THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

The Role of Medical Camps in Ensuring Equity in Accessing Health Care Services in Kenya

Jane Wambui Karia
Lecturer, Department of Training, Kenya School of Government, Embu, Kenya
Moses Gicheru Njoroge
Lecturer, Department of Training, Kenya School of Government, Embu, Kenya
William Nyabuto
Lecturer, Department of Training, Kenya School of Government, Embu, Kenya

Abstract:
This study was carried out to help improve the management and organization of the medical camps in Kenya by the various key stakeholders thus enabling the medical camps achieve the overall goal of enabling access of quality affordable health care services to the disadvantaged and marginalized population in Kenya in acknowledgement that equity in the accessing and provision of health care services is an underlying principle intertwined in the human rights principles. Everyone irrespective of their social and economic status are entitled to a standard of health that is enjoyed by majority of the advantaged populations within a society and deliberate multi-disciplinary efforts need to be taken to ensure access of quality affordable health care services for all. Medical camps organized by public sector, private and Non-governmental organizations are initiatives aimed at achieving the goal of availing high standard of health to especially the vulnerable and disadvantaged populations in a community. This study sought to establish the role of medical camps in ensuring equity in accessing health care services in Kenya. The study targeted 500 patients who attended a medical camp, mounted by Embu County Government, one of the 47 county governments in Kenya, in Karaba, Mbeere South Sub-County on 1st of November 2019. A total of 50 respondents were sampled which was 10% of the total population as it was not possible to involve all the patients due to time and cost constraints. A convenience sampling technique was employed where the study relied on information provided by willing respondents.
The data was collected using a structured interview schedule comprising of both closed and open-ended questions. The data was analysed using factor analysis by use of SPSS software. Descriptive statistics in form of frequencies and percentages were used. The findings revealed that there was 100% response rate where majority of the respondents were female. It was notable that majority of those who attended the medical camp were vulnerable persons most of them with primary level of education, unemployed and earning a meagre monthly income of estimated US$ 139. The findings established that the medical camp was well planned and organized. The location was convenient to majority of the respondents; it was easy to locate and navigate through and majority resided within 5 kilometres of the venue. The majority of the respondents were to a great extent satisfied with services offered, level of professionalism and friendliness of the health professionals, proximity of the medical camp; hygiene and as well as free services. The study therefore concluded that to a great extent medical camps ensure equity in accessing health care services among the disadvantaged populations and recommended that such medical camps be organized on a regular basis. The study also recommended that consideration be given to build the capacity of local health staff to enable them offer follow up services after medical camps are offer. Expanding and equipping health facilities should also be a priority given that not all services could be offered during medical camps such as complicated major surgeries.

Keywords: *Medical camps, equity, health care services, disadvantaged communities*

1. Introduction

1.1. Background of the Study

The health of a person is of paramount importance as it determines the person's holistic wellbeing and productivity. Health is a state of being physically, mentally, psychologically and socially fit. American Health Public Association notes that for a nation to provide health equity to all especially the vulnerable population, certain essentials that need to be observed. It is important to be explicit in ensuring that vulnerable people have access to the social and economic services they need to be as healthy as possible. Discrimination must be recognized as a health determinant, and public health and health care practitioners must identify and resolve their own cultural implicit bias through meaningful education and training. Adopt a 'Health in All Policies' strategy that focuses on enhancing disadvantaged communities' access to nutritious foods, safe housing, affordable transportation, quality education, equal jobs, safe green spaces, and economic growth opportunities. Internal capacity is needed to advance health equity and an organization's position in

enhancing the health of marginalized communities, such as by incorporating equity targets in the mission, enforcing culturally inclusive hiring practices, delivering cultural competency training to staff, holding national or county healing medical camps, aligning funding decisions with equity goals, and engaging in interdisciplinary research. Vulnerable groups should be given meaningful opportunities to engage in the planning of services, interventions, and policies aimed at advancing justice in order to advance health equity. The elimination of multiple health inequalities, such as social and economic barriers to health, narrowing discrepancies in health outcomes, and rising equal opportunities to be healthy, is used to track progress toward advancing health equity (American Health Association, n.d.).

Universal health coverage promoted by World Health Organization (WHO) aims at ensuring that all people have access to quality and affordable health care services that do not subject them to financial difficulties. It also implies access to a full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Sustainable Development Goals number three (3) advocates for good health and wellbeing for all. This in essence emphasizes equitable distribution and access to health care services by all irrespective of a person's social or economic background

Equity means fairness and impartiality in distribution of available resources and or opportunities irrespective of persons' unique characteristics, vulnerability or disadvantages. Equity in health refers to equal access of health care services for all. The concept of equity is an ethical principle and resonate well with human rights principles. The right to health as set out in the WHO constitution and the United Nations Universal Declaration of Human Rights (UNDHR) is the right to the highest attainable standard of health which is understood to mean the standard of health enjoyed by most of the advantaged groups within a society. Despite decades of studies documenting inequalities in health care, identifying underlying root causes, and testing remedies, disparities remain. Differences in the quality of treatment and health outcomes based on patient race, ethnicity, and socioeconomic status result in a lot of human misery and great economic cost. Unconscious prejudice and cultural insensitivity by physicians and health care organizations, unequal health care, and systemic inequities in people's social, economic, and physical environments are all factors that contribute to inequalities in health outcomes (DeMeester, et al., 2017).

A Free Medical Camp is a life-saving initiative that seeks to deliver free medical and surgical care to vulnerable communities in rural and urban areas through a mobile team that offers a variety of medical specialized services. Some NGOs, Charitable Medical Trusts, and medical practitioners are motivated by strong medical ethics, believing that it is their moral duty and obligation to treat all patients equally regardless of their incomes, race, or social status. A medical camp's primary purpose is to provide immediate treatment to people in life-threatening situations by incorporating the particular strengths and goals of medical ethics. When the majority of hospitals and clinics close, leaving the poor to die from infections, trauma, and other health problems, free medical camps become their only hope. And the poorest are entitled to the dignity of basic human rights, which we cannot deny (Transparent Hands, 2018).

Health care refers to the organized provision of medical care to people and communities. Wikipedia defines health care as maintenance or improvement of health through prevention, diagnosis, treatment, recovery, or cure of diseases, illness, injury and other physical and mental impairments in people. Health care is delivered by health professionals and allied health care fields (Wikipedia) through an integrated and collaborative approach that creates a health care system. Health care systems refer to the method by which health care is financed, organized and delivered to a population. It includes issues of to whom, what services and with what resources which include health care workers and facilities (encyclopaedia.com). The goal of a health care system is to enhance the health of a population in the most effective manner possible in light of a society available resources and competing needs.

Kenya's healthcare system is divided into three categories: public, private, and faith-based or non-governmental organizations. Around 48 percent are public and managed by the Ministry of Health, 41% are private, 8% are faith-based health services, and 3% are run by non-governmental organizations. The fundamental shortcoming of Kenya's healthcare systems is the mismatch between needs and accessible treatment, especially specialist care and the workforce – from doctors to technicians – required to operate it. Geographically and economically, the imbalance between available care and needs expresses itself in two ways. There is a significant geographic difference between what is accessible in rural and urban areas. The majority of Kenyans, about 70% of the population, live in rural areas. They primarily depend on community health volunteers and health centres staffed by nurses who provide primary health care services such as immunization. Sub-county hospitals provide more services, and though they have few medical doctors on hand. Many that are poor or uninsured have a harder time accessing medical services available. If they have access to healthcare, they risk huge bills that could drive them into poverty (Mohiddin & Temmerman, 2020). Medical camps are aimed at reaching out to these vulnerable population by taking services closer to them, offering free specialized medical services as well as providing education and creating awareness especially for prevalent diseases thus promoting prevention and healthy lifestyles.

1.2. Research Problem

Medical camps refer to situations where highly qualified medical experts 'camps' to offer a variety of health care services to needy persons in the society. The health care systems and especially in developing countries are hardly favourable to the poor populations in the society. Health care facilities are very limited and mainly concentrated in urban areas. Even in the urban areas the number of facilities is not equivalent with the size of the population; bed capacity is always limited; medical personnel to patient ratio is very low and most of them are hardly equipped with necessary infrastructures and supplies (WHO, 2017). In Kenya health care system is categorized into 3 that is the public, private and faith based or NGOs managed facilities. The Kenya primary health care (PHC) system is made up of six levels: Level 1,

community services; level 2, dispensaries and clinics; level 3, health centres and maternity and nursing homes; level 4, sub-county hospitals and medium-sized private hospitals; level 5, county referral hospitals and large private hospitals; and level 6, national referral hospitals and large private teaching hospitals (WHO, 2017). The majority of the rural based population is mainly served by community health facilities which lack adequate health infrastructure and medical professionals. Private health facilities with necessary infrastructure, supplies and ideal doctor/ nurse patient ratio, are too expensive for the ordinary poor population and concentrated in urban areas. Medical camps are organized to reach out to this disadvantaged population.

Numerous medical camps have been organized in the recent times in Kenya by different organizers; governments, private organisations, NGOs and medical professionals. In April 2016 a medical camp targeting orphaned children was organized at Jaffrey Islamic Centre in Mombasa. Free Medical, Surgical and Eye camp organized by Kenyatta University Muslim Medical Students Association in collaboration with Kenya Association of Muslim Medical Professionals (KAMMP) and Centre for Health and Education Programmes (CHEPs), held at Garrisa Primary School and Garissa County Referral Hospital on 8th and 9th September 2018.Kenyatta National Hospital in partnership with Safaricom Foundation and Flying Doctors Society of Kenya carried out a weeklong free fistula camp in Makueni and Nyeri Counties in Kenya from 6th July to 12th July 2019 where screening and treatment was available free of charge. The County Government of Embu has organized several medical camps, specifically one in Kiritiri in 2019 and another at Karaba in the same year. The Medical Camp at Karaba, Mbeere South Sub-County, Embu County, Kenya forms the basis of this study.

In spite of these numerous medical camps held in Kenya, there is limited knowledge pertaining to the success of these medical camps with respect to their intended priority objective of ensuring access of quality and affordable health care services to marginalized and disadvantaged population in Kenya. This study sought to examine the role of medical camps in ensuring equity in health care services in Kenya. Specifically, it aimed at answering the question; what is the role of medical camps in ensuring equity in accessing health care services in Kenya.

1.3. Significance of the Study

The findings of this study will help streamline the organization and management of medical camps by providing insights as to the best practices in management of medical camps and facilitate the review and or development of the law, policies and regulations that govern the operations of medical camps in Kenya making them more effective and beneficial to the target populations

2. Literature Review

2.1. Medical Camps

The health of a person is of critical importance as it determines a person's wellbeing and productivity. A healthy person has a sense of self-esteem, self- image and is relatively happy. A country's social and economic development is to a great extent hinged to its populations' state of health. Access of quality health care services is considered a basic human right and should be accessible to all irrespective of social or economic background. All efforts must be made to ensure that the less fortunate segments of any society/ community access quality and affordable health care services and that they should not be made to suffer any financial hardships by accessing them. Medical camps are initiatives taken by various multi-disciplinary groups of persons/ institutions and aimed at achieving the goal of enabling the less fortunate and disadvantaged populations' access quality and affordable health care services. Medical camps initiatives are aimed at helping achieving this goal.

Medical camps are outreach health programmes where a team of medical specialist's'camp' at a designated location to offer specialized medical services to marginalized and disadvantaged populations in the society(Gajuryalet al, 2019*)*. Medical camps are organized by governments, Non-governmental organizations, medical trusts, medical professionals and other allied professionals with different interests and scope. Whereas different organizations or professionals undertake medical camps to pursue their respective interests the overriding factor remains to reach out to the disadvantaged populations in the society. These people suffer poor income levels, harsh geographical terrains that make it difficult to access transport infrastructures, live in areas with limited health facilities especially the rural areas and informal settlements that are densely populated as well as those lacking basic health information and education. John Rawls (1971) argues that a fair society must ensure that people in the most disadvantaged position are not discriminated against but supported to access all positions. Some NGOs, Charitable Medical Trusts, and medical professionals are driven by strong ethics of medicine and believe that they have moral responsibility and obligation to treat each patient regardless of their incomes, race, or social status. Medical camps are set up with a sacred aim to bring awareness amongst the deprived population of the country who have no access to basic healthcare services or knowledge about the diseases they are suffering from. Medical camps are also aimed at providing free and high-quality medical services for the poor population; Working as an emergency team in disasters; raising health awareness among the community and teaching them to deal with communicable and non-communicable diseases. Medical camps are also used for registering rare and severe cases and referring them for specialized treatment in hospitals. Various studies have suggested that medical outreach camps have proven to be more convenient than outpatients' clinics with excellent satisfaction levels of the patients (S. H Gajuryalet al 2019).

To achieve the objectives proper planning and management of medical camps is crucial. Planning involves considerations such as venue, resource allocation, including human, logistical preparations and equipment and seeking clearance. Health camp should always be conducted during holidays or weekends so as to allow maximum number of

participants in the camp. Venue should be accessible from the area where there is dense population, preferably in school, local health post, colleges where there are adequate waiting area and examination space. Organizers need to collaborate with the interested stakeholder so as to ensure adequate budget for conducting the camp. Medicine and consumable supplies can be obtained from prior request to various pharmaceutical companies (S. H.Gajuryalet al 2019). Knowledge of the prevalent diseases in the targeted community is essential in medical camps planning. Such knowledge help in identifying the medical specialists to be involved, medicines and equipment to be included. After initial planning the organizers should seek permission to hold the camp from relevant authority mainly institution responsible for regulating health services. Upon receiving authority, the organizers should through different channels disseminate information about the camp to the targeted community. Such channels may include pamphlets, round speakers, announcements in churches and schools as well as local administration officers' meetings popularly known as 'Barasas'. Health camp should always be led by multidisciplinary manpower ranging from helper, health assistant to different categories of consultants. Even a specific camp should have multidisciplinary approach as those health camps in unreached area tend to have a multiple disease specific service seekers(S. H.Gajuryalet al 2019). Another essential element of medical camps is technology transfer. This refers to sharing of knowledge and technology in disease management from competent camp health professionals to local health professionals. This help build the capacity of local health professionals enabling them manage patients who come for follow ups after the camp. Other aspects to be considered in the planning and organization of medical camps is involvement of the local community at different capacities in the entire process. Community participation increases the possibility of success and provide the locals with opportunity to learn. It was also important for medical camps organizers to integrate education and creating awareness on diseases prevalent in the community (S. H Gajuryal et al 2019).

2.2. Equity in Health Care Services

John Rawls (1971) opines that differences are inherent and equitable treatment should be the main concern of any health care organization. In his second principle of justice, he argues that a fair society must ensure that people in the most disadvantaged positions are not discriminated against and can potentially access all positions. Amartya Sen (2009) emphasizes a just society and not only a fair one and defines such a society as one that creates better conditions of life for those most in need 'not as a result of logical deductions but as a matter of public reasoning'. In the context of health services this implies that health care services should not be a reserve of the middle class or those who are capable of paying for the services but should be made available to the less fortunate in the society as well without subjecting them to any financial distress. In Kenya 40% (The World Bank, 2020)of the population live below poverty line, 70% of them live in the rural areas where health care facilities are very scarce and geographically far apart. Even those living in the urban areas and particularly in the informal settlements are not any better. The health facilities are not adequate to cater for the big numbers of slum dwellers; are often congested and lack medical resources-human, equipment and supplies. Medical outreach camps are aimed at reach out to such vulnerable populations but proper planning and management is a prerequisite for the achievement of the goals.

Cattacin S et al (2013) developed a theoretical framework that provides insight regarding equity standard in health care services. The framework identified five key domains of equity in health care services namely; equity in policy, equity in access, equity in quality of care, equity in participation and promoting equity.

Equity in policy advocates for government guidelines and legal rules to require all service providers to avail their services to all including the disadvantaged populations in a society. The other standard is equity in access which emphasizes equitable access to and equitable utilization of the services provided. The access barriers to be put into consideration are physical accessibility and geographical distribution of facilities and services including outreach interventions for the most disadvantaged populations. Communication and information must be improved for consolidation and to maintain developments. Cattacin S et al, 2013 asserts that greater efforts to provide information in different forms and with different tools taking into account different levels of health literacy should be considered. The standard equity in access also encourages health care organizations to address other barriers such as power-imbalance in patient-doctor communication; improvements of trust, respect, openness and empathy which affect relationship between patients and health professionals. Legal and financial barriers such as lack of formal entitlement or health system and socio-political context of local norms and values as well as resource constraints. Medical outreach camps are organized and intended to overcome these barriers

The third standard, equity in quality of care contends that health organizations/ health professionals should provide high quality person-centred care for everyone. This in acknowledgement of the unique characteristics of individuals and the relational environment. It is worth noting that (Cattacin S et al 2013) do not refer to the general categories of individuals such as cultural background, disability, gender or ethnicity but to the unique individual lifeworld. Health care staff are encouraged to learn to work across differences and invest in the relationship with the user by acknowledging that only the patient is uniquely qualified to help the health care provider to understand the relevance and impact of his/ her uniqueness in relation to the represented illness experience. It is important to know that patients will only open up and freely provide their information on an environment of trust and mutual respect. Trustful interactions create a safe environment that promotes person-centred quality of care. The fourth standard equity of participation, emphasizes the need for development of equitable participatory processes that respond to the needs and preferences of patients. The standard requires that patient be seen as active participants rather than passive recipients. It is worth noting that participation here means the involvement of patients at individual level in assessing the effectiveness of the services in meeting patient individual needs and preferences. The fifth and last standard, promoting equity, is intended to promote

an understanding of the health care organization as part of a wider social and political system required to influence the broader society in promoting equity. It is aimed at encouraging organizations to participate in net workings, think tanks and research initiatives and work in partnerships to deliver innovative services to disadvantaged populations. An effective medical camp should be able to meet the standards of equity as prescribed by the theoretical framework outlined by Cattacin et al (2013).

Despite decades of studies documenting inequalities in health care, identifying underlying root causes, and testing remedies, disparities remain. Differences in the quality of treatment and health outcomes based on patient race, ethnicity, and socioeconomic status result in a lot of human misery and great economic cost. Unconscious prejudice and cultural insensitivity by physicians and health care organizations, unequal health care, and systemic inequities in people's social, economic, and physical environments are all factors that contribute to inequalities in health outcomes (DeMeester, et al., 2017).

Several physicians in public health centres work for both the government and the private sector illegally. They are always late and arrive at the private clinic early. Many of them do not show up for work at all. Government hospitals are in poor condition due to severe infrastructure deficiencies. Free Medical Camps are held mainly in rural areas and in informal settlements where residents are unable to afford medical care and lack basic knowledge of health and hygiene. As a result, these services provide people with a variety of health-related advice. Aside from that, basic health conditions and illnesses are diagnosed and free drugs are given. On the other hand, the patient attended to in a medical camp is not followed up on because the camp is a one-time event. Certain diagnoses are made based on a single test, which is insufficient and undesirable. The drugs provided are only for a short time, and for chronic non-communicable diseases, life-long care and follow-up is needed, which medical camps cannot provide. Even after a thorough clarification, patients referred from the camps are unaware of where the specialist's services are available. At times a patient travels all the way to the referred hospital, the specialist doctor may not be present. Medical camps should not be promoted for personal benefit or popularity, but rather for the sole purpose of providing service (SpeakforHealthyIndia, n.d).

A Free Medical Camp is a life-saving initiative that seeks to deliver free medical and surgical care to vulnerable communities in rural and urban areas through a mobile team that offers a variety of medical specialized services. Some NGOs, Charitable Medical Trusts, and medical practitioners are motivated by strong medical ethics, believing that it is their moral duty and obligation to treat all patients equally regardless of their incomes, race, or social status. A medical camp's primary purpose is to provide immediate treatment to people in life-threatening situations by incorporating the particular strengths and goals of medical ethics. When the majority of hospitals and clinics close, leaving the poor to die from infections, trauma, and other health problems, free medical camps become their only hope. And the poorest of us are entitled to the dignity of basic human rights, which we cannot deny (Transparent Hands, 2018).

2.3. Health Care Systems

The goal of a health care system is to enhance the health of a population in the most effective manner possible in light of a society available resources and competing needs. By the beginning of the 21st Century access to health care services had become regarded as a basic human right by most countries and the United Nations. Article 25 of Universal Declaration of Human rights states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. A person's health is of critical importance as it overrides other aspect of well-being. A health person is productive in every sphere of live; may it be economically, socially, politically and even biologically and a country's economic a social development is pegged on the health status of its people. The United Nations sustainable development goals (2030), goal no. 3 aims at ensuring healthy lives and promotion of well-being for all at all ages. This is to be achieved through reduction of global maternal mortality ratio to less than 70 per 100,000 live births (3.1); End preventable deaths of new-borns and children under 5 years of age by reducing neonatal mortality rate to as low as 12 per 1000 live births, and under 5 mortality to at least as low as 25 per 1000 live births (3.2); end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water bone diseases and other communicable diseases (3.3). It also aimed at reducing by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being (3.4). The goal also aimed and ensuring universal access to sexual and reproductive health care services including for family planning, information and education and the integration of reproductive health into national strategies and programmes (3.7). Universal health coverage (UHC), a major goal for health reform in many countries and a priority objective of WHO, aims at ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. UHC advocates for equity in access to quality health care services and that they should not suffer financial risk by accessing the services

In Kenya the constitution of Kenya in the bill of rights Chapter four 2 Article 43 (1) states that every person has the right (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 27 on equality and freedom from discrimination, section (1) states that every person is equal before the law and has the right to equal protection; including protection from diseases and all forms of ailments, and equal benefit of the law. Section (2) further sates that equality includes the full and equal enjoyment of all rights , including right to access quality and affordable health care services, and section (3) states that women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres; that

accommodates the health services; and that no one should be discriminated on the basis of economic, political, religious, geographical or cultural factors Art. 27 sec (4). The National government Big 4 Agenda initiative has prioritized the universal health coverage as one of the Agenda priorities that aim at ensuring all Kenyans have access to quality and affordable health care services. All the above initiatives and objectives are aimed at ensuring that all persons including the marginalized and disadvantaged persons are given every support to be able to access quality health care services. Medical camps are organized on this premises of availing the health care services to marginalized, disadvantaged and vulnerable populations in the society. This is the population constrained by financial limitations, difficult geographical terrains and lack of information and education on health care matters. In spite of their difficult circumstances, they should be supported to be able to access health care services of an equal standard as that accessible to majority of the advantaged population

2.4. Health Care systems in Kenya

The healthcare system in Kenya is composed of the government both National and County governments, Private hospitals, Non-governmental organizations, faith-based organizations. The government managed facilities are put in various categories based on services offered; Level one, community services; level 2 dispensaries and clinics; level 3 health centres, maternities and nursing homes; level 4 sub-county hospitals; level 5 county referral hospitals and large private hospitals and level 6 national referral hospitals and large private teaching hospitals. The total number of government owned hospitals is shown in the table below:

Key Health Infrastructure	**Community**	**Primary Care Facilities**					**County Hospitals**	**National Hospitals**	**Totals**
		Dispensaries	**Health Centres**	**Medical Clinics**	**Maternity Homes**	**Nursing Homes**			
Government		2954	682	35	1	0	268	16	3956
Faith- Based		561	166	61	3	11	79	-	881
NGOs		200	24	73	4	5	-	-	306
Private		196	60	2098	32	150	116	-	2652
Total		3911	932	2267	40	166	463	16	

Table 1: Number of Government Owned Hospitals
Source: KHSSP 2013-2017

The Kenya Health Sector Strategic Plan III (2012–2017), on the other hand, divided the service delivery system into four levels. The Community Health Services that were formerly referred to as Level 1 are now referred to as Tier 1. It encompasses all community-based programs, primarily health promotion, disease prevention, and the recognition of cases requiring referral to higher levels of treatment. Tier 2 is the Primary Care Level, which includes the previously mentioned Levels 2 and 3. Maternity homes, dispensaries, and health centres are all included. Tier 3 refers to health facilities staffed by a specific jurisdiction and is referred to as county referral hospitals. It includes services that were previously referred to as Level 4. National referral hospitals that were formerly classified as Level 5 or Level 6 are now classified as Tier 4(Government of Kenya, 2017).

There are two main sources of funding for healthcare: private and public. Government general taxes, loans from multilateral organizations and bilateral arrangements, grants, charitable contributions, and mandatory insurance payments all contribute about 70% to healthcare funds. Direct consumer fees, companies paying for their employees or offering health benefits, privately paid insurance programs, and voluntary donations from nongovernmental organizations are all examples of private sources of healthcare funds(Government of Kenya, 2017).

Faith-based hospitals, private for-profit hospitals, and public government hospitals all provide health services in Kenya. A limited population of private medical practitioners also receives treatment. Technical assistance and resource mobilization are provided by development partners.

As several health workers decide to return to national government, devolved governments work to provide services in the face of multiple protests, health staff shortages, health workers leaving some counties for more desired places, or resigning from the public sector to enter the private sector, human resource management has become one of the most difficult obstacles to devolution. There is a need for a consistent framework and guidelines for health care staff in terms of advancement, retention, and pension for health workers(Government of Kenya, 2017).

2.5. Conceptual Framework

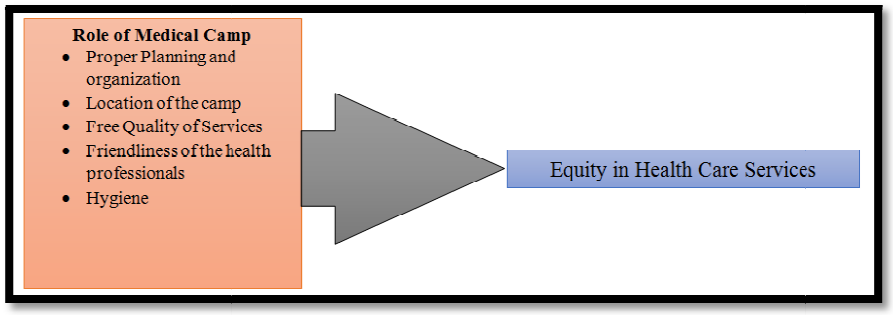

Figure 1: Conceptual Model

3. Research Methodology

The study targeted 500 patients who attended a medical camp, mounted by Embu County Government, one of the 47 county governments in Kenya, in Karaba, Mbeere South Sub-County on 1st of November 2019. A total of 57 respondents were sampled which was 11.4% of the total population as it was not possible to involve all the patients due to time and cost constraints and because some of the patients declined to participate in the study. A sample size of 10%was considered ideal for descriptive studies(Mugenda & Mugenda, 2003). This was to ensure that the sample was representative of the target population while taking care of time and cost constraintsA convenience sampling technique was employed where the study relied on information provided by willing respondents. Data was collected usinga structured interview guide that had both closed and open-endedquestions. The data was analysed using factor analysis by use of SPSS software. Data was presented using charts and tables. Descriptive statistics was used to draw a meaning from both qualitative and quantitative data obtained. Descriptive statistics enables a researcher to meaningfully describe a distribution of scores or measurements using a few indices or statistics ((Mugenda & Mugenda, 2003).

4. Findings

4.1. Response Rate

The study registered 100% response rate where all the 57 respondents sampled were interviewed.

4.2. Gender of the Respondents

Majority of the respondents (36) 63% of the total number of respondents were female while 21 (37%) were male as shown in the figure 1.

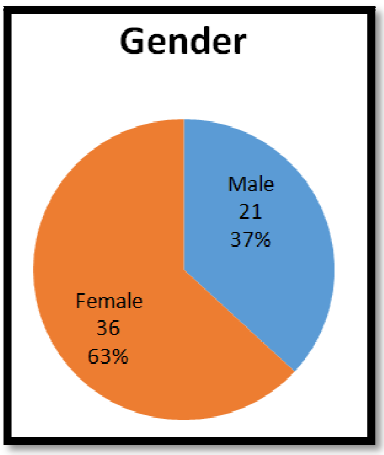

Figure 2: Gender of the Respondents

In spite of the number of females being higher than that of male, the study attributed the difference to the fact that female was more than male in attendance and in the sample. The finding therefore indicated that there was an even distribution of responses across gender and this was critical as it enhanced the objectivity of the study. It also served as an evidence that majority of the patients who attend medical camps are women and children who are considered a minority group that require support and fair treatment and especially in matters of health.

4.3. Age of the Respondents

With respect to the age, majority of the respondents 19 (33 %) were aged between 26-35 years followed by those in the age bracket of 36-45 at 12 (21%) and those that were of age bracket 46-55 were 9 (16%) and those above 55 years

of age were 10 (18%) whereas the least number of respondents at 7 (12%) were aged between 18-25 years as shown in figure 2.

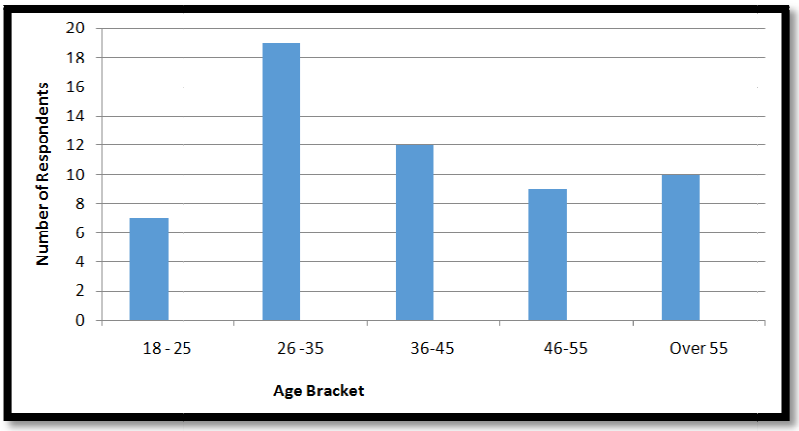

Figure 3: Age of the Respondents

It is notable that majority of the respondents were youthful population in the age bracket 26-35. This constitutes the population that has just entered the labour market; either searching for employment, newly employed or trying to enter in self-employment. It is the segment of population with meagre or unstable income and may find it difficult to meet the cost of health care services. This population also constitute young parents with children below 15 years who are vulnerable to diseases. The next population segment that falls within the age bracket of 36-45 years and 45-55 years had a low response rate of 21% and 16% respectively. These two segments of population have relatively stable income having been in the employment or in business for a longer period. This segment of population has a relatively stable income and could afford to meet the high cost of health care services in hospitals hence the reduced turnover in the medical camps. Those employed are likely also to have taken health insurance cover that enable them to attend expensive hospitals. Worth noting is the increased number of responses among those aged 55 years and above. This could be attributed to the fact that majority in this age bracket have retired from gainful employment, have no regular income and at their advanced age are very vulnerable to non- communicable diseases. It is this category of disadvantaged population that medical camps are aimed at reaching out to. The category of population within the age bracket of 18-25 registered a low response rate 12 %. This is the youthful population with high immune system that resists most forms of ailments. Again, majority of them are still within the education system and dependent on parents. All in all, it is evident that medical camps are popular to persons at all ages.

4.4. Respondents Level of Education

Responding to the question of level of education majority of the respondents 36 (64%) had primary level of education; followed by those who had a post primary education certificate were 12 (21%). Those who had attained diploma level were 6 (10%) while 5% that is three of the respondents never went to school. None of the respondents had attained degree, masters or PhD.

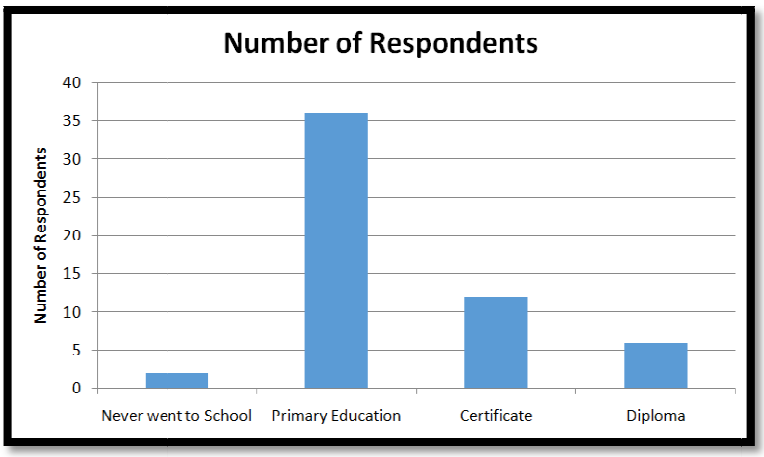

Figure 4: Level of Education

The above findings indicate that the number of attendances to medical camps decreases with the level of education. This could be attributed to the fact that the higher the level of education the more likely that one is in gainful employment and thus earning regular income or in stable business venture. Majority of the educated also are likely to have moved urban centres hence the low attendance in the medical camps. The ones with lower level of education registered the highest number of responses at 64% which could also imply that they were the majority attendants in the camp.

Medical camps are aimed at this category of population who lack adequate finances to enable them seek quality health care services as well as to educate them on matters of health lifestyles and diseases prevention.

4.5. Source of Information about the Camp

Responding to the question on how they received information about the medical camp, majority 18 (32%) of the respondents indicated they received from churches/ mosques; 15(26%) from health centres; 9 (16%) of the respondents were informed by community health workers and 4 (7%) from radios and relatives. The remaining 11% of the respondents received information from community meetings (Barazas), Television and women group meetings. There was no indication that any of the respondents received the information about the medical camp through social media as shown in the figure 5.

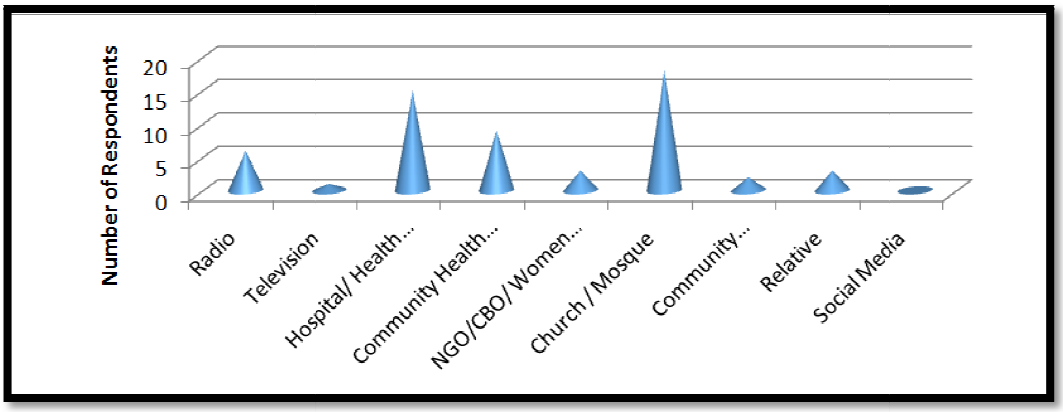

Figure 5: Information Channel

The findings implied that it was necessary to employ a variety of channels when passing information about medical camps. The study established that places of worship such as churches and mosques are the most reliable channels of passing information on medical camps with a registered response of 32% while health centres and community health workers comes second and third at 26% and 16% respectively. Appropriate choice of channel of passing information on medical camps is thus critical for the camp to be successful as Cattacin S et al, 2013asserts that different forms and tools of communication should be considered when passing health information

4.6. Respondents Employment Status

On employment status majority of respondents 48 (84%) were unemployed while those employed were 9 (16%) as indicated in figure6.

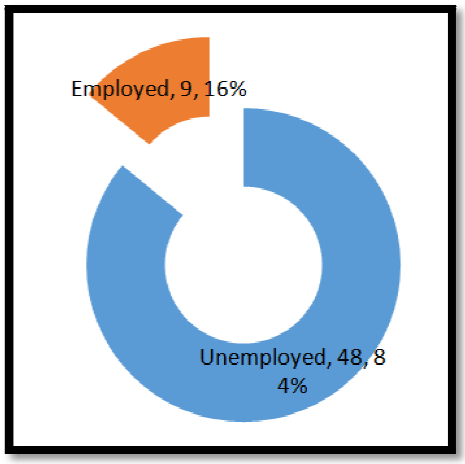

Figure 6: Employment Status

This was evident that majority of people who attended the medical camps were disadvantaged populations in the community who had no access to quality health care services as a result, among other factors, financial constraints. The unemployed population in Karaba, Embu County took the opportunity of the medical camp to seek specialized health services that they could not get from hospitals mainly due to the cost of the services.

4.7. Respondents Estimated Monthly Income

When answering to the question about their estimated monthly income, majority 42 (74%) stated that they earned below KES 15,000 (US$ 139), whereas the rest 15 (26%0 earned between KES 16,000(US$ 148.6)-30,000 (US$ 278.6). None of the respondents earned more than KES 30,000. (US$ 278.6) as shown in figure 7.

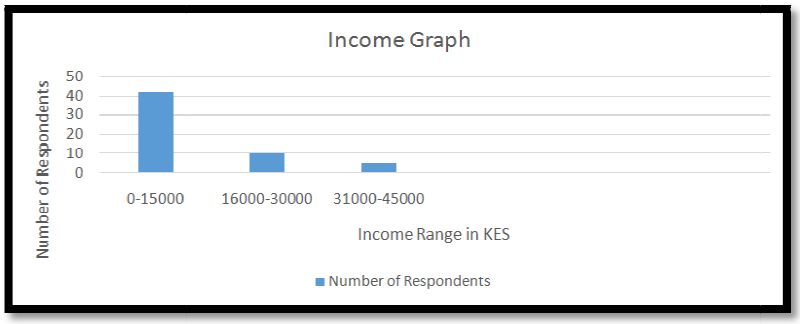

Figure 7: Respondents Estimated Monthly Income

This is clear indication that majority of the people who attended the camp were less fortunate members of the society who earn meagre income that is hardly enough for food let alone for medical expenses. Medical camps are aimed at enabling such disadvantaged populations access quality health care services as a matter of not just fairness but human right (Sen A. K 2009).

4.8. Respondent's enrolment to Medical Scheme

Responding to the question on enrolment to any medical scheme, majority at 70% or 40 out of the 57 respondents stated they were enrolled with National Hospital Insurance Fund (NHIF) while the remaining 17 (30%) of the respondents were not enrolled with any medical scheme as indicated in figure 8.

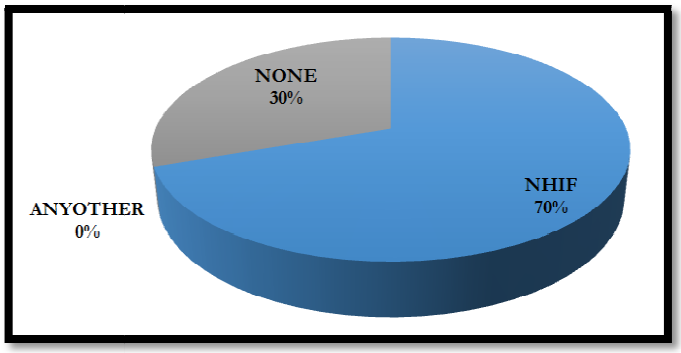

Figure 8: Respondent's Enrolment with a Medical Scheme

The high number registered with the medical scheme was an indication that people in Karaba area were concerned about their health despite the challenges that hindered them from accessing quality health services. The Medical Scheme (NHIF) is government controlled and highly subsidized hence affordable

4.9. Respondents Distance from home to the Medical Camp

On the question about the distance from home to the camp majority of the respondents stated they resided within 5 kilometres from the camp. A total of 14 (25%) of the respondents lived less than a kilometre away from the camp, 30 (53%) between 1-5kilometres, 7 (12%) of the respondents lived at a distance of between 5-10KM and only 6 (10%) resided at a distance of more than 10 kilometres from the camp as shown in figure 9.

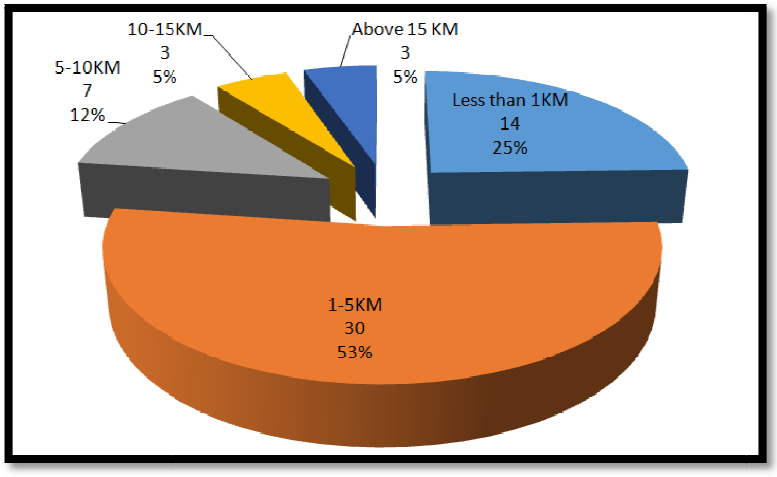

Figure 9: Distance from the Camp

This corroborate Cattasin S et al, 2013 assertion that all forms of barrier including physical barrier should be considered in the efforts of ensuring all disadvantaged persons have access to health care services. The medical camp in Karaba availed an opportunity for the rural population to access quality specialized health care services without having to travel for long distances to health facilities. Others who could not otherwise have gone to hospital took the opportunity to present themselves for screening. The proximity of the medical camp not only saved them money but also time as they were attended and went back to their routine work.

4.10. Respondents Ease to Locate the Medical Camp

On the question about the ease of locating the medical camp majority of the respondents 10 (18 %) indicated it was very easy and a total of 29 (51%) indicated it was easy to locate the camp while 4 (7%) were indifferent. The rest 12 (21%) and 2 (3%) indicated it was difficult and very difficult respectively as shown in figure 10.

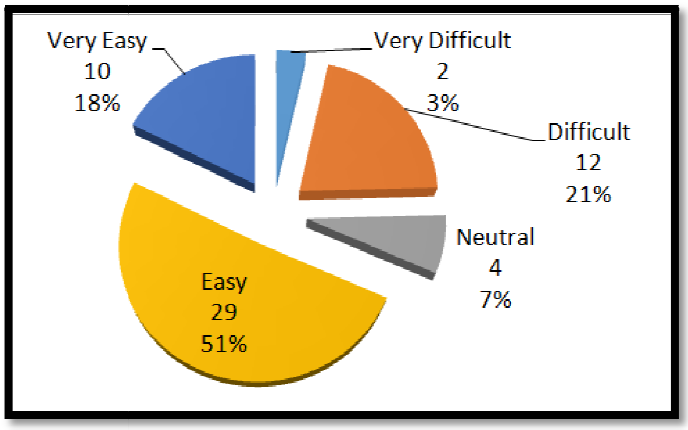

Figure 10: Ease of Locating the Camp

This implied that logistical arrangements were well thought out and planned hence the positive response by respondents. It was a possibility that those who had difficult locating the camp were those who resided far from Karaba area.

4.11. Respondents Knowledge of the Health Services Provided at the Camp

Figure 11 shows that most respondents became aware of the healthcare services provided by the medical camp after asking for them.

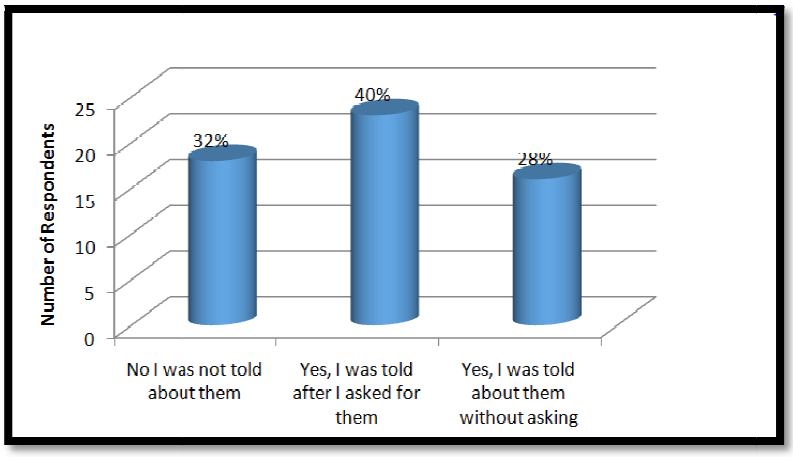

Figure 11: Healthcare Services Knowledge

4.12. Respondents Satisfaction with the Health Services Offered

When asked about their perception on the quality of services offered, majority 28 (49%) indicated; 14 (25%) stated they were satisfied making it a total of 74% of those who were satisfied with the services offered. Nine (16%) indicated they were neutral and only 6 that is (10%) of the respondents who expressed dissatisfaction with services offered.

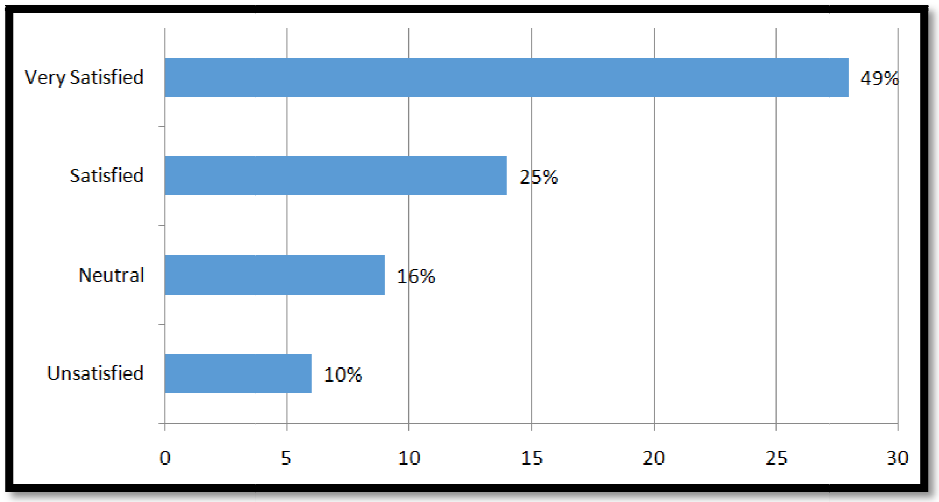

Figure 12: Satisfaction with the Health Services Offered

This finding resonated well withS. H Gajuryal et al 2019 assertion that medical camps provide excellent satisfaction levels than outpatient clinics. The staff in medical camps are more friendly and empathetic to patients.

4.13. Level of Satisfaction with Professionalism of the Staff

Responding to the question on level of satisfaction with professionalism of the staff, majority of the respondents at 39 (68%) indicated that they were very satisfied with the level of professionalism demonstrated by staff at Karaba medical Camp; 17 (30%) were satisfied and only 1 (2%) was indifferent as indicated in figure 13.

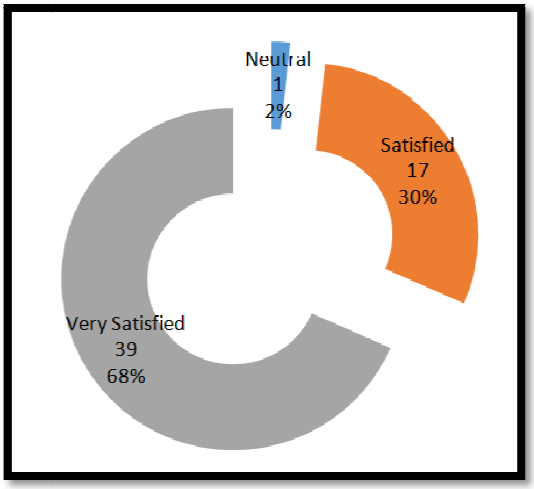

Figure 13: Level of Satisfaction with Professionalism of the Staff

This finding was an evidence that majority of staff who attended patients at Karaba Medical camps were highly professional thus resonate well withS. H Gajuryal et al 2019 views that medical camps provide excellent levels of satisfaction than outpatient clinics. This implied that the vulnerable community in Karabaarea had the opportunity to access quality and specialized treatment like those financially well off.

4.14. Level of satisfaction with Hygiene at the Medical Camp

On the question about respondent's satisfaction with level of hygiene at the medical camp, 38 of the respondents representing 67% of the total number of respondents stated that they were very satisfied; 17 of the respondents representing 30% of the total number indicated that they were satisfied and only 2 representing 3 percent were indifferent as shown in figure 14.

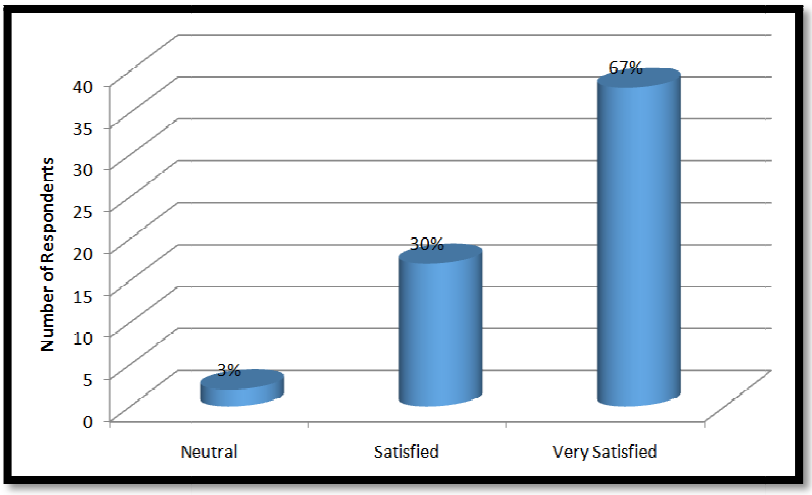

Figure 14: Level of Satisfaction with Hygiene at the Camp

The findings were evident that medical camps were planned and organized to meet standards of hygiene expected of any health facility. The organizers made every effort to ensure patients had a feel of an ordinary health facility

4.15. Level of Satisfaction with the Friendliness of Staff

When asked about their level of satisfaction with friendliness of the staff at the camp, majority of the respondents, 34 (60%) stated they were very satisfied; 22 (38%) indicated they were satisfied and only 1 (2%) of them expressed indifferent as indicated in figure 15 below.

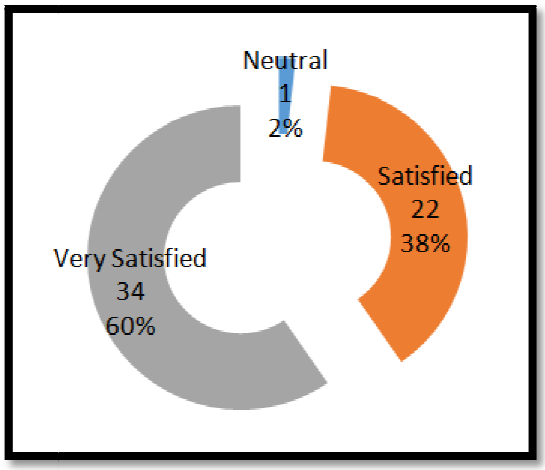

Figure 15: Level of Satisfaction with Friendliness of Staff

The findings were indication that the staff at the camp were friendly and empathetic with the patientsasCattasin S et al, 2013 in the third standard, equity of care, asserts that health professional should give person-centred services to all patients. This friendliness inspires confidence in patients encouraging them to communicate freely with the health professional thus reducing the power-imbalance that usually exists between patients and health professionals creating communication barrier between them (Cattasin S et al, 2013).

4.16. Respondents Satisfaction with Time spent with the Doctor

On the question on satisfaction with time spent with the doctors, majority of the respondents, 28 (49%) indicated they were very satisfied and an equal number were satisfied. Only one (2%) of the total number expressed indifferent with time spent with the doctor as shown in figure 15.

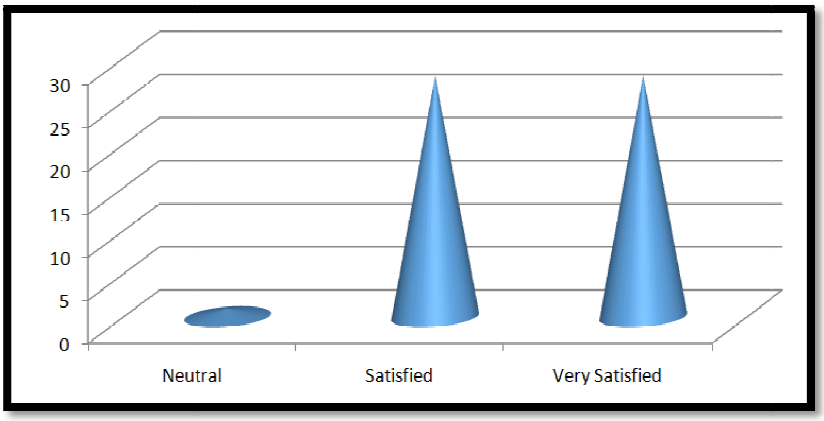

Figure 15: Satisfaction with Time Spent with the Doctor

This finding emphasizes the notion that medical camps offer quality services comparable to outpatient clinics. The health professionals were patient and empathetic to the patient and were likely to have been attentive to the patients hence taking reasonable time. This is in line with the standard of equity of quality of care (Cattasin S et al 2013) that required the reduction of power imbalance between health professional and patients.

4.17. Likelihood of Recommending a Medical Camp to a Friend

When answering the question on their likelihood of recommending a medical camp to a friend, 33 of the respondents at 58% stated they were very likely to recommend; 11 (19%) indicated they were likely to recommend while 8 (14%) remained neutral. Only a paltry 9 % indicated that they were unlikely to recommend the camp to a friend as indicated in the figure 16.

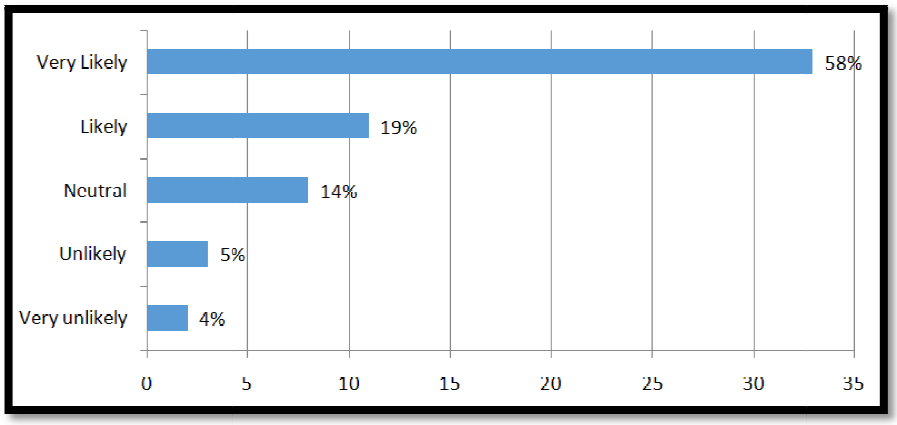

Figure 16: Likelihood of Recommending a Medical Camp to a Friend

The findings were indication that majority of the people who attended the camp were satisfied with the services offered as well as other logistical conveniences. The small number of those who stated that they were not likely to recommend medical camps to friends is within allowable margin.

4.18. Expenses Incurred for Services at the Medical Camp

On the question about expenses incurred for services offered at the medical camp all the respondents (100%) indicated they did not incur any expenses an indication that the services were free of charge as shown in table 2.

Have You Incurred Any Expense		***N***	**%**
	No	57	100.0
	N	57	100.0

Table 2: Cost of the Services Received in the Medical Camp

4.19. Suggestions on Areas of Improvement

With regard to the question on suggestions on areas of improvement majority of the respondents (48%) suggested that there was need to increase the variety of medicines to be provided; a reasonable number (19%) suggested increased number of health professionals and singled out opticians and dentists. A few other respondents suggested increased frequency of such medical camps; increased cancer testing capacity, improved laboratory services and provision of theatre services as indicated in Table 3.

	Suggestion	% of Respondents
Medicine	Increase in variety of medicines	48.0
		3.0
Doctors	Increase the number	19.0
	Add opticians	10.0
	Add dentists	3.0
Remote areas	Visiting regularly	6.0
Cancer	Increase cancer test capacity	3.0
Theatre	Lack of theatre	1
Urinalysis test	Improve	1
Time	Doctors to keep time and start early	1
Laboratory	Improve on laboratory services	1

Table 3: Suggestions on Areas of Improvement

The above findings were indication that majority of the people in Karaba who attended the medical camp were satisfied with the services offered in spite of the few improvements suggested. This also was an indication that the camp was well planned and organized but the number of health professionals involved was not adequate mainly due to the large turnout of the patients.

5. Summary of Findings, Conclusions and Recommendations

5.1. Summary of Findings

The findings of this study were aimed at addressing the research objective which sought to examine the role of medical camps in ensuring equity in accessing health care services in Embu County and specifically focused on medical camp held in Karaba, Mbeere South Sub County. The study established that all the 57 respondents sampled to participate in the study actually responded. Majority of them being female an indication that more women than men attended the camp. With respect to age, the study established that the respondents were spread out throughout all the age brackets with majority falling within the age bracket of 26-35 years. Those within the age bracket of over 55 years followed and those within the age brackets of 36-45 years and 46-55 years came third and fourth respectively. Notably those within age bracket 18-25 were comparably few. This finding was an indication that persons of all ages attended the medical camp. However young adults and the elderly persons were more dominant. These could be attributed to the fact that those within the age bracket 26-35 years were young parents with children of less than 5 years who are considered vulnerable to diseases. Also, there was a likelihood that majority of them were searching for jobs, newly employed or newly venturing in to businesses and thus lacked stable income to enable them seek health services in hospitals. Those of over 55 years and above were elderly persons who are usually less productive hence low income and vulnerable to non- communicable diseases due to advanced age. On employment status majority of the respondents were unemployed and probably depended on casual work for their upkeep with majority of them earning less than Ksh 15000 (US$ 139) per month. However, it was notable that majority had registered with government owned medical scheme (NHIF) an indication that despite their financial challenges they took their health seriously hence sacrificing to meet the cost of the medical cover.

With respect to level of education the study established that majority of the respondents were of primary level of education with only a few having attained a post –primary education certificate and diploma certificate. None of the respondents had a degree certificate. This finding corroborates that of employment status and income levels as it was unlikely for people of lower level of education to acquire well-paying jobs neither have entrepreneurial skills to enable them venture in businesses. With regard to channels of communication used to pass information about the medical camp, the study established that a variety of channels were employed with the most popular ones being the places of worship namely the churches and mosques as well as the hospitals and health centres. A few respondents stated they had received the information from relatives or through radios. Notably Televisions and social media were the less popular channels probably because the targeted populations did not have access to the channels.

With regard to distance between the respondent's home and medical camp, the study established that majority of the respondents were within a distance of less than 5 Kilometres with only a few residing beyond 5 Kilometres. This was an indication that proximity to health care services motivated people to seek treatment.

5.2. Conclusions

Based on the findings the study concluded the medical camp held in KarabaEmbu County played a critical role in ensuring equity in excess of health care services. It was notable that majority of those who attended the camp were vulnerable, disadvantaged people who required support to access quality health care services. Majority were women and in the age bracket of 26-35. This population constituted young adults who were likely young parents with children of less than 5 years who are considered to be vulnerable to diseases. These were closely followed by those within the age bracket of 55 years and above. These were elderly persons who are less productive hence low income and vulnerable to non-communicable diseases due to advanced age. On the basis of financial capability, the study concluded that majority of the patients were financially constrained. Most of them were unemployed and earned less than Ksh 30000 (US $ 278) per month that was hardly adequate for their upkeep. With regard to proximity to the camp the study concluded that majority of the patients attended the camp due to proximity. Majority resided in Karaba area and lived within a distance of less than

5 Kilometres to the medical camp. The study also concluded that use of variety of communication channels in passing the information about the medical camp must have contributed to the high attendance registered.

On the basis of quality of services offered the study concluded that the services were relatively of high quality. The time health professionals spent with patients was adequate, most of the health professionals demonstrated high level of professionalism and were friendly and empathetic with the patients. With regard to adequacy of information on medical camps the study concluded that lack of uniformity of information disseminated through different media might have affected the attendance of the camp as majority stated that they were not aware of the health care services to be offered at the medical camp.

5.3. Recommendations

Based on the conclusions, majority of the vulnerable community in Karaba area Embu County took advantage of free medical camps to access quality health care services. This study recommended that the organizers of medical camps consider increasing the frequency of such camps as they were seen to be popular to vulnerable communities. It also recommended that a lot of care be taken to ensure that adequate, uniform information about the camp is communicated by the different channels used as majority stated that they were not aware of the services to be offered at the medical camp

It is worth noting that medical camps are outreach programmes held on a temporarily basis taking between one to seven days. They may not be able to offer follow up services where required. The study recommended that the responsible organs/ government consider improving and expanding health care facilities to cater for vulnerable communities so as to fill the gap that medical camps may not be able to fill. It also recommended that whenever medical camps are held the health experts should consider building the capacity of local health professionals who were responsible for follow up services after the medical camps are over.

6. References

i. Akiko maenda, e. a. (2013). UNIVERSAL HEALTH COVERAGE FOR INCLUSIVE AND SUSTAINABLE DEVELOPMENT.
ii. American Health Association. (n.d.). Creating The Healthiest Nation:Advancing Health Equity. Retrieved April 25, 2021, from https://www.apha.org/:https://www.apha.org/media/Files/PDF/factsheets/Advancing_Health_Equity.ashx
iii. American Public Health Association. (n.d.). Health Equity. Retrieved April 25, 2021, from https://www.apha.org/: https://www.apha.org/topics-and-issues/health-equity
iv. ASSEMBLY, U. N. (2012, 12). Retrieved from 2. UNGA resolution Dec 2012: http://www.http://www.un.org/en/ga/info/draft/index.shtml&Lang=E
v. Bärnighausen T, S. R. (2002). One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries? . Health Systems and Reforms.
vi. Beveridge, S. H. (1943). developments and trends in social security legislation. Health Systems and Reforms.
vii. Carrin G, J. C. (2005). Social health insurance: key factors affecting the transition towards universal coverage. . health systems and reforms .
viii. Daniel Cotlear, S. N. (2015). Going Universal: How 24 Developing Countries Are Implementing Universal Health Coverage Reforms from the Bottom Up. Retrieved from http://dx.doi.org/10.1596/978-1-4648-0610-0 .
ix. DeMeester, R. H., Xu, L. J., Nocon, R. S., Cook, S. C., Ducas, A. M., & Chin, M. H. (2017, June). Solving Disparities Through Payment And Delivery System Reform: A Program To Achieve Health Equity. Retrieved April 25, 2021, from HealthAffairs.org: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0979
x. dennis, m. (2015). importance of free medical camps in exposing rural communities detal health issues and mitigating morbidity associated with dental caries.
xi. Edwine Barasa1 2, P. N. (2019, JANUARY). TOWARDS UNIVERSAL HEALTH COVERAGE IN KENYA. measuring progress towards development goal on universal health coverage.
xii. Gorsky, D. M. (2015). Any Lesson from History for Universal Health Coverage Centre for Global Health Histories.
xiii. Gorsky, D. M. (2015). Any Lesson from History for Universal Health Coverage Centre for Global Health Histories. The University of York 2015. NEW YORK: London School of Hygiene and Tropical Medicine .
xiv. Government of Kenya. (2017). Kenya Health Workforce Report: The Status of Healthcare Professionals in Kenya, 2015. Nairobi: Ministry of Health.
xv. HE., S. (1943). From Bismarck to Beveridge: developments and trends in social security legislation. Health Systems and Reforms.
xvi. health care systems- four basic models. (2019). physicians for a national health program PNHP.
xvii. Hennock, E. P. (2007). The origin of the welfare state in England and Germany, 1850-1914: social policies compared. Cambridge University Press.
xviii. How Outreach Programs Can Improve Health Outcomes. (2012, 02 01). Retrieved from Health Outreach Patners: https://outreach-partners.org/2012/02/01/how-outreach-programs-can-improve-health-outcomes/
xix. Importance and Objectives of the Free Medical Camp. (2018, April 17th). Retrieved from phttps://www.transparenthands.org/importance-and-objectives-of-the-free-medical-camp/.

xx. Mohiddin, A., &Temmerman, M. (2020, July 27). COVID-19 exposes weaknesses in Kenya's healthcare system. And what can be done. Retrieved from https://theconversation.com/: https://theconversation.com/covid-19-exposes-weaknesses-in-kenyas-healthcare-system-and-what-can-be-done-143356

xxi. Mugenda, O. M., &Mugenda, A. G. (2003). Research Methods: Quantitative & Qualitative Methods. Nairobi: Acts Press.

xxii. Nzayiramboho, N. M. (2014). Universal Health Coverage in Rwanda Dream not Reality. The Pan African Medical Journal, 232.

xxiii. Rosenberg, T. (2012, JULY 03). Health Care Coverage That Eludes the U.S. The New York Times.

xxiv. SpeakforHealthyIndia. (n.d). Medical Camps useful or counterproductive. Retrieved from http://www.speakforhealthyindia.com/: http://www.speakforhealthyindia.com/medical-camps-useful-or-counterproductive/

xxv. The World Bank. (2020, November 25). https://www.worldbank.org/. Retrieved from Kenya Economic Update: COVID-19 Erodes Progress in Poverty Reduction in Kenya, Increases Number of Poor Citizens: https://www.worldbank.org/en/country/kenya/publication/kenya-economic-update-covid-19-erodes-progress-in-poverty-reduction-in-kenya-increases-number-of-poor-citizens

xxvi. Transparent Hands. (2018, April 17). Importance and Objectives of the Free Medical Camp. Retrieved from https://www.transparenthands.org/: https://www.transparenthands.org/importance-and-objectives-of-the-free-medical-camp/

xxvii. UNGA. (2012, DEC). Retrieved from www.un.org/en/ga/info/draft/index.shtml&Lang=E: www.un.org/en/ga/info/draft/index.shtml&Lang=E

xxviii. Universal Health Care As Inspired By The Kenya Vision 2030. (2018). Retrieved from vision2030: https://vision2030.go.ke/universal-health-care-as-inspired-by-the-kenya-vision-2030/

xxix. Van Den Heever, A. (2016, 06). South Africas universal Health Coverage Reforms in the post-apartheid period. health policy, 120.

xxx. World Health Organisation. (2017). PRIMARY HEALTH CARE SYSTEMS - Case Study from Kenya. Retrieved from https://www.who.int/: https://www.who.int/alliance-hpsr/projects/alliancehpsr_kenyaabridgedprimasys.pdf

xxxi. Xu, K. D.-R. (2007). protecting household from catastrophic health spending. health affairs.