The Moderating Effect of Finance in Determination and Provision of Universal Health Care in Kenya' (*repository.kemu.ac.ke*1 October 2022) <http://repository.kemu.ac.ke/handle/123456789/1365>.
[26] Esther W Muhia, 'Barriers to Adolescents' Access and Uptake of HIV-Related Services in Kawangware Informal Settlements, Nairobi County' (*erepository.uonbi.ac.ke*2023) <http://erepository.uonbi.ac.ke/handle/11295/163961> accessed 14 June 2024.

limited available health centers in rural areas are understaffing, lack of medicine supplies and infrastructure underdevelopment. This lack of access to health facilities contributes to disparities in health outcomes between urban and rural populations, as the latter usually suffer more morbidity and mortality through preventable diseases.

3.2 Technological Advancements

Nevertheless, they have significantly transformed the healthcare infrastructure and access in Kenya. Significant healthcare delivery changes have been influenced by developments in technology, including telemedicine, electronic health records, on the one hand, and mHealth applications.

Through telemedicine, characterized by videoconferencing or telephone, such processes as consultation and diagnostics are made remotely available to urban centers from the vast rural and far-apart distances where the services are usually provided.[27] More particularly, this technology tremendously enhances patients from remote regions' access to specialist services, reducing their apportionment of associated high costs incurred during prolonged travel. Through electronic health records (EHRs), patient's medical history data have been adequately digitized, enhancing accuracy and efficiency in all other services. The potential of EHRs is great, providing health professionals with the ability to access patient information electronically in seamless coordination of care across different healthcare settings, reduced risks of medical errors, and improved patient outcomes.

Mobile health applications are another powerful element towards opening access to health services in Kenya. The applications are accessible via smartphones and other mobile devices. The applications offer health-related services, such as appointment scheduling, medication reminders, health tips, and other educational resources. With such extensive use of mobile technology throughout the territory of Kenya, the mHealth applications hold vast potential for reaching millions of people with intense activities, perhaps most likely to take place in some of the larger, still-rural and underserved areas, where the primary healthcare infrastructure remains at a low level.

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[27] Reiner Klingholz and others, *Leapfrogging Africa: Sustainable Innovation in Health, Education and Agriculture* (African Sun Media 2020) https://books.google.com/books?hl=en&lr=&id=mikDEAAAQBAJ&oi=fnd&pg=PA3&dq=Through+telemedicine> accessed 14 June 2024.

4.0 Public Health Initiatives

4.1 Government Programs

The Kenyan government has implemented several major public health programs aimed at addressing key health challenges facing the population, with a focus on maternal and child health, HIV/AIDS, and other infectious diseases.

4.2 Maternal and Child Health Programs:

The flagship among the government's maternal and child health initiatives is the Beyond Zero Campaign, launched in 2013 by former First Lady Margaret Kenyatta.[28] It targets improved access to crucial health care services under the antennae of antenatal care, climate birth preparedness and complication readiness, skilled birth attendance, and postnatal care in the general effort to reduce the increasing maternal and infant mortality rates.[29] The Beyond Zero Campaign has reached many marginalized populations in rural and underserved areas with innovations like mobile clinics and maternal health outreaches. Further, there is the Free Maternity Services Program, through which public health facilities offer free maternal healthcare services.[30]

4.3 HIV/AIDS Programs

It has, for instance, been at the forefront in responding to HIV/AIDS globally, with very robust programs both in terms of prevention and treatment and care. The National AIDS Control Council coordinates the national HIV/AIDS response through initiatives such as the Kenya AIDS Strategic Framework - KASF - and the National HIV Prevention and Control Plan.[31] These programs focus on promoting strategies for preventing HIV, increasing access to HIV testing and counselling, and making ART available to all people living with HIV. Notably, eMTCT has received attention through the PMTCT program from the government as well. The use of antiretroviral drugs for HIV-positive pregnant women and their infants has made Kenya attain remarkable moves towards ensuring a reduction in mother-child transmission of HIV.

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[28] https://www.beyondzero.or.ke/

[29] Felista Timaado, 'Influence of Community Health Strategy on Utilisation of Maternal Health Care: A Case of Laisamis Ward in Marsabit County, Kenya' (*erepository.uonbi.ac.ke*2017) <http://erepository.uonbi.ac.ke/handle/11295/101416> accessed 14 June 2024.

[30] Ibid, n(29)

[31] Bernadette Mutinda, 'Influence of Alignment on Strategy Implementation in HIV/AIDS Non-Governmental Organizations in Kenya' (*ir.jkuat.ac.ke*28 October 2020) <http://ir.jkuat.ac.ke/handle/123456789/5313>.

5.0 Universal Health Coverage (UHC)

5.1 Policy Framework

5.1.1 National Health Insurance Fund (NHIF)

The National Health Insurance Fund is the driving force behind most initiatives that will enable Kenya to achieve universal health coverage. Fresh from its formation in 1966 as a small fund charged with the primary responsibility of taking care of mainly the salaried employees, NHIF has, over the years, evolved to become a comprehensive health insurance scheme for the benefit of all citizens of Kenya - including the informal workers. The NHIF has several critical strategies from the policy framework to increase coverage and enhance service delivery. First, the NHIF provides a comprehensive benefits package covering inpatient care, outpatient care, maternal health services, chronic disease management, and emergency care—working favors the benefits package because it tries to cover the working population has varied healthcare needs.

To increase accessibility, the NHIF introduced the "Supa Cover." It is supposed to have affordable premiums that are considerate to those working in the informal sector and self-employed individuals. This move targeted to close the gap between the formal and informal sector workers, so more Kenyans are brought into the fold of the health insurance scheme. Another strategic move is the recent decentralization of the NHIF services into the devolved system of government at the county level. Many in rural and remote areas have, therefore, been able to access healthcare services. The creation of partnerships with private providers has also led to the addition of more healthcare facilities that NHIF members can access.

5.1.2 Challenges

Despite these, various challenges hinder the full realization of UHC in Kenya. The first challenge concerns low coverage by the NHIF. As much as the fund has made encouraging strides in expanding its membership, vast portions of the population remain uncovered, mainly those from rural and low-income settings. This occurs typically due to the inability to pay for the premiums and lack of appreciation for the need for health insurance. The other pressing concern is the quality of services offered in NHIF-accredited facilities. Most public health facilities have a constant shortage of personnel, worn equipment, and medicines are often unavailable. This strips the health sector of its confidence despite efforts to recruit community officers, gain accreditation for the private wing, and attain ISO certification.

Another important one is that of financial sustainability. About this, NHIF has been over-reliant on the contributions of its members. That is to say, the current funding model may not be able to take care of the skyrocketing demand for services. Questions of efficiency and transparency about managing these funds have also arisen. Corruption and mismanagement have been associated with it in the past.

6.0 Legal Framework and Human Rights

6.1. Constitutional Provisions:

The Constitution of Kenya 2010 is the supreme law and, in itself, has strong protections in health rights. At the center of the protections is Article 43 (1) (a), which categorically states as follows: "Every person has the right to the highest attainable standard of health, which includes the right to health care services, notably reproductive health care.[32]". It places an obligation squarely on the state to ensure that all citizens can avail themselves of whatever healthcare services are needed.

Article 53(1)(c), explaining this commitment, specifies the rights of children, giving entitlement to every child to receive, among other things, essential nutrition, shelter, and health care, and enhances the commitment of the state to protecting the health of its youngest citizens.[33] Article 55(a) calls on the state to adopt affirmative action programs that provide appropriate education and training to the youth and protect them from harmful practices and exploitation, indirectly promoting their right to good health.[34] In addition, Article 56(e) provides that the state remains obligated to ensure that minority and marginalized groups have reasonable access to health services, thereby making access to health care more inclusive and equitable.[35]

6.2 Statutory Acts:

These provisions of the Constitution in Kenya are operationalized through several statutory acts that detail the delivery of health care. A yardstick piece in the area is that of 2017, the Health Act, which operationalizes and provides a framework under which this progressive realization of the right to health is contemplated under the Constitution. It spells out the functions and roles of

[32] Constitution of Kenya, Article 43(1)(a)
[33] Constitution of Kenya, Article 53(1)(c)
[34] Constitution of Kenya, Article 55(a)
[35] Constitution of Kenya, Article 56(e)

national and county governments in delivering health services and setting health standards and health regulations.

The Public Health Act (Cap 242) concerns itself with preventing and controlling diseases and making arrangements to secure reasonable levels of public health and sanitary standards.[36] The same act ensures the population is provided health-wise and works on keeping the disease burden through the unfavorable effects of its prevention. The Mental Health Act (Cap 248) provides for the care, treatment, and protection of the mentally ill from any discrimination and stigma.[37]

7.0 Comparative Analysis and Case Studies

7.1. Maternal Health Improvement in Kitui County

Kitui County has presented significant improvement in maternal health since implementing the MHIP. MHIP is designed to be a flagship program aimed at achieving reduced maternal and infant mortality across the globe by improving access to quality maternal healthcare services.[38]

Mainstream features of the MHIP covered the training of midwives, facilities' upgrading, and community sensitization on maternal health.[39] By 2018, more than 300 midwives had been trained in Kitui County, beefing up the quality of care accorded by midwives to expectant mothers. Additionally, the county has boosted 50 health facilities and equipped them with maternity units and equipment. Community health volunteers were essential at this stage as they sensitized women on the importance of antenatal care and safe deliveries. Since then, reports show that visits by women to antenatal clinics have increased by 40%, and skilled birth attendance rates have increased by 30%. This reduced the maternal mortality rate from 488 per 100,000 live births in 2014 to 250 per 100,000 live births four years later in Kitui County.

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[36] Public health act,2015

[37] Mental health act, Cap 248

[38] Alex Ergo and others, 'Creating Stronger Incentives for High-Quality Health Care in Low-and Middle-Income Countries' (2012) <https://mchip.net/sites/default/files/QoC%20and%20PBI_Full%20report_Final.pdf> accessed 15 June 2024.

[39] Wacu Ndirangu, 'MATERNAL CHILD HEALTH FACILITY in DANDORA SLUMS, NAIROBI, KENYA: THE NEED Date' (2016) <https://cdr.lib.unc.edu/downloads/9s161c008> accessed 15 June 2024.

7.2. HIV/AIDS Control in Turkana County:

The county of Turkana is one of the most misbehaving Northwestern counties in Kenya in terms of multiple health challenges and high HIV prevalence.[40] Turkana HIV/AIDS Control Program has since the year 2016 been booted into operation to complement other interventions. This program was conducted hand in hand with the county government, NGOs, and international partners.[41] The critical strategies include intensifying the HIV testing and counseling services, ART services, and community outreach.[42]It further established and implemented 20 additional sites for people infected with HIV in remote areas for testing and counseling, services brought closer to home. Over and above that, more than 15,000 people were enrolled in ART programs and, therefore, could be assured of the much-needed treatment. The majority of the information was passed through the CHW, who led door-to-door campaigns where they sensitized people on HIV prevention and treatment. The results were already excellent by 2020: infection rates from HIV had plummeted from 6.9% to 3.5% in Turkana County, and the improvement in ARV adherence and new infections halved.

8.0 Comparative Analysis

8.1 Global Comparisons

To better understand the strengths and weaknesses of Kenya's healthcare system, it is helpful to compare it with the healthcare systems of other African countries and developing nations.

8.1.1 Rwanda

For a country with meagre resources, Rwanda has managed to pull off some remarkable health outcomes courtesy of the innovations it uses to deliver health care. One of the approaches Rwanda utilized entailed designing and establishing community-based health insurance (CBHI).[43]This concretely means a system that ensures that over 90% of the people can access health services, even among the poorest of her citizens. Besides, Rwanda has invested so much in people, primary health care, mainly preventive care, and innumerable health community

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[40] Rubai Mandela, 'Re-Energizing Gender Learning in the Context of the Competency Based Curriculum in Kenya' (2021) 5 Msingi Journal 37 <https://journal.ku.ac.ke/index.php/msingi/article/view/233> accessed 7 December 2021.

[41] Ibid, n(43)

[42] Ibid, n(43)

[43] Benjamin Chemouni, 'The Political Path to Universal Health Coverage: Power, Ideas and Community-Based Health Insurance in Rwanda' (2018) 106 World Development 87.

workers.[44] On the other hand, Kenya has had her NHIF limping in achieving the same reach, which is its levels of coverage; that is, between Rwanda and Kenya, like what has come to be recognized as Rwanda's national coverage, especially among informal sector workers. Learning from Rwanda, Kenya could fine-tune the insurance scheme to ensure it functions without hitches and covers more of her citizens.

8.1.2 Ghana

Ghana's health state is well advanced following the initiation of the National Health Insurance Scheme in 2003.[45] The NHIS pursues universal health coverage, whereby every Ghanaian can access quality health care without much financial difficulty.[46] This scheme is covered by providing cheap health insurance. The scheme is financed by the mob sum of taxes, premiums of the citizens, and the well-wishers. Ghana's NHIS is well off and has cut over the tail of 40% of the total population.[47] This program has limited access to healthcare, especially to the most vulnerable people in the population. The challenges in the two most critical areas of the scheme's financial sustainability and quality of care threaten to eclipse these innovations. At face value, one looks at Kenya, which has so much to borrow from the Ghanaians regarding financial sustainability and ensuring quality care out of the NHIS.

9.0 Recommendations

9.1. Policy Recommendations

To address healthcare disparities and improve access to quality services, the Kenyan government should undertake the following policy changes and initiatives:

a. Expand Health Insurance Coverage:

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[44] Ibid, n(46)

[45] Christmal Dela Christmals and Kizito Aidam, 'Implementation of the National Health Insurance Scheme (NHIS) in Ghana: Lessons for South Africa and Low- and Middle-Income Countries' (2020) Volume 13 Risk Management and Healthcare Policy 1879.

[46] Ibid, n(48)

[47] O Couturier, 'Éditorial' (2023) 47 Médecine Nucléaire 225 <https://repository.library.georgetown.edu/bitstream/handle/10822/1082442/Couturier%20Final%20Thesis.pdf?sequence=1> accessed 15 June 2024.

The government should introduce targeted subsidies for low-income families to increase NHIF enrollment.[48]Implementing a sliding scale for premiums based on income can make health insurance more affordable for informal sector workers and vulnerable populations.

b. Strengthen Primary Healthcare:

Investing in infrastructure and services of primary healthcare is another way to go. The government should invest more in upgrading the facilities of primary health, training community health workers, and ensuring that there is a regular supply of essential medicines and equipment.

c. Enhance Health Data Systems:

Developing robust health information systems can enhance the planning, resourcing, and monitoring of health services. The Government has to invest in EHRs and ensure that different health systems share information via an interoperable system.

9.2. Community Engagement

a. Community Health Committees:

The government should establish community health committees involving local leaders and residents in the decision processes. Such committees make it possible for the needs and priorities of the community to be articulated and that the running interventions are within the culturally proper frameworks.

b. **Health Education Campaigns:**

Comprehensive health education should be implemented that focuses on preventive care, nutrition and maternal/child health, and the need for health insurance. The creation of materials in local languages and the use of culturally relevant material increases their effectiveness.

c. **Volunteer Health Workers:**

They must be trained and deployed to visit door to door, provide essential health services, and give health education. Since these are the volunteers who can bridge the gap between the

[48] Robinson Oyando and others, 'Evaluating the Effectiveness of the National Health Insurance Fund in Providing Financial Protection to Households with Hypertension and Diabetes Patients in Kenya' (2023) 22 International Journal for Equity in Health.

communities and the healthcare facilities, they must ensure that essential health services reach the doorstep of even the remotest areas.

9. 3. Public-Private Partnerships

Effective government and private sector collaborations can enhance healthcare access and quality.[49] The following models for public-private partnerships (PPPs) are recommended:

a. **Joint Health Programs:**

There are the joint health programs, in which private companies provide funding, technology, or even expertise, but for which the government guarantees regulatory compliance and equal access. Example: "Pharmaceutical companies are to run vaccination campaigns in partnership with the government."

b. **Corporate Social Responsibility (CSR):**

The government should leverage CSR initiatives to support health projects. Companies can adopt health facilities, sponsor medical camps, or fund health education and infrastructure improvements.

9.4. Technological Innovations

Technological solutions can significantly improve healthcare access and quality. The following recommendations are proposed:

a. Telemedicine Services:

The government can expand telemedicine services remotely to consult, diagnose, treat, and manage patients' conditions. This may significantly help areas with poor populations of healthcare professionals, usually in rural areas. Most of these services can easily be realized through mobile applications in health, otherwise called mHealth.

b. **Health Management Information Systems (HMIS):**

[49] Tara Tancred and others, 'How Can Intersectoral Collaboration and Action Help Improve the Education, Recruitment, and Retention of the Health and Care Workforce? A Scoping Review' [2024] the International Journal of Health Planning and Management.

The government should Implement and integrate HMIS across all healthcare facilities to improve data collection, analysis, and decision-making. A centralized HMIS can streamline patient records, track disease outbreaks, and optimize resource allocation.

c. **Mobile Clinics:**

The government should deploy mobile clinics with modern medical equipment to provide healthcare services in remote and underserved regions. These clinics can offer preventive care, maternal and child health services, and chronic disease management.

10.0 Conclusion

So, in a nutshell, addressing inequality in the health care system within Kenya involves policy reforms, community engagement, public-private partnerships, technological innovations, and capacity building. Much remains to be done from the historical context and the current landscape, as well as significant challenges and massive potential for improvement. Such initiatives are success stories played out in the narration and a comparative analysis of best practices that are likely to allow further guidance toward the future. It is a pressing need for the government, private sectors, and communities to take up sustained efforts and collective action towards bridging the gaps for access to healthcare and equity. With the right policies, local community empowerment, collaborations, technology, and increased healthcare capacity, the objectives of Universal Health Coverage can be met. This is a future where the visions of a more equitable healthcare system for Kenya have been actualized; by coordinating different county activities, available services are accessible. With combined efforts and the will to be innovative and inclusive, we can make the reality of quality healthcare natural to every Kenyan, whatever their socioeconomic status. Let us all work together to make this vision a reality.

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