INTRODUCTION

According to Dr. Margaret Chan, Director General of the World Health Organization, Universal Health Coverage (UHC) "is the single most powerful concept that public health has to offer" (Chan 2012). UHC refers to the ability to ensure that all citizens have access to health services (including prevention, promotion, treatment, and rehabilitation), which are of sufficient quality and are affordable (WHO 2010). While the tone of the global campaign surrounding UHC continues to be the subject of debate (O'Connell et al. 2013; Abiiro & De Allegri 2015, Kutzin & Sparkes 2016), researchers have only recently begun to examine the political dimensions of UHC at country-level (Yamey & Evans 2015, Nicholson 2015) and few scholars have evaluated how actors understand and are affected by new UHC policies (Sheikh et al. 2014, Abiiro and De Allegri 2015). Experience from several low- and middle-income countries (LMICs), however, shows that several paths to UHC exist and are largely dependent on the broader historical, political, and economic features of a particular country (Savedoff et al. 2012).

Policy arguments based on notions of health equity and sustainability underpin the UHC campaign (Gwatkin and Ergo 2009, Abiiro et al. 2014). To achieve UHC, international organizations recommend for countries to reduce health inequalities by extending coverage to the poorest, while increasing public investment in health through the development of sustainable health financing arrangements (WHO 2010; WHO 2013). Strategies such as these, that involve re-distributive policy decisions, are vigorously contested in the political realm (Stone 2012). Policy theorists argue that at the heart of these policy controversies lie fundamentally conflicting value systems, such as those

underlying social health systems and those preferring market-based systems (Schön and Rein 1994). While this presumably occurs in many countries embarking on a path towards UHC, limited evidence exists about how actors on the ground understand the broader movement, how their professional lives are affected, and how this shapes the interplay of competing values (Walker and Gilson 2004). This article investigates how nurses understand concepts related to UHC and make value-based judgement about how to behave.

Nurses provide a window into how frontline health workers interpret domestic health policy reforms. Scholars in health policy and systems research (HPSR) are increasingly interested in understanding more about how international health priorities affect individuals responsible for executing carrying them out (Sheikh et al. 2014). For example, research from medical anthropology has demonstrated the difficulties faced by community health workers in Ethiopia (Maes and Kalofonos 2013) and healthcare providers in Malawi (Rosenthal 2015) working in HIV/AIDS programs.   Despite the fact that nurses, as frontline health workers, are key actors in carrying out policy directives, research on how they understand policy or respond to policy change in their professional lives is largely underrepresented in the HPSR literature (Richter et al. 2013, Juma et al. 2014). This knowledge gap is conspicuous in LMICs, like Kenya, where physician shortages position nurses as central agents in the delivery of primary healthcare (WHO 2006). Nevertheless, nurses have been historically marginalized within health systems (Freidson 1970) and their views are rarely solicited on issues such as national health reform or UHC more generally (Walker and Gilson 2004). Thus, because of their central

role in healthcare delivery, and because little is known about how they engage with global policy agendas, there is a need for more research to understand how nurses collectively interpret and influence domestic policy reform measures.

Kenya is an interesting country to explore understandings of the UHC movement because, despite meager resources, the country has a long history of mandatory health insurance (Abuya et al. 2015; Chuma et al. 2013) and is currently involved in governance reforms (Lipsky et al 2015). Nevertheless, health financing is regressive (Munge & Briggs 2013) and just 10% of the population is covered by health insurance (MMS/MPH 2009). In the wake of constitutional change, the newly elected government recently sought to accelerate progress towards UHC by initiating key administrative and budgeting procedures to devolve the health sector from the national government to 47 counties (Tsofa, Molyneux, and Goodman 2015). Early evidence suggests that this dramatic change to service delivery in Kenya has placed tremendous strain on frontline health workers (Nyikuri et al. 2015). In addition to these changes, specific policies have been introduced that align with the UHC movement, including free maternal healthcare, removal of user fees from primary care facilities, and governance reforms within the largest health insurance organization (Leftie 2013; Abuya, Maina, and Chuma 2015). (Leftie 2013; Abuya, Maina, and Chuma 2015).

Despite the potential promise of strengthening access to essential services for the poor and vulnerable, these recent reforms have been met with resistance by the nursing profession in Kenya (Onsarigo 2014). This is somewhat surprising giving the altruistic

nature of the nursing profession. A goal of this study is to understand if this indeed

appears to be the case in Kenya and, if so, why. Contrary to the literature on professional

organizations in LMIC health systems (Walt 1994), the nursing profession in Kenya is

increasingly organized. Through the National Nurses Association of Kenya and the

Kenyan National Union of Nurses, nurses have been engaged in bitter policy disputes

over representation, remuneration, and the devolution process (BBC 2012) (Onsarigo

2014) n (Wahito 2013) (SMG 2015). Because these disputes threaten to undermine

progressive movement towards UHC, research is urgently needed to understand the basis

for contestation and the extent to which front-line health workers should be involved in

subsequent policy design.

In this way, the study also addresses another knowledge gap in HPSR by providing

evidence about the the politics of UHC and how health policies affect those responsible

for executing its mandates (Koon & Mayhew 2013). HPSR scholars increasingly point to

the limited body of health policy research within HPSR (Ghaffar et al. 2016), which leads

to uncertainty about the policy process and the political forces that create path-departing

policy change (de Leeuw, Clavier, and Breton 2014). Thus, HPSR scholars have called

for more qualitative, interpretive studies on the politics of health policy, particularly in

LMICs (Gilson & Raphaely 2008; Koon, et al. 2016).

This research brings to the fore an in-depth qualitative approach, interpretive policy

analysis, for understanding human behavior in the policy process. This approach focuses

on the the various ways in which actors continuously make sense of policy and how these

interpretations affect everyday life (Schwartz-Shea & Yanow 2012). In this way, interpretive policy analysis is a useful avenue for exploring "people-centered" health systems (Sheikh et al 2014). Interpretive policy analysis is premised on a distinction between the natural and social worlds, that humans assign meaning to events and actions (Fischer 2003). Thus, people are perpetually engaged in the social construction of reality, which is inherently open to change, reconstruction, and multiple legitimate interpretations (Berger and Luckmann 1967). Interpretive policy analysis uses a constructivist epistemology to look at the tacit role that values, beliefs, and feelings play on our ability to understand complex phenomena (Yanow 1996) and political contests that arise from conflicting interpretations (Stone 2012). This article investigates how 60 Kenyan nurses interpret UHC, health politics, and the effects of rapid policy implementation in Kenya.

METHODS

We conducted an interpretive policy analysis using interviews from a cross-sectional study of 60 nurses in Nairobi and a rural location in Kenya. Interpretive analysis focuses on the intersubjective basis for meaning-making among research subjects. For this reason, interviews were open, broadly framed, and analyzed using thematic inductive analysis within an interpretive research paradigm. Nurses were invited to participate from three facilities: one public urban hospital (*n=20*), one private urban hospital (*n=20*), and one public rural hospital (*n=20*). We invited participants from a mix of public/private and rural/urban facilities to participate in order to provide balance in perspective across nursing roles as opposed to recruitment for comparative purposes. Two Research Assistants (RAs) visited the facilities for two-week periods and invited

nurses to participate in an interview, when available. Our established relationships with the public facilities and professional connection with the private facility fostered interest in the study and our ability to interview nurses amidst competing work demands. Very few declined (*n*=2), and interviews were conducted the same day. Inclusion criteria were nurses employed in one of the hospitals, who had worked at the facility for six months or more, ability to consent in Kiswahili or English, and willingness to participate.

The second author, fluent in Kiswahili and English, led the interview process while the third author observed and took detailed field notes. Informed consent was obtained in a private clinical room before the interview. All interviews were tape recorded. Demographic and occupational details were collected. Interviewers engaged in semi-structured in-depth interviews about their jobs, views on UHC, patient interactions with the health system, equity, and the politics of health policy.

The interviewers transcribed interviews directly, and small portions of Kiswahili were transcribed in Kiswahili and translated to English. We used well-established interpretive methods from policy studies (Schwartz-Shea and Yanow 2012) to generate an understanding of nurses' views on UHC and the Kenyan health sector. We developed a codebook with definitions agreed upon by the first two and last authors. Two RAs coded narrative interviews and codes were analyzed for repetition and compared within and between nurses from each hospital. Representative quotes of emergent themes are listed below.

The study received ethical approval from the IRBs at XXXX and XXXX.

RESULTS

Nurses enrolled in this study were predominantly women (63%) of 11 different ethnic groups. On average, study participants were 38 years old and had 5.25 years of nursing experience. Two-thirds of the nurses work in urban settings, and two-thirds work for public hospital facilities (see Table 1).

Table 1: Overview of study participants

Interpreting the global UHC movement

Most nurses were unfamiliar with the term UHC. However, most used syntax to construct a definition consistent with the global movement. Respondents frequently were unfamiliar with the term and uncomfortable defining UHC, although most thought the term 'Universal' referred to global or being provided in Kenya in similar ways to other countries. Many interpreted UHC to mean the provision of care to all citizens without discrimination or barriers. Others focused on the 'Universal' to be holistic, meaning care of the patient physically, mentally, and psychologically.

Many were interested in the "real" international definition of UHC. Moreover, some respondents asked interviewers for more information on UHC, wanting to confirm if their understanding was correct and expressing a desire to learn more.

> *This is very new to me. I cannot tell you this is what it means unless you tell me*
>
> *the meaning of it because it's the first time for me to come across that. (rural,*
>
> *public)*

While unfamiliar with the specific concept of UHC, some nurses understood that UHC was linked to the WHO, or financing efforts at the national-level. The following study participant reveals how some perceived a distinction between UHC as an international and Kenyan issue.

> *When I was at training they talked so much about the World Health Organization*
>
> *and they still talk about it, what the World Health Organization has done is they*
>
> *set policies that are being followed by other countries then the nurse. […] You*
>
> *have those international standards. Not Kenyan standards. (urban, private)*

Respondents were near unanimous that other Kenyans, including family members, have limited or no exposure to the term UHC. The concept of 'equity', as espoused by the UHC movement, was mentioned by eleven respondents unprompted (18%). When asked if Kenyans think healthcare is equitable, nearly all nurses said "no". They often referred to healthcare access for poor Kenyans, focusing both on differences between urban and rural ("up-country") citizens and socioeconomic inequality.

Interpreting UHC in the Kenyan context

Nurses responded to a series of questions about the implementation and medium-term impact of incremental UHC policy measures, such as free maternal healthcare and the removal of user fees from primary healthcare facilities. Most respondents primarily focused on maternal health services: nearly equal numbers reported feeling that the roll-out met expectations and was improving, and another half were quite critical of the process (See Table 2).

> *It was abrupt. Yeah, but you know […] I think it was too fast. They could have taken some time or done […] some like surveys to do know the cons and pros of the whole process. (rural, public)*

Table 2: Interpreted Effects of Free Maternal Healthcare

Respondents repeatedly mentioned that occupational concerns, including compensation, job security and job choice, and quality of work environment (supplies, patient case load, etc.), were primary barriers to achieving UHC (see table 2). Many agreed that nurses in the public sector had greater job security and room for advancement, while those in the private sector were relatively better remunerated. Nurses at the rural facility felt isolated and wished for a transfer more than nurses working at either urban facility.

Questions related to work environment, pay, and advancement elicited the most detailed responses. Work environment challenges, however, were similar across facility type: although those in public facilities had a higher patient load, all nurses felt there were more patients than they could effectively handle. The following study participant

describes how at the private facility, respondents reported a dip in those seeking

maternity care immediately after the policy change of free maternal healthcare, but a slow

return of patients after the problems with quality began to appear in the public facilities.

> *For those patients who remain with us because the workload is slow we have time*
>
> *to be with them, so we give quality care, but when they're going […]like the*
>
> *public health sector, the workload was too high, and you could find mothers*
>
> *delivering on the floors, so after a while they started coming back, you see. Yes.*
>
> *The first few months we lost clients—majority went to the public sector, but after*
>
> *a while, like 3 months, they came back. Yeah. (urban, private)*

Identity and powerlessness

Nurses had complex and sometimes contradictory impressions of their role in the health

system. Though overall nurses shared a strong occupational identity, responses diverged

as to whether nurses in Kenya are valued. Some nurses felt under-appreciated as

evidenced by limited resources and negative patient perceptions about quality of care.

Others felt valued on account of their occupational identity, social role, and position as a

member of the 'backbone' of the health workforce.

Respondents were consistent in the view that health workers' voices are not heard. Many

stated that they give suggestions about policy but their ideas are not acted upon. This

was attributed to the fact that nurses are not regarded highly, but also that voices get lost

amidst the bureaucratic shuffle, as demonstrated by the following:

Who do I share to? No one has come to ask me about it. […] Even now I've

shared with an administrator, but who does he or she share with? There are no

channels. There are no structures in health where you can pass […]maybe to the

county level and maybe the ideas are just dying there (rural, public)

The politics of health policy and UHC

Although we did not ask directly about constitutional reforms, nurses suggested changes

in health care are related to constitutional change. Some specifically mentioned this

when discussing the reasons for the introduction of UHC or its implementation:

First of all, [it is] in the constitution itself. The [new] Constitution of Kenya sets

out very clearly the right to health for all […] and now there is the responsibility

of the government to provide that right. (urban, private)

Nurses were asked if they think about health care policy as a political issue. Despite their

critical role in the health system, some nurses said they do not think about healthcare

policy when they vote and that politicians do not care about the concerns of the

community. Nurses, therefore, felt powerless in the wake of constitutional reform and

sweeping changes made to service delivery.

Very few nurses felt political leadership met the healthcare needs of the population.

They believed politicians focused narrowly on industry purchasing at the expense of

systematic health care reform. Many questioned leadership in the Ministry of Health (MOH), such as the following respondent, suggesting that health officials were technocrats fixated with policy-development rather than implementation.

> *I am not sure whether those people who come up with policy are the right people to formulate the policies or if these policies are being formulated by particular group of people there is no wide consultation that is done. (urban, private)*

Nurses felt strongly, usually negatively, about the recent devolution of healthcare from the national government to newly delineated counties. The rushed nature of implementation resulted in a considerable degree of upheaval and confusion amongst the health professions. The fact that new county structures are responsible for paying health workers, for example, was perceived to be a source of frustration as salaries are often delayed or not received. Most saw devolution as another top-down political development that has occurred without proper representation of those most affected, namely frontline service providers. The disarray has reinforced the negative perception of leadership within MOH causing at least one respondent to question, "who is in charge of health?" Furthermore, respondents voiced concerns about devolution's strain on professional relationships and its potential impact on the quality of patient care, as demonstrated below:

> *We had a challenge when the devolution was done. The Ministry of Health has had so many crises. It has been a problem. There is the lateness in paying the*

salaries to the health workers, and once the health workers strike it brings so

many problems. The patients are the ones who are suffering. (urban, public)

DISCUSSION

This study brings to light critical understandings about how frontline health workers interpret global policy movements such as UHC and how they relate such movements to recent developments in Kenya's health sector. The concept of UHC is not familiar to most frontline providers in Kenya. More importantly, political and systemic challenges have clearly affected UHC implementation and its perceived impacts on health professionals. Also, it is unclear whether or not the values espoused by the global movement resonate with Kenyan citizens. There seems to be some support for "collective" and equitable solutions to health care needs, but the nurses interviewed for this study did not provide concrete examples for how that is best accomplished. While nurses felt underappreciated, most expressed some form of intrinsic value associated with the profession and thought of themselves as the 'backbone' of the health system. Concurrently, nurses unanimously agree that their voice is not heard. Finally, frontline health workers perceive the policy and politics of healthcare in Kenya to be associated with a higher, elite level of discourse that rarely consults their views or needs. This is somewhat curious as recent strikes, discussed below, suggest Kenyan nurses are becoming increasingly politically active. We discuss four key findings below.

First, our data suggest that the UHC movement has not left the offices of the international community and the policy elites scattered around Nairobi. Insufficient penetration of the

concept is illustrated by the fact that health workers and their families, who should be on the frontlines of the campaign, have not heard of UHC. When pressed, our interlocutors defined UHC based on the easily identifiable three words: Universal Health Coverage. Although the UHC movement has been explicit that the concept will mean different things across contexts (WHO 2010), research from policy studies has shown that ambiguity is often favored, for a variety of reasons, by policymakers (Stone 2012). Taken as a whole, this suggests that while nurses' interpretations were limited by exposure to the concept, the salience of UHC as an abstract but simple idea that evokes commensurate interpretations.

While not explicitly, nurses in our study often interpreted events using similar values to that of the global UHC movement. Almost all nurses reported that the health system in Kenya is not equitable. Equally as many said that it should be. Many described socioeconomic discrepancies as well as differential access to care between rural and urban communities. This suggests that while nurses have yet to be engaged in the broader campaign, their views are potentially consistent with it. More research should be conducted to see how frontline health workers in other contexts feel about UHC to know if global values espoused by this campaign resonate with domestic actors.

Second, nurses identified one policy measure that reflected the equitable realignment of care in Kenya: free maternal healthcare. This is possibly because all nurses were directly affected, often in negative ways, by the sudden implementation of this new policy directive. Yet, nurses failed to mention efforts to expand the mandate of the large public

insurer (NHIF) or the removal of user fees from primary care facilities. When pushed, they did, however, link constitutional change with changes in the health sector, particularly devolution of services. But, as a whole, nurses viewed UHC through the prism of free maternal healthcare, which they associated with a host of problems.

The Kenyan nurses' experiences in our study exemplified why health policy scholars have cautioned against abrupt removal of fees for service delivery (Gilson and McIntyre 2005). Research in other African countries suggests that the manner in which these policies are implemented often yields unintended consequences for health workers and patients alike (Ridde, Robert, and Meessen 2012). This study reveals that this appears to be true in Kenya, too, as the rushed implementation of free maternal healthcare meant that nurses were left scrambling to ensure that their facilities and colleagues could cope with the torrent of new patients. There was evidence that this may be temporary, as some nurses suggested that quality issues in the public sector spurred the volume of patients in private facilities to return to what it was before the policy implementation. This finding is consistent with research in five other African countries that also found that high levels of utilization in public facilities were not sustained following removal of fees (McPake et al. 2013). Furthermore, nurses alluded to a sense of injustice, not only at having not been consulted about the policy change, but also from being told that their work load will increase significantly without increasing their pay. Unfortunately, this finding too is supported by work in six African countries that illustrated nurses were never consulted during policy formulation on fee removal policies (Meessen et al. 2011). Additional strain placed on an already overloaded and thinly stretched workforce contributes to the

widespread belief that nurses are not valued in the health system, as seen in South Africa (Walker and Gilson 2004; Joyner et al. 2014). Moreover, there is a concern that patients' needs are not being met. For example, nurses reported that sometimes they have to attend to simultaneous deliveries, multiple women may have to share a bed for recovery, and women are found to be giving birth in unusual places.

Third, many nurses communicated systemic failures using symbolic language, such as women giving birth on the floor, in the hallways of health facilities. Interpertivists argue that not only does symbolic representation allow individuals to order and interpret reality, but also to reconstruct it (Firth 1973). By endowing an object with meaning, value, or significance (Elder and Cobb 1983), language assumes a political character that elicits human emotion and subsequent action (Edelman 1985). In this example, the visual characterization of an unattended mother in labor in an overcrowded facility bridges multiple evidence claims and elicits an emotional response from the listener, including the visualization of an expectant mother deprived of privacy, who is vulnerable, and possibly suffering through an unhygienic labor. We argue that this discursive construct is commonly employed to elicit emotion and perhaps anger around nurses' everyday challenges and that such emotive claims will continue to be a primary means of substantiating the position that there are problems with free maternal healthcare. This is consistent with social movements research on HIV/AIDS, which provides a convincing account of the role emotion plays in political life (Gould 2009).

Regardless of the negative effects of the free maternal healthcare policy for nurses, most supported the policy because of the benefits it represented for patients, including ensuring the safety of mothers and expanding access to antenatal care. Most felt that ordinary Kenyan citizens strongly favor the free maternal health policy as well. This ability to represent a position (that free maternal healthcare is good) despite conflicting interpretations of how it affects themselves (that it is largely bad), suggests that nurses are committed to the communities they serve, a finding shared by the South African study (Walker and Gilson 2004). It also demonstrates that disagreement with the larger political processes associated with health policy notwithstanding, nurses understand that policy-makers have to balance political demands of the citizenry.

Finally, like many Kenyans, nurses appeared disenchanted with policymakers and placed little faith in the ability of leaders to strengthen the health system. Some nurses blamed policymakers in the Ministry of Health, which was characterized as disorganized, out-of-touch with frontline workers, and naïve about implementation challenges. Many voiced concerns about a lack of leadership across all decision-making institutions, but especially in the health sector, in Kenya. nurses remain marginalized within the health system. While doctors and teachers are represented on the NHIF board of directors, nurses are not. Similarly, nurses occupy few leadership roles within the Ministry of Health or Parliament, which are both well represented by physicians. Nevertheless, nurses, who outnumber doctors 10:1, provide the bulk of healthcare in Kenya (Wakaba 2014; WHO 2006). Given the increased demands being placed on nurses by policies such as free

maternal healthcare, it is difficult to imagine that highly charged political contests will end anytime soon. Furthermore, it is unknown how citizens view these contests.

This research is instructive because nurses are likely to protest over the implementation of health policies, but not necessarily the content of them. In this way, nurses' views provide a deeper understanding of behavior and viable explanations for political dissatisfaction, on one side of a divisive policy debate. Future engagement of nurses in policy decisions may help to preempt workplace disputes and thus work to better sustain progress towards UHC.

LIMITATIONS

This study had several limitations. First, as with all interpretive ideational approaches, this study is complicated by the "double hermeneutic," meaning researchers and policy actors together are engaged in a process of sense-making (Giddens 1993). Constructivist research therefore involves implicit assumptions about how actors and researchers themselves interpret and construct meaning in the policy process (Yanow 1996). This is somewhat uncommon in HPSR (Shiffman 2009). Second, the extent to which our sample reflects the experience of nurses across the country is limited by the small sample and three clinics. Third, nurses' understandings of the issues could have been influenced by subtle ways in which interviewers primed the participants during data collection. Fourth, the collaborative nature of this research poses certain challenges for interpretive studies, which we tried to overcome through close communication and deliberation throughout.

CONCLUSIONS

This study provides the first research into how nurses interpret the current UHC

movement and its relationship to their work in a LMIC. Despite limited recognition of

the concept, most nurses interpreted UHC through the recent policy of free maternal

healthcare. Nurses were favorable of the idea for its benefits to patients, but critical of its

implementation because of its effects on their workload. Nurses consistently perceived

the health system in Kenya as inequitable and understood that it should change. Nurses

appeared to unknowingly share values consistent with the UHC movement. For

successful adoption of a path towards UHC, however, nurses should be consulted as

legitimate stakeholders in the process. While a sizable degree of contestation is to be

expected in the health sector, the process of policy deliberation, and the discursive

mobilization of interests in Kenya, provides insight for other countries working towards

UHC. Equipped with this knowledge, stakeholders can more effectively engage in the

process of collectively working towards equitable health systems strengthening.

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