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Influence of Resource Mobilization on Sustainability of Universal Health Coverage in Vulnerable Livelihoods in Wajir County, Kenya

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Abstract

The objective of the study was to assess the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Wajir County, Kenya. Wajir County is one of the poorest arid and semi-arid counties where the absence of universal health coverage may make some households to experience catastrophic disruption in lifestyles. The study was guided by the Resource Dependency Theory. The study used a descriptive research design. This method of research was preferred because it enabled the collection of data to answer question concerning the status of the subject of study. The target population was beneficiary households, universal health care workers, and local leaders in Wajir County. The target population of beneficiaries estimated at 677. The study adopted stratified random sampling technique to select a sample of 204. A questionnaire was used to collect primary data. Data was analyzed qualitatively and quantitatively with the aid of SPSS. Quantitative data generated was subjected to descriptive statistics feature in SPSS to generate mean, and standard deviation which was presented using tables, frequencies and percentages. The study established that resource mobilization influence sustainability of universal health coverage. The study found out that government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance. The Government should involve every stakeholder in the health sector through training and provision of education for sustainability of universal health coverage in vulnerable livelihoods to achieve equitable access to skilled delivery services across the country. This is line with the Government of Kenya Vision 2030 economic development blue print, of making Kenya a newly industrialized nation. The Big Four Agenda of manufacturing, affordable housing, universal healthcare and food security that are premised on a foundation of a healthy nation through human resources for the achievement and sustenance of a competitive advantage. The study recommends that Kenya's State Department for Health and the County Governments should focus on investments in Universal health care through mobilization of resources to improve county health facilities so as to achieve equitable access to skilled delivery services across the country.

Key words: Kenya, Resource mobilization, sustainability of universal health coverage, vulnerable livelihoods, Wajir County

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Abdullahi Sheikh Abdirahman and Evans Vidija Sagwa

Introduction

The purpose of his study was to assess the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Wajir County, Kenya. The study is predicated on the contemporary global dynamics where health care is viewed by some as a fundamental right but by others as a tradable commodity. In the course of just over a century, Universal Health Care (UHC) has gone from being an aspiration to a reality in most industrialized countries. Yet for many, especially in the developing world, it remains no more than a dream (Carrin and James (2005). For those who have it, never before has it been so insecure. Throughout most of recorded history, the concept of UHC was essentially meaningless because health care had so little to offer. To the extent that care was provided, it was delivered largely by lay people with no formal training. The care consisted largely of basic first aid or, in some cases, herbal remedies whose efficacy had been established by long experience (Hammer and Berman. 1995). Most of what passed for health care was ineffective, or worse, hazardous and unpleasant, such as cupping, bleeding, purges, and similar remedies, so that the treatment was often worse than the disease.

Moving towards UHC can help tackle endemic challenges for health and wellbeing across all societies. This is dependent on the level of universality and engagement within those societies, particularly for marginalized groups. Potential for progress is evident in the case of addressing neglected tropical diseases, which could substantially alleviate poverty and expand productivity of the vast number of people affected by them overwhelmingly in poorer settings (Bangert et al., 2017). UHC can also improve maternal and child health, key to the long-run socioeconomic potential of countries and established goals for health such as Millennium Development Goal (MDG) 4 and MDG 5 (Bain and Ebuenyi, 2017). Deliberated measures have to be undertaken to enhance universal health coverage especially for marginalized societies.

While global maternal mortality ratios decreased across all countries by 44% between 1990 and 2015, many states and sub-national regions were left behind in the wake of aggregate progress, leaving an inequity gap (Lieberman, 2016). The rising burden of Non-Communicable Diseases (NCDs) globally also threatens gains in maternal health, with the stresses caused by chronic disease expected to increase as causal factors for maternal mortality. Addressing such critical health and wellbeing issues is further constrained by the estimated 12.5 million deaths that are linked annually to diseases associated with environmental hazards. Universal Health Care is being championed as a pro-poor pathway for development that explicitly engages the most vulnerable in society. Health and wellbeing framed as human rights further strengthen domestic accountability for moving towards UHC (Gostin and Friedman, 2017). Exploring

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resource mobilization options ii developing countries is critical to sustainability of gains made in health care.

According to UNICEF, (2013) involvement by individuals, communities and distinct groups in universal health care should be followed as a foundation for positive programs and services to uphold and improve their health. Government agencies in Australia nationwide and at state level have upheld a concern in people participation since it has some perceived benefits. Rural health service development people participation has remained to result in more reachable, significant, and suitable services. Moreover, it is often implied that people participation will result in greater community fulfillment with health services, and certainly improved health results, however, proof to support this statement is inadequate (Tallon-Baudry, 2012). Opportunities for resource mobilization from stakeholders need to be explored for improvement of healthcare systems with emphasis to the most vulnerable in society.

In Rwanda, universal health care remains an important challenge, with millions of households struggling with high percentage of Out-Of-Pocket (OOP) in total household expenditure for health services. Rwanda was recognized as one of the nine countries in Africa and Asia making significant progress to make universal healthcare systems possible. This is due to the ability of the ministry of health in Rwanda to ensure majority of the people are enrolled in the programme and thus improving their health status. According to Hsiao (2013) until September 2012 the universal health care built on Community-Based Health Insurance had been observed nowhere in the world; the model of Rwanda UHC would be therefore the first of the kind.

In Kenya, though access to quality healthcare is a constitutional right, the scarcity of quality public and private health facilities, as well as the high cost of care has limited people participation in accessing health care (Ayeni, 2015). This therefore means that universal health coverage remains little more than words on paper for much of the population. The World Bank estimates that only a fifth of Kenyans are the only ones who have enrolled in the universal health care by having any sort of medical cover, which means that as many as 35 million Kenyans are vulnerable to the financial devastation occasioned by a medical emergency. This therefore indicates that very few people in the country have the capacity to participate in the scheme as many of the households do not have the financial capability to participate (Ekman, 2014). If efforts are not sustained to reverse this trend, quality healthcare as a constitutional right may be difficult to be actualized in Kenya.

In Kenya various factors have been found to impede the sustainability of the universal health care among the vulnerable livelihoods especially in Wajir County. First, majority of Kenyans cannot afford the high cost of treatment and medication. The rising cost of doctor consultations, medical procedures and drugs has pushed healthcare beyond the reach of millions of Kenyans. Research shows that 32 per cent of Kenyans' household health budget is financed out-of-pocket. Second, there is lack o f a clear legal framework as to how the costs of treatment and drugs are computed. Third, public health facilities are under-funded. Government spending on healthcare is approximately six per cent of GDP. This is low compared, for instance, to education or infrastructure. State funding for the health sector needs up-scaling.

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In addition, there is lack of appropriate monitoring and evaluation to ensure UHC is implemented appropriately. The stakeholders involved have not been up to task and this has affected the sustainability of the health coverage significantly. Wajir County has been struggling on the part towards adopting universal health coverage from the devastating effects of the violence in the county that has seen many livelihood projects and activities reduced to nothing. As the recovery process continues, one hopes that wise moods including universal health coverage is embraced. Universal health coverage is a cheaper option. This study set out to establish the influence of resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya.

Statement of the Problem

Health care provision has been one of the key priorities of the Kenyan government. Despite advocacy by various governmental and non-governmental organizations explaining health care as a fundamental right, its provision remains a milestone yet to be achieved. Many countries today are actively seeking to bring about Universal Health Care (UHC) ensuring quality health services for all at a price that does not create undue financial pressure for individuals seeking care (Kanyiva, 2012). The effort has stirred expanded interest and guidance from international organizations such as the World Health Organization (WHO) and the World Bank, and led to new platforms for developing countries to learn from each other.

Universal Health Care will remain a work in progress for many countries for many years and it has the potential to attract greater attention to health spending, health systems, and improved equity, advances that will benefit human development more broadly (Omollo, 2012). The new Constitution of Kenya 2010 has entrenched the right to health; however, enjoyment of this right by the poor through participation will depend on what measures are implemented to improve access to health care services for all including the poor, that is, universal access. Irrespective of where poor people seek health care, this depends to a large extent on their access to cash or household assets that can be sold to meet the required out-of-pocket health expenditures.

Despite universal health coverage being important to the wellbeing of the vulnerable groups in the society, it has not been well embraced in Kenya. Various factors have existed as a barrier to its sustainability (Ekman, 2014). With health now a devolved function, inadequate funding of counties has imposed financial constraints on the public health system. Throw in recurrent strikes by health personnel and one begins to fathom the enormity of the crisis facing Kenya's health system. Inadequate funding compromises quality and availability of health services. Dilapidated public health facilities force many Kenyans to resort to private health facilities which are often expensive. In addition, most public hospitals suffer chronic lack of drugs forcing patients to purchase these from private pharmacies (Ayeni, 2015). The rising prevalence of non-communicable diseases like cancer has further strained the health system and impoverished many families.

Few studies have been conducted on the sustainability of the universal health coverage with it being a new concept in the health sector. Wamai (2013) studied the health system in

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Kenya, analyzing the situation people participation in health insurance in Kenya and concluded that health cost remains the greatest barrier for people participation in universal health care. Deloitte (2011) studied the reciprocal relationship between poverty and participation in health initiatives in Kenya and concluded that 46% of Kenyans live on less than a dollar per day, and these high poverty levels among the population limit their participation in universal health care scheme. This has created a knowledge gap that needs to be filled. It is for this reason that the current study set out to investigate the factors influencing the resource mobilization on sustainability of universal health coverage in vulnerable livelihoods in Kenya: a case study of Wajir County.

Significance of the Study

The study was expected to determine the influence of resource mobilization on sustainability of universal health coverage in vulner5able livelihoods in Wajir County, Kenya. The study would benefit the management and practitioners in the health sector who deal with issues of sustainability of universal health coverage. The government would have a better understanding of the factors influencing resource mobilization for universal health coverage sustainability and therefore come up with intervention policies and strategies that may enhance the provision and expansion of medical services through attraction of more medical service providers to the county.

Under the country's new decentralization strategy, counties are responsible for delivering health services and implementation of health programs. In addition, Wajir County would use this research in designing better structures that may ensure sustainability to guarantee better provision of Universal Health Coverage in all health facilities in the County. To the academia, the results of this study will go a long way in building a body of knowledge on health and medical services. Various stakeholders can use the study to facilitate further research in private and other public health sectors in Kenya.

Literature Review

Sustainability as health promotion capacity refers to the extent to which a community has local access to the knowledge, skills and resources needed to conduct effective health promotion programs (Stephens, 2015). Sustainability thus appears to be a multidimensional concept of the continuation process whose reality remains elusive. The sustainability of health care systems, particularly those supporting universal health care, is a matter of current discussion among policymakers and scholars. Public financing is essential for countries to make sustainable progress towards Universal Health Coverage (UHC). These funds need to be used efficiently and directed to priority populations and services to ensure equitable access to quality health services and financial protection for all.

Recognizing this, WHO has been implementing the jointly agreed upon Collaborative Agenda on Fiscal Space, Public Financial Management (PFM) and Health Financing from 2014. As the global community continues to scale up HIV/AIDS, TB, and malaria interventions, it is vital to understand the state of the health systems in which these services are being delivered.

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Good health systems should be able to deliver effective and quality health care services to the needy in a cost-effective way. To address the health challenges facing the health sector, the health ministries have, in recent years, been implementing health sector reforms with health system strengthening as a top health reform agenda.

The National Health Sector Strategic Plan (NHSSP II) underscores the importance of health system strengthening with major efforts directed at institutional strengthening, organizational development, improving the availability of human resources for health, health financing, service delivery and information, medical commodity availability, and improved donor coordination (World Bank, 2013). As the ministries continue to strengthen the health system, a thorough understanding of its unique strengths and weaknesses becomes paramount. The Health Systems Assessment (HSA) process allows countries to systematically assess their national health system and provides policymakers with information on how to strengthen the health system. The HSA approach, therefore, provides a comprehensive assessment of key health systems functions, organized around the six WHO building blocks: governance, health financing, health service delivery, human resources, medicines and medical product management, and health information systems (World Bank, 2013). Lack of adequate and sustainable health services and facilities in vulnerable societies provides a gap for studies on resource mobilization.

The link between spending and health outcomes has been as controversial as the relationship between health care and economic growth. This issue is of particular relevance in the debate over consolidated universalist health systems, in which achieving further health gains appears to require unaffordable new investments (Bain and Ebuenyi, 2017). In the past, the literature has provided inconclusive results regarding the contribution of health care expenditure to health outcomes. The case of the United States has often been proposed as the clearest example of a health care system that, if compared with other Organization for Economic Cooperation and Development (OECD) countries, displays “more-than-expected” spending with less-than-expected life expectancy (World Bank, 2013). Expenditure on health should aim at better health outcomes.

More recently, however, evidence of a positive relationship between spending and health outcomes has begun to emerge in studies that compare either health care systems at the macro level or local health authorities/organizations and their processes of care at more macro and micro levels. Macro-level studies have shown that total health care costs or investments in human capital for health (Ekman, 2014) contribute to reducing overall and infant mortality and, more rarely, to increasing life expectancy. Several methodological challenges, however, remain in this type of analyses, given the difficulty in isolating the impact of spending from all other determinants and the potential of several explanatory variables utilized in the studies. This literature draws attention to the fact that UHC or health care spending per se is not economically unsustainable but rather the part that is poorly allocated and wasted without producing health.

Dealing with economic sustainability means devising better ways to assess what are critical, defining priorities in the allocation of resources and, simply, getting the most out of health care systems (Hammer and Berman, 1995). In principle, this is not very different from what has been done in other sectors that, when facing issues of long-term sustainability, have not

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revised their core principles but rather have redesigned their work processes to be more efficient and effective. Some scholars have proposed that a more explicit analysis of health care costs might be a critical step in the understanding of how costs are generated and in solving the efficiency issue. We suggest that the production of evidence on the economic sustainability of health care, particularly UHC, is a much wider research enterprise that entails an analysis of the processes, competences, and organizational models that make a difference for health (Bain and Ebuenyi, 2017). Researchers in health management and economics might be in a privileged position to work with both policymakers and managers in the analysis of data and information, including information on costs, with the explicit aim of supporting priority-setting decisions. These decisions have the potential to be based on justifiable and reasonable arguments about why some things are prioritized and others are not, grounded in the reality of health care organizations and systems (Ekman, 2014). Combined efforts by researchers in health management, policymakers and managers are important towards building infrastructure for Universal Health Coverage.

According to Carrin and James (2005), achieving Universal health coverage is a key objective for advancing the Sustainable Development Goals (SGDs), however a big challenge in achieving this is how best to afford good health services for the whole population. Funding public services will always be a matter of prioritizing limited resources. Continuing the theme of the previous discussion on Global Health Security (GHS), estimates of the cost of delivering even basic health protection services are significantly more than many countries are able to afford (Hammer and Berman, 1995). UHC is about more than just health protection, with issues such as the rising costs of Non-Communicable Diseases (NCDs) putting an ever-increasing burden on national health budgets.

Lieberman, (2016) stated that resource mobilization systems for health care financing are fundamentally national by definition. Domestic fiscal resources can be enhanced and in many cases in both advanced and emerging world are very substantially enhanced by international and regional funding. However, it is paramount that sustainable health care financing systems are to rely first and foremost on domestic revenue collection (Bain and Ebuenyi, 2017). Efficient health care system is about pooling risks by definition; every universal health care system is insurance system. In turn, the very nature of insurance implies resource allocation from those in good health towards sick. Therefore, domestic political input is needed to set up modalities of how the insurance premiums are paid and to what extent resource transfers will take place between healthy and sick, but also between generations and between higher and lower income strata in society.

Ayeni, (2015) argued that the key to health care financing is its political and fiscal sustainability that, in turn, requires that certain time consistent ground rules as per revenue sources are in place. Health care prioritization is concerned not only with absolute amounts of health care spending, but predictability of revenues that are safeguarded to the largest extent possible from yearly negotiations on general state budget (Roseland, 2015). The ground rules for health care financing should establish whether the bulk of UHC costs are credited to some tax or, as the case may be, directly to insured persons, or these costs are internalized so as they are

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covered by general budget revenues (Bain and Ebuenyi, 2017). Most systems combine these two approaches, albeit using very different weights. Sustained financing models can be technically developed under both systems or by combination thereof.

The starting point for health care sustainable prioritization and sufficient revenue mobilization would in any case be the needs assessment. Nevertheless, transfers from general budget should be determined by using concrete and time consistent budget rule (Ayeni, 2015). Finally, two essential points are to be made: first, that total amount of health care spending is determined via an interactive (political) process that would result in eventual agreement on how much society as a whole is willing to spend on health and second, that while technically the use of any particular financing model can be regarded as fiscally neutral, the ultimate choice between insurance-based (either public or private) and budget-based approach may have, in turn, impact on the delivery side (Hammer and Berman, 1995). A proper balance should be maintained.

According to Hammer and Berman. (1995), between US$ 70 and US$ 90 billion in additional health spending annually is needed in order to ensure that a set of key health services identified in the SDGs as important stepping stones towards UHC are universally available. That means that, at current levels of health spending, LICs and LMICs will need to increase health expenditures by a third (Bain and Ebuenyi, 2017). These are a significant amount of resources but there has been some progress towards increasing resources for health. Between 1995 and 2013, global health spending increased, driven by economic growth. Indeed, total health expenditure grew more rapidly than GDP, with average spending as a share of GDP increasing from 4.9 to 6.4 per cent over the same period (World Bank, 2013). This underscores the place of resource mobilization in the provision of quality healthcare.

However, although very positive, this does not paint the full picture. A closer look reveals that although General Government Health Expenditure (GGHE) increased during this period, the majority of this increase came from high income countries (Bain and Ebuenyi, 2017). Countries would also need to ensure that catastrophic and impoverishing Out-Of-Pocket Payments (OOPPs) are kept to a minimum. OOPPs can be large and unpredictable, and can often be the triggers that push a family into poverty. Because of this, they act as a very real barrier to health services and economic success for the poorest members of society (Hammer and Berman. 1995). To remove these barriers, it is recommended that governments commit to ensure that OOPPs represent at least less than 20 per cent of the total health expenditure and there are no OOPPs for priority health services or for the poorest families. Currently, however, Low Income Countries (LICs) and Low and Middle-Income Countries (LMICs) are only halfway towards this target, with OOPPs accounting for an average 43 per cent and 34 per cent respectively of total health expenditures.

Most LICs and LMICs, even with the economic downturn, have considerable scope to raise revenue through increases in tax collection efforts and government charges. For example, the International Monetary Fund (IMF) estimates a potential of up to 4 percentage of GDP in additional tax revenues for LICs. Developing countries can improve tax collection through more efficient tax administration, and broadening the tax base (Bain and Ebuenyi, 2017). This is not easy and can take time but is do-able. In addition, there is scope within developing countries to

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increase tax revenues by reforming tax policy. For example, indirect taxes like VAT are still low in some countries, and this offers an opportunity for increase (Roseland, 2015). Similarly, tackling tax avoidance and evasion, and tax incentives for companies, such as those related to natural resources can raise additional revenues in LICs and LMICs. Governments could also greatly benefit from plugging leakages in revenues resulting from corruption and the illicit flow of funds.

The study was guided by the Resource Dependence Theory (RDT). The Resource dependence theory is the study of how the external resources of organizations affect the behavior of the organization. RDT is based upon how the external resources of organizations affect the behavior of the organization. The theory is based upon the following tenets: organizations are dependent on resources, these resources ultimately originate from the environment of organizations, the environment to a considerable extent contains other organizations, the resources one organization needs are thus often in the hand of the organizations, resources are a basis of power, legally independent organizations can therefore be dependent on each other (Pfeffer and Salancik, 1978).

In as much as organizations are inter-dependent, the Resource Dependence Theory needs a closer examination. Its very weakness lies in its very assertions of dependence. With changing trends of financial uncertainties, there is need to lean towards other theories of uncertainties. According to this theory, organizations depend on resources for their survival; therefore, for any organization to achieve sustainability, resources are indispensable. For community-based projects to achieve sustainability, resources are important. These resources will come in the form of human resource therefore the need to involve all the stakeholders in the project for sustainability. Other resources include land and finances.

The Resource Dependence Theory was applicable in the study given that it informed the researchers on how resources are used to implement and ensure sustainability of UHC. The Resource Dependence Theory was used to explain how resources of Health Ministry affect sustainability of the universal health coverage project. The sustainability of universal health coverage project is affected by the resources both financial and human resource of the Health Ministry.

Research Methodology

The study used descriptive research design. This method of research was preferred because the researchers were able to collect data to answer questions concerning the status of the subject of study. Descriptive research helps to determine and report the way things are done and also helps a researcher to describe a phenomenon in terms of attitude, values and characteristics (Mugenda and Mugenda, 2003). According to Orodho (2003), descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals. This method was appropriate for the study in that it helped in portraying the accuracy of people's profile events and situations. A descriptive research design also allowed for in-depth analysis of variables and elements of the population to be studied and as well as collection of large amounts of data in a highly economical way. It enabled generation of factual information about the study.

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This is so because the descriptive design relies much on secondary data which helps in developing the case basing on facts, sustained by statistics and descriptive interpretations from archival materials and data.

Population refers to all people or items (unit of analysis) with the characteristics that one wishes to study. The unit of analysis may be a person, group, organization, country, object, or any other entity that you wish to draw scientific inferences about (Orodho, 2003). The target population for the study were the beneficiary households, universal health care workers, and local leaders in Wajir County. The target population of beneficiaries was estimated at 677. This target population comprised, beneficiary households 551(81.3%), universal health care workers 29(4.3%) and local leaders 97(14.4%).

A sample is a smaller group or sub-group obtained from the accessible population (Mugenda and Mugenda, 2003). This study adopted the stratified sampling technique. Stratified sampling is a probability sampling technique wherein the researchers divided the entire population into different subgroups or strata, then randomly selected the final subjects proportionally from the different strata. The reason for the choice of the sampling method was that it enabled the researchers to representatively sample even the smallest and most inaccessible subgroups in the population. This allowed the researchers to sample the rare extremes of the given population. The study used the following formula proposed by Using Yamane (1973) to determine the sample size; Using Yamane (1973) formulae, $n = N/ (1+N^*) (e)^2$ Where, n = sample size, N = the population size, e = the acceptable sampling error (7%) at 93% confidence level, Thus; $n = 677/ (1+677) (0.07)^2$, n = 204. Therefore, the sample population size (n) was 204 respondents.

Sampling is the process of selecting the people who will participate in a study. This process should be representative of the whole population. Sampling is hence the procedure, process or technique of choosing a sub-group from a population to participate in the study (Ogula, 2005). This study adopted the stratified sampling technique. From the possible total sample population of 204(100%), stratified random sampling was employed to select strata of beneficiary households 166(81.3%), universal health care workers 9(4.3%) and local leaders 29(14.4).

A questionnaire was used to collect primary data. The questionnaire comprised of questions, which sought to answer questions related to the objective of this study. The questions entailed both closed-ended questions to enhance uniformity and open ended to ensure maximum data collection and generation of qualitative and quantitative data. The questionnaire was divided into two sections, the background information section and the research questions section according to the research objective. Data for the study was analyzed both qualitatively and quantitatively. The data collected was keyed in and analyzed with the aid of SPSS. The Quantitative data generated was subjected to the descriptive statistics feature in SPSS to generate mean, and standard deviation which was presented using a table, frequencies and percentages.

Piloting helps the researcher to generate an understanding of the concept of the people being interviewed. In conducting the pilot study, the researcher was interested in establishing whether the respondents had the same understanding of the questions and thus would offer the

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information required. Mugenda and Mugenda (2003) posit that "even the most carefully constructed instrument cannot guarantee to obtain one hundred percent reliability". Piloting was important as it helped in determining the reliability of the instrument. In this research, 20 respondents were chosen to participate in the pilot study and were not included in the sample chosen for the study. Test-retest reliability was conducted obtained by administering the same test repeatedly over a period of time and still produced the same results. During piloting the researchers administered the questionnaire to a different set of respondents who are not part of the groups of sampled respondents, but similar in characteristics to those sampled for the study. The piloting process also played the important role of checking the respondents for their suitability, clarity, relevance of information and appropriateness of the language used.

Validity is the degree to which an instrument measures what it purports to measure (Mugenda and Mugenda, 2003). It is the accuracy and meaningfulness of inferences, which are based on the research results. In this regard, experts in the field of projects achieved the content validity through an evaluation of the content. The instrument was given to two groups of experts, one group was requested to assess what concept the instrument was trying to measure and the other group was asked to determine whether the set of items accurately represents the concept under study.

Reliability refers to the consistency of data arising from the use of a particular research method. Mugenda and Mugenda (2003), states that reliability is the measure of the degree to which a research instrument yields the same result after repeated trials over a period. In this regard, test-retest was employed to check on reliability. This involved administering the same instruments twice to the same group of subjects, but after some time.

Hence, to determine stability, a measure or test was repeated on the subject at a later date. Results were compared and correlated with the initial test to give a measure of stability. Responses obtained during the piloting were used to calculate the reliability coefficient from a correlation matrix. The reliability of the instrument was estimated using Cronbach's Alpha Coefficient which is a measure of internal coefficient.

The researchers assured the respondents that the data was confidential and was to be used for academic purposes only and no disclosure of the names. In addition, participation in the study was voluntary and no respondent was compelled to participate in. the interview with the respondents commenced through an introduction from the researchers to the respondents. The researchers were true to their word and aimed at collecting the truthful information only

Findings and Discussions

Out of the sampled population of 204(100%), unreturned questionnaires were 29(14.2%), the questionnaires that were returned duly filled in making a response of 175(85.8%). The response rate was considered representative and was adequately used to answer the research questions. According to Mugenda and Mugenda (2003) a response rate above 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent.

The respondents were requested to indicate their gender. From the findings, out of the 175(100%) respondents, majority 90(51.4%) of the respondents were male and 85(48.6) of the

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respondents were female. This implies that even though most of the responses emanated from males there was also gender representation.

The study sought to establish the age of the respondents. According to the findings, 56(32%) of the respondents were between 35-39 years of age, 49(8%) were 30-34 years of age, 23(13.1%) were 25-29 years of age, 18(10.3%) were 40-44 years of age, 12(6.9%) were 45-49 years of age, 10(5.7%) were below 24 years of age and 7(4%) respondents were above 50 years old. This depicts that most of the respondents were aged enough and thus could offer high quality information because of their experience.

The respondents were requested to indicate their level of education. From the findings, most 66(37.7%) of the respondents had certificate/diploma level of education, 56(32%) were graduates, 30(17.1%) had secondary education while 25(14.3%) were postgraduate. This implies that respondents were well knowledgeable and hence higher chances of getting reliable data.

The study also sought to establish the duration the 175(100%) respondents had known universal health coverage. Based on the findings, 73(47%) of the respondents had been aware of universal health coverage for a duration between 4-6 years, 57(32.6%) of the respondents were aware of universal health coverage for between 1-3 years, 31(17.7%) of the respondents knew UHC for less than a year, while 14(8%) of the respondents knew about universal health coverage for a duration of over 4 years. This illustrates that most of the respondents were aware of the UHC and therefore had accumulated a lot of knowledge and skills over time.

The 175(100%) respondents were requested to indicate whether resource mobilization influence sustainability of Universal Health Coverage. A majority 125(71.4%) of the respondents indicated that resource mobilization influence sustainability of Universal Health Coverage while 50(28.6%) were of contrary opinion. This depicts that resource mobilization influence sustainability of Universal Health Coverage.

The respondents were requested to indicate the extent to which they agreed with statements on resource mobilization influence on sustainability of Universal Health Coverage. The responses were placed on a five likert type scale where 1=strongly disagree, 2-disagree, 3-moderate, 4=agree, while 5=strongly agree. The findings are shown in Table 1.

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Table 1: Extent of Community Participation influence on sustainability of Universal Health Care

Statements	Mean	Std Dev.
Sustainability of universal health coverage should engage stakeholders from all sectors of society	3.61	0.1569
Various stakeholders, the government of Kenya has over the years-initiated policy reforms and strategies earmarked towards universal health coverage	3.99	0.2378
The government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance	3.78	0.1872
The public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system	3.57	0.1920
Sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers	3.70	0.1389

Source: Research Data

From the findings the respondents agreed that various stakeholders, the government of Kenya has over the years initiated policy reforms and strategies earmarked towards universal health coverage (mean=3.99), followed by the government provides a legal framework for ensuring a health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance (mean=3.78), sustainability of universal health coverage requires a sufficient capacity of well-trained, motivated health workers (mean=3.70), sustainability of universal health coverage should engage stakeholders from all sectors of society (mean=3.61), and that the public and private health practitioners have collaborated to ensure successful and sustainable universal health coverage system (mean=3.57). This depicts that various stakeholders, the government of Kenya has over the years-initiated policy reforms and strategies earmarked towards universal health coverage.

The study established that resource mobilization influence sustainability of Universal Health Coverage. The study also found that various stakeholders, the government of Kenya has over the years-initiated policy reforms and strategies earmarked towards universal health coverage. The findings contradict a study by Bain and Ebuenyi, (2017) who stated that efficient health care system is about pooling risks by definition; every universal health care system is an insurance system. In turn, the very nature of insurance implies resource allocation from those in good health towards sick. Therefore, domestic political pact is needed to set up modalities of how the insurance premiums are paid to what extent resource transfers will take place between healthy and sick, but also between generations and between higher and lower income strata in society.

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In Kenya, with support of various stakeholders, the government of Kenya has over the years since independence in 1963 initiated policy reforms and strategies earmarked towards universal health coverage. Some of these are outlined in various policy documents including Kenya Health Policy Framework (KHPF 1994–2010), Health Sector Strategic Plans, Vision 2030, the Constitution 2010, and finally, the Health Bill of 2015. Notably, the government recognized a high quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation (Tallon-Baudry, 2012).

Conclusion and Recommendations

The study concluded that resource mobilization influence sustainability of Universal Health Coverage in vulnerable livelihoods in Kenya: a case study of Wajir County. The study also concluded that various stakeholders, the government of Kenya has over the years-initiated policy reforms and strategies earmarked towards universal health coverage.

Based on the study findings the study recommends that Kenya's State Department for Health and the County Governments should focus on investments in Universal health care through mobilization of resources to improve county health facilities so as to achieve equitable access to skilled delivery services across the country.

Opportunity for further research in the subject matter exists thus: it would be interesting to compare the findings with lower the units of analysis such as the sub-county. The population of the study would be much bigger; a second study is suggested to come up with a standard acceptable utilization level. This will provide a standard upon which such studies can be replicated.

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