

From Innovation to Transformation: Leveraging Murang'a and Kisumu Counties' Experiences for National Universal Health Coverage in Kenya

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Abstract

Background: Kenya's commitment to Universal Health Coverage (UHC) by 2030 has produced an ambitious legislative landscape, yet persistent gaps between policy and implementation remain. The 2018 four-county pilot, the 2023 Social Health Insurance Act, and the replacement of the National Hospital Insurance Fund by the Social Health Authority (SHA) in October 2024 represent bold reforms, but one year after SHA's launch, 92% of health facilities reported financial distress, with claims settlement rates averaging just 34% (Kawira, 2025).

Method: Drawing on a review of peer-reviewed and grey literature, this paper examines two counties as analytical anchors: Murang'a, which has achieved near-complete health system digitisation and a pioneer telemedicine hub-and-spoke programme, and Kisumu, an original UHC pilot county that developed the Marwa Solidarity Health Cover and M-TIBA digital insurance platform. An integrated analytical framework combining the WHO health systems building blocks, Diffusion of Innovations theory, implementation science, and knowledge transfer theory underpins a comparative analysis matrix and a new County Innovation-to-National Transformation (CINT) conceptual model.

Result: Murang'a and Kisumu Counties demonstrate strategically complementary innovations – Murang'a strengthening supply-side efficiency and geographic equity, Kisumu strengthening demand-side financial protection and income equity – constituting a comprehensive county-generated architecture for national UHC. Fifteen evidence-grounded policy recommendations are proposed across five thematic clusters.

Conclusion: Three reforms are most urgent: establishing SHA reimbursement for telemedicine services, fully operationalising community health workers through the Primary Healthcare Fund, and creating a national inter-governmental UHC learning platform.

Keywords: Universal Health Coverage; devolution; digital health; community health; health financing; Murang'a County; Kisumu County; Kenya; Social Health Authority; telemedicine; policy learning

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1. Introduction

Universal Health Coverage (UHC) – the assurance that all people can access the quality health services they need without suffering financial hardship – sits at the heart of Sustainable Development Goal 3 (WHO, 2010). Kenya formally committed to this goal in December 2018, when President Uhuru Kenyatta declared UHC a national priority under the 'Big Four Agenda' and launched a one-year supply-side pilot in four counties: Kisumu, Machakos, Nyeri, and Isiolo (Ministry of Health, 2019). The subsequent 2023 legislative package – comprising the Primary Health Care Act, Digital Health Act, Facility Improvement Financing Act, and Social Health Insurance Act – was intended to provide the institutional architecture for national-scale transformation,

replacing the long-embattled National Hospital Insurance Fund (NHIF) with a new Social Health Authority from October 2024 (Ernst & Young, 2023).

The ambition has, however, consistently outrun execution. As Nyawira et al. (2024) document across the four UHC pilot counties, persistent challenges included staff shortages, supply chain failures, inadequate and untimely financing, and insufficient community engagement; public financial management systems, moreover, proved poorly suited to sustaining pilot-generated gains once start-up funding tapered off (Adjagba et al., 2025). The SHA transition has deepened rather than resolved these pressures: Kawira (2025) reports that one year post-launch, 92% of health facilities were in financial distress, with a national SHIF claims settlement rate of just 34%, and primary care facility non-payment in 45% of cases. SHA was capitalised at Ksh 6.1 billion against a Ksh 168 billion full implementation requirement (Ministry of Health, 2025). These are not mere teething problems – they reflect a structural financing gap and an implementation architecture that has not adequately incorporated the lessons of county-level experience.

Yet within this system-wide stress, particular counties have developed and demonstrated innovations of national significance. Murang'a County, ranked first nationally in health system automation by the Kenya Vision 2030 Delivery Secretariat (Wanzala, 2026), has transformed facility revenue from Ksh 500 million to Ksh 1.3 billion annually through digitisation, and delivered telemedicine consultations to 30,000 patients – 75% of them rural women – while national SHA reimbursement for these services remains absent (Kangata, 2025). Kisumu County, building on its role as a national UHC pilot site, enrolled 273,350 households on the M-TIBA digital health platform and created the Marwa Solidarity Health Cover, a county-financed insurance scheme that extended meaningful coverage to 45,000 vulnerable households when the national pilot ended (PharmAccess, 2021; ILO, 2024).

This paper makes three contributions to the Kenya UHC literature. First, it develops an integrated analytical framework combining established health systems and policy learning theories to examine county-level UHC innovations. Second, it presents a County Innovation-to-National Transformation (CINT) model specifying the mechanisms through which county innovations become national policy. Third, it produces a comparative matrix and fifteen actionable policy recommendations grounded in evidence from Murang'a and Kisumu. The paper advances the argument that Kenya's two leading county models are not isolated success stories but are strategically complementary – collectively addressing the full range of UHC system failures that national policy alone has so far failed to resolve.

2. Analytical Framework

The framework integrates four theoretical lenses spanning the full innovation-to-transformation pathway. First, the WHO (2010) health systems building blocks – service delivery, health workforce, health information systems, essential medicines, health financing, and leadership/governance – provide the primary diagnostic structure, assessing which systemic functions each county innovation strengthens, which remain deficient, and how blockages in one domain cascade through others.

Second, Rogers' (2003) Diffusion of Innovations theory, extended by Dearing and Cox (2018), explains how innovations spread from early adopters to mainstream adoption via five attributes: relative advantage, compatibility, complexity, trialability, and observability. This lens assesses whether the county innovations examined here are plausibly scalable to Kenya's remaining counties, or contingent on unique local conditions.

Third, the Objective-Oriented Health Systems Reform framework (Ng'ang'a et al., 2024) and Barasa et al.'s (2017) contextual analysis situate innovations within macro (national), meso (county), and micro (facility/community) levels. This implementation science lens attends to political economy – who benefits, who resists, and what coalitions sustain transformation across electoral cycles.

Fourth, Rose's (1991) lesson-drawing concept and Moyson et al.'s (2017) policy learning framework distinguish copying, adaptation, synthesis, and inspiration as modes of inter-governmental policy transfer,

addressing how county innovations become national policy – not through automatic diffusion, but deliberate institutional mechanisms.

These four lenses are operationalised through five analytical dimensions and six evaluative criteria, presented in Tables 1 and 2 respectively. The dimensions – innovation architecture, enabling conditions, health system impact, constraints, and scalability – structure the comparative analysis in Section 4. The criteria – equity, effectiveness, efficiency, financial sustainability, replicability, and governance alignment – provide the evaluative standard against which both county models and national recommendations are assessed.

Table 1. Integrated Analytical Framework: Dimensions, Key Questions, and Theoretical Lenses

Dimension	Key Questions	Primary Theoretical Lens
1. Innovation Architecture	What innovations were developed? What problems did they solve? What was the design logic?	WHO Building Blocks (WHO, 2010); Rogers (2003)
2. Enabling Conditions	What political, institutional, technical, and financial conditions enabled innovation to emerge and persist?	Implementation Science (Ng’ang’a et al., 2024; Barasa et al., 2017)
3. Health System Impact	What measurable changes occurred across the six WHO building blocks? What was the equity impact?	WHO Building Blocks (WHO, 2010)
4. Constraints & Failure	Where did innovations stall? What structural, financial, or political barriers emerged?	Implementation Science; Rose (1991)
5. Scalability	What elements are universally applicable vs. context-specific? What adaptation is needed for national scale?	Rogers (2003); Moyson et al. (2017)

Note. Analytical dimensions applied consistently across Sections 3 (conceptual model), 4 (comparative matrix), and 5 (policy recommendations).

Table 2. Evaluative Criteria: Definitions and Weighting

Criterion	Definition	Weight
Equity	Degree to which the innovation reduces inequities in access, quality, or financial protection for vulnerable and marginalised populations.	High
Effectiveness	Strength of evidence for improved health service utilisation, quality, or health outcomes attributable to the innovation.	High
Efficiency	Degree to which the innovation produces better outcomes per unit of resource input, including elimination of waste or financial leakage.	Medium
Financial Sustainability	Capacity for long-term financing without excessive dependence on donor funds or county discretionary budgets.	High
Replicability	Transferability of the core design logic across diverse county contexts with proportionate adaptation.	High
Governance Alignment	Compatibility with national governance frameworks, devolution architecture, and the SHA/PCN system.	Medium

Note. Criteria grounded in WHO (2010) health system performance assessment framework and Ng’ang’a et al. (2024). Weight reflects importance in the context of national UHC scale-up.

3. The CINT Conceptual Model

The County Innovation-to-National Transformation (CINT) model synthesises the analytical framework into a dynamic, multi-level pathway through which county health innovations become the building blocks of national UHC transformation. Its foundational premise departs from the conventional top-down diffusion assumption: rather than treating counties as passive recipients of national policy, the CINT model positions them as co-producers of national solutions – entities with superior contextual knowledge, tighter accountability relationships with communities, and demonstrated capacity for innovation under constraint (Barasa et al., 2017; Ng’ang’a et al., 2024). This repositioning reflects the empirical reality documented by Nyawira et al. (2024), McCollum et al. (2018), and the Vision 2030 Secretariat (Wanzala, 2026): Kenya’s most effective UHC innovations have emerged from counties, not from the national level.

The model operates through four stages, presented in Table 3. In Stage 1 (Problem-Driven Innovation), counties identify specific health system failures – revenue leakage, geographic inaccessibility, informal sector exclusion from insurance – and develop localised, often technology-enabled responses. Rogers’ (2003) diffusion framework identifies relative advantage as the primary driver of innovation adoption; both Murang’a’s automation (160% revenue increase) and Kisumu’s Marwa scheme (45,000 households covered after the national pilot ended) demonstrate this advantage concretely. In Stage 2 (Evidence Generation and Learning), innovations are piloted, evaluated, and documented through research partnerships. The peer-reviewed outputs from the M-TIBA/Kisumu collaboration (Huisman et al., 2022) and the telemedicine programme assessment (Ateng & Wanyoike, 2026) exemplify the evidence base required for Stage 3. In Stage 3 (Policy Translation and Adaptation), evidence is converted into national instruments – legislation, reimbursement codes, financing frameworks. Rose (1991) distinguishes between direct copying and adaptation; the CINT model argues that Kenya’s SHA architecture should adapt, not copy, county models. In Stage 4 (Institutionalisation and Transformation), adapted innovations are embedded in national systems with adequate financing, governance structures, and human resource frameworks, with counties remaining adaptive partners rather than passive implementers.

A critical design feature of the CINT model is its iterative rather than linear structure, depicted in Table 3 through bidirectional feedback arrows between Stage 4 and Stages 1-2. SHA’s current financial distress (Kawira, 2025; SPARC Africa, 2025) is itself a Stage 4 signal feeding back to Stage 3 (policy translation needs revision) and Stage 2 (new financing evidence emerging), distinguishing CINT from linear diffusion models and making it responsive to the politically contested reality of devolved health reform (Barasa et al., 2017).

Table 3. The CINT Model: Four Stages, Core Logic, and Primary Actors

Stage	Name	Core Logic	Primary Actors
Stage 1	Problem-Driven Innovation	Counties identify specific health system failures and develop localised, technology-enabled responses. Innovation driven by political will, disease burden, and devolution accountability (Rogers, 2003).	County governments, development partners, private sector, CHVs
Stage 2	Evidence Generation & Learning	Innovations are piloted, evaluated, and documented. Research partnerships generate peer-reviewed evidence. Critical failure points acknowledged alongside successes (Ng’ang’a et al., 2024).	KEMRI, universities, MoH, Council of Governors Maarifa Centre, PharmAccess
Stage 3	Policy Translation & Adaptation	Evidence is converted into national policy instruments. Context-specific elements are distinguished from universally applicable principles. Adaptation, not copying, is the primary mode (Rose, 1991; Moyson et al., 2017).	MoH, National Assembly, SHA, National Treasury, WHO/World Bank

Stage	Name	Core Logic	Primary Actors
Stage 4	Institutionalisation & Transformation	Adapted innovations embedded in national systems with adequate financing, governance, and human resources. Counties remain adaptive partners. Feedback loops to Stages 1-2 sustain iterative improvement (Barasa et al., 2017).	All 47 Counties, MoH, SHA, National Assembly, Development Partners

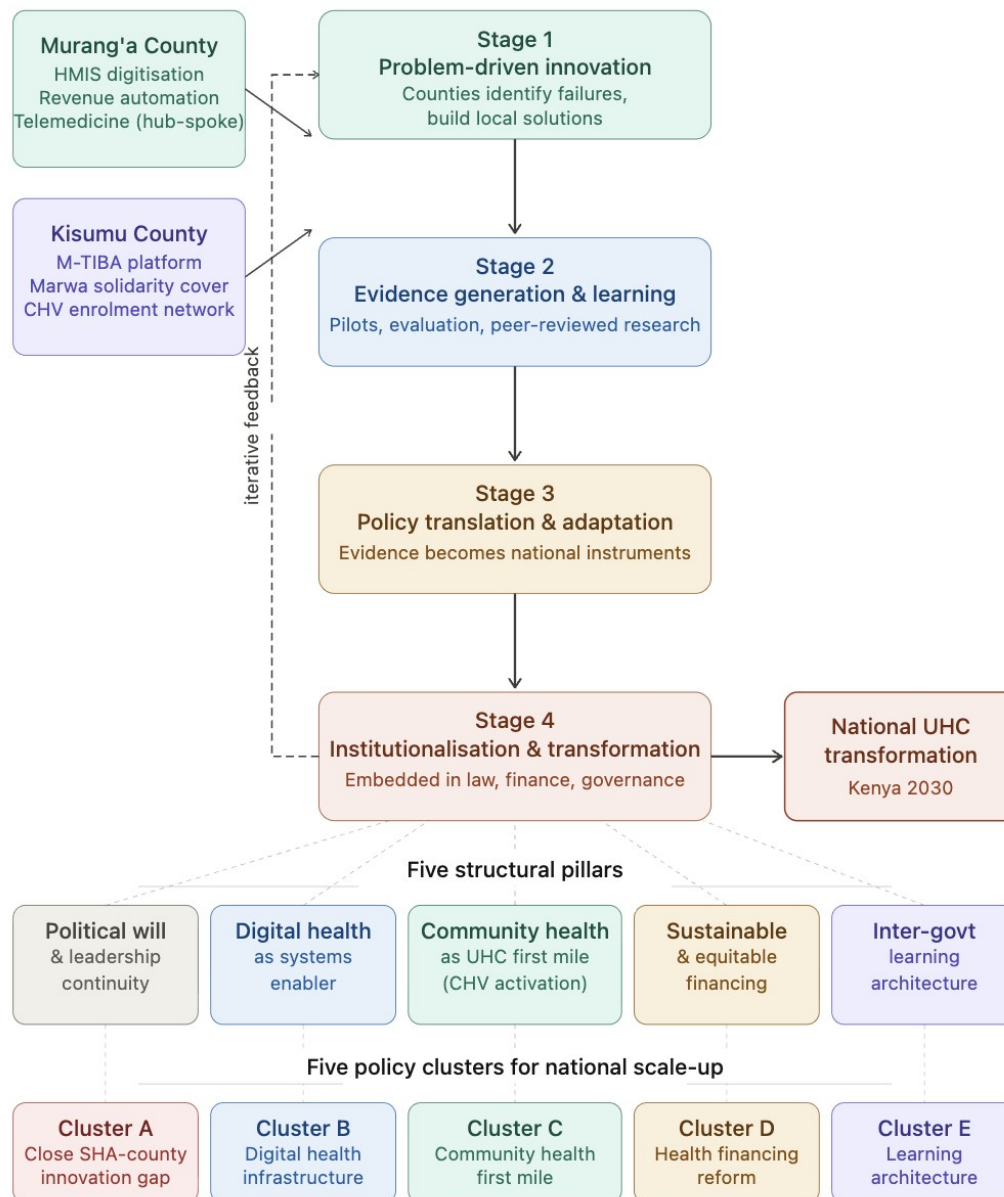


Figure 1. County Innovation-to-National Transformation (CINT) Model

Note. Arrows in the figure representation indicate bidirectional feedback from Stage 4 to Stages 1 and 2, reflecting the iterative rather than linear nature of the transformation process.

The model is held up by five structural pillars that cut across all four stages, summarised in Table 4. These pillars represent the institutional, technical, financing, human resource, and governance foundations without

which movement between stages will stall. Political will and leadership continuity (Pillar 1) is identified across the Kenya UHC literature as the decisive variable: McCollum et al. (2018) demonstrate that county health investment variation is primarily explained by governor-level political preferences, not by resource availability. Digital health as a systems enabler (Pillar 2) is distinguished from technology-as-add-on: Murang'a's experience shows that digitisation is simultaneously a fiscal strategy, a governance tool, and an equity mechanism. Community health as the 'first mile' of UHC (Pillar 3) recognises that facility-centred UHC strategies fail without a strong community health foundation; Mwenda (2023) documents the national failure to resource Community Health Volunteers (CHVs) adequately despite their demonstrated centrality to coverage. Ponge and Ochieng (2025) describe Community Health Promoters (CHPs) — the institutionalised successor cadre to CHVs — as “*Nyamrerwa*” (eyes on the ground), whose household-level trust and cultural proximity make them indispensable to UHC uptake, yet who remain constrained by chronic commodity shortfalls (a CHP serving 800 people may receive only ten anti-malarial doses a month) and uneven eCHIS digital literacy. Ponge and Ochieng (2026) further show that Community Health Committees are frequently colonised by local elites rather than genuinely community-selected, so operationalising CHPs as accountability actors — not merely service-delivery conduits — is itself a precondition for Pillar 3 to function. Sustainable and equitable health financing (Pillar 4) addresses the SHA paradox of ambitious coverage mandates meeting inadequate capitalisation (Ministry of Health, 2025; SPARC Africa, 2025). And an inter-governmental learning architecture (Pillar 5) provides the mechanism through which county innovations systematically become national policy – currently largely absent from Kenya's governance architecture.

Table 4. CINT Model: Five Structural Pillars, Descriptions, and County Evidence Anchors

Pillar	Description	County Evidence Anchor
1. Political Will & Leadership	Executive commitment operationalised into budget lines, performance frameworks, and accountability mechanisms that survive electoral cycles.	Governor Kang'ata (Murang'a): automation as anti-corruption strategy, sustained across term. Governor Nyong'o (Kisumu): Marwa as rights-based commitment embedded in County Health Act 2019 (Kisumu County Government, 2022).
2. Digital Health as Systems Enabler	Digital platforms as connective tissue – enabling revenue integrity, real-time management information, equitable targeting, and SHA claims processing; not a sectoral add-on.	Murang'a: revenue Ksh 500M to 1.3B via digitisation (Wanzala, 2026). Kisumu: 273,350 households on M-TIBA; eCHIS piloted in Kisumu, scaled to all 47 counties (Ileri et al., 2025).
3. Community Health as First Mile	CHVs as the non-negotiable link between the formal health system and full population coverage; community health elevated from supplementary to structural function.	Kisumu: CHV-led Marwa household mapping and enrolment (UNFPA Kenya, 2022). Murang'a: community facilities as telemedicine access nodes (Muranga County Government, 2024). Primary Health Care Act 2023 (Ernst & Young, 2023). National: 100,000 CHP kits launched September 2023 with 50-50 national-county stipend matching (Ponge & Ochieng, 2025).
4. Sustainable & Equitable Financing	A three-tier architecture: national SHA floor; county complementary financing (Marwa model, Murang'a automation); strategic partnership co-financing. Addresses the fundamental paradox of ambitious mandates with inadequate capitalisation.	SHA: Ksh 6.1B vs Ksh 168B required (MoH, 2024). Murang'a: automation as self-financing loop. Kisumu: Ksh 67.5M county premium co-financing (PharmAccess, 2021). SPARC Africa (2025) strategic purchasing analysis.

Pillar	Description	County Evidence Anchor
5. Inter-Governmental Learning	A structured mechanism for horizontal (county-to-county) and vertical (county-to-national) policy learning – systematically harvesting county innovations for national policy.	Vision 2030 Secretariat: 'solutions are here at home' (Wanzala, 2026). Murang'a benchmarking visits to Kisumu. eCHIS flexible adoption approach enabled national scale-up success (Ileri et al., 2025).

Note. County evidence anchors are drawn from the primary and secondary sources reviewed in Section 4. Pillar 5 is identified as the most underinvested structural element in Kenya's current national UHC architecture.

4. Comparative Analysis: Murang'a and Kisumu

4.1 County Profiles

Murang'a County, home to approximately 1.1 million residents across seven sub-counties and approximately 170 public health facilities, was not among the four original UHC pilot counties; its innovation trajectory is entirely county-driven, emerging from a political commitment to digitisation as a governance philosophy. Beginning in September 2022 with the abolition of cash payments and introduction of M-Pesa USSD-based revenue collection with Safaricom, the county adopted the Ministry of Health's Afya.KE Health Management Information System, benchmarking against Kisumu, Nakuru, Vihiga, and Kajiado before piloting at the Level 5 referral hospital in July 2023 and cascading it countywide (Mwende & Mukii, 2023). The telemedicine programme, launched in August 2024 through a hub-and-spoke model anchored at Muriranjas Sub-County Hospital and connecting 38 peripheral facilities, was grounded in NCD prevalence research conducted with Jomo Kenyatta University of Agriculture and Technology (Maina & Gatabi, 2025; Kangata, 2025).

Kisumu County, with a population of approximately 1.15 million, was selected as a 2018 UHC pilot county due to its high burden of infectious diseases – particularly HIV/AIDS and tuberculosis – alongside high maternal mortality and road traffic injury rates (Kenya Vision 2030, 2019; WHO, 2018). This disease burden, combined with existing HIV/AIDS programming and research infrastructure (including the Kenya Medical Research Institute/Centre for Global Health Research), created enabling conditions for innovation drawing on established community health systems. The county's collaboration with PharmAccess Foundation and CarePay (operators of the M-TIBA mobile health platform) generated the most comprehensive digital household health database at county level in sub-Saharan Africa – 273,350 enrolled households with 42,000 digitised healthcare transactions (Huisman et al., 2022). When the national pilot ended, Kisumu translated this infrastructure into the Marwa Solidarity Health Cover, underwritten by NHIF (now SHA) and co-financed by the county at Ksh 67.5 million for Phase 1 covering 45,000 households (PharmAccess, 2021).

4.2 Comparative Analysis Matrix

Table 5 applies the five analytical dimensions to a systematic comparison of the two counties. Table 6 synthesises their strategic complementarity for national UHC architecture.

Table 5. Comparative Analysis Matrix: Murang'a and Kisumu Across Five Analytical Dimensions

Dimension	Murang'a County	Kisumu County
1. Innovation Architecture	Full HMIS digitisation (Afya.KE); automated M-Pesa revenue collection (Safaricom partnership); telemedicine hub-and-spoke model (Muriranjas hub, 38 nodes); supply chain digitalisation and real-time dashboards. Entry point: supply-side efficiency and geographic equity (Mwende & Mukii, 2023).	M-TIBA household registration and digital claims management; Marwa Solidarity Insurance (90,000 HH target, 45,000 Phase 1); CHV-led community enrolment network; PPP with PharmAccess Foundation and CarePay. Entry point: demand-side financial protection and income equity (PharmAccess, 2021; ILO, 2024).
2. Enabling	Governor Kang'ata's personal championship	Governor Nyong'o's rights-based framing;

Dimension	Murang'a County	Kisumu County
Conditions	of automation as anti-corruption; strong county ICT department; Safaricom USSD infrastructure; JKUAT NCD research partnership; phased benchmarking visits to other counties before adoption (Wanzala, 2026).	Kisumu County Health Act 2019 mandating universal insurance; PharmAccess technical assistance for actuarial design; existing KEMRI/CGHR research infrastructure; pre-existing M-TIBA platform from 2018-19 UHC pilot (Kisumu County Government, 2022).
3. Health System Impact	Service delivery: 30,000 telemedicine patients (75% rural women); Ksh 1,200 average patient saving per visit. Health financing: daily Level 5 revenue Ksh 100-150K to Ksh 5M; annual county revenue Ksh 500M to 1.3B. Health information: 98.3% national automation score. Workforce: specialist task-sharing across facilities. Critical gap: SHA non-reimbursement for telemedicine; Ksh 200M in unpaid SHA claims (Kangata, 2025).	Service delivery: increased facility utilisation; improved skilled birth attendance and ANC uptake; Marwa benefit package covering oncology, dialysis, maternity, surgery. Health financing: Ksh 67.5M Phase 1 investment; 45,000+ HHs insured. Health information: 273,350 HH database; real-time claims data. Workforce: 200 additional staff hired during pilot; CHV network formalised. Critical gap: SHA transition disrupted NHIF/Marwa foundation (UNFPA Kenya, 2022; Africa Press, 2021).
4. Constraints & Failure Points	SHA non-reimbursement of telemedicine services; power and internet instability; specialist scarcity limiting throughput; risk of political discontinuity at electoral transition; single-source funding dependence on county budget for telemedicine operations (Kangata, 2025; Ateng & Wanyoike, 2026).	SHA transition destabilised NHIF/Marwa underwriting relationship; persistently low informal sector enrolment in Phase 2; CHV attrition due to inadequate stipends and equipment; multi-party governance complexity (County, SHA, PharmAccess, CarePay); political dependency risk if innovation perceived as governor's personal project (Africa Press, 2021; ILO, 2024; Mwenda, 2023).
5. Scalability (Rogers, 2003 attributes)	Relative advantage: Very High (revenue ROI concrete and measurable). Compatibility: High (Afya.KE is a national MoH system). Complexity: Medium (hardware + training required). Trialability: High (automation is a replicable first step). Observability: Very High (Vision 2030 ranking publicly available). Overall scalability: 4.2/5.0. Primary constraint: SHA reimbursement gap.	Relative advantage: High (financial protection for poorest). Compatibility: Medium-High (M-TIBA aligns with SHA digital architecture). Complexity: High (actuarial design + means-testing + multi-party governance). Trialability: Medium (requires critical mass for actuarial viability). Observability: High (ILO and UNFPA documentation). Overall scalability: 3.8/5.0. Primary constraint: SHA transition disruption.

Note. Scalability scores are authors' composite ratings based on Rogers' (2003) five diffusion attributes, scored 1-5 per attribute and averaged. Critical gaps identified under each county's health system impact reflect the national-county interface failures analysed further in Section 5.

Table 6. Strategic Complementarity: Combined National UHC Value of Murang'a and Kisumu Models

UHC Dimension	Murang'a Contribution	Kisumu Contribution	Combined National Value
Population Coverage	Expands access to specialist care for rural and geographically remote populations via telemedicine	Expands financial protection for the poorest and informal sector workers via solidarity insurance	Universal coverage: geographic equity AND financial equity
Health Financing	Automation generates a self-financing loop (revenue growth eliminates dependence on external funding)	County premium subsidies extend insurance to households excluded from contributory schemes	Revenue generation AND equity-targeted expenditure
Health Information	Real-time facility-level HMIS: revenue, drugs, patients, disease surveillance	Household-level enrolment and claims data: socioeconomic targeting, coverage tracking, COVID-19 response	Complete population data architecture from community to tertiary care
Equity Focus	Addresses rural-urban and geographic access inequity	Addresses income-based financial inequity and informal sector exclusion	Comprehensive equity: location AND income – the two primary drivers of Kenya's UHC gap
Community Health	Community health facilities as telemedicine access nodes; community-based NCD management	CHVs as UHC enrolment agents, household data collectors, and maternal health demand generators	Fully activated community health system integrating care delivery and population coverage

Note. The complementarity in this table is not incidental – it reflects the two structural dimensions of Kenya's UHC deficit identified in the WHO building blocks framework (WHO, 2010): service delivery coverage gaps and financial protection gaps. The two county models address these dimensions from opposite entry points, suggesting that a national UHC architecture integrating both models would be more comprehensive than either alone.

4.3 Cross-Cutting Implications for National Policy

Five implications for national scale-up emerge from the comparative analysis. First, the SHA-county financing interface is the critical fracture point: both models are financially unsustainable under current SHA rules – Murang'a absorbs telemedicine costs without reimbursement, and Kisumu's Marwa scheme was destabilised by the NHIF-to-SHA transition. SPARC Africa (2025) confirms that payment delays, administrative complexity, and insufficient provider autonomy are primary threats to SHA's strategic purchasing function. Second, digitisation is simultaneously a governance, financing, and equity strategy – not a technical add-on. Mwende and Mukii (2023) and Wanzala (2026) together demonstrate that health information digitisation transforms the entire fiscal architecture of county health systems, generating resources that can then be reinvested in coverage. Third, CHVs are the non-negotiable first mile of UHC coverage, yet Mwenda (2023) documents persistent national failure to resource them: shared kits among 20 workers, absent or irregular stipends, no standardised referral system. Ponge and Ochieng (2025, 2026) corroborate this from the community health governance literature, showing that commodity stock-outs and weak digitisation are compounded by a structural accountability gap: Community Health Committees are readily captured by local elites, and County Health Stakeholder Forums remain “invited spaces” convened by the very county health departments they are meant to scrutinise, so CHV/CHP investment alone will not guarantee that community priorities reach county

budgets. The Primary Health Care Act (2023) creates the legal foundation; operationalisation through the Primary Healthcare Fund capitation, paired with genuinely community-selected oversight structures, is the urgent next step.

Fourth, political will must be institutionalised rather than personalised. Kisumu's embedding of Marwa in the County Health Act 2019 is a model of institutionalisation; Murang'a's innovations remain more vulnerable to future political discontinuity. McCollum et al. (2018) demonstrate that priority-setting under Kenya's devolution is primarily driven by gubernatorial political preferences – a dynamic that systematically disadvantages counties whose governors prioritise infrastructure over health innovation. Ponge and Ochieng (2026) extend this argument through elite capture theory, arguing that Kenyan devolution has in practice produced “recentralisation within decentralisation” (Barasa et al., 2017): power concentrates at the county executive tier even as it is formally moved away from Nairobi, leaving facility- and community-level actors with the least discretion over resources. Institutionalisation in law, as Kisumu achieved with Marwa, is therefore not simply good governance practice but a specific defence against this recentralising tendency. Fifth, Kenya urgently needs a structured inter-governmental learning mechanism. The Vision 2030 Secretariat's 2026 assessment states explicitly that county-level solutions are available and that cross-county benchmarking should replace international study tours (Wanzala, 2026). The national eCHIS rollout, documented by Ileri et al., (2025) as successful precisely because the Ministry of Health allowed flexible county-specific adoption approaches, provides the template for this learning architecture.

5. Policy Recommendations for National Scaling

Fifteen recommendations are organised across five clusters, sequenced from immediate crisis response to long-term structural reform. Table 7 provides the priority matrix. Each recommendation is directly grounded in county evidence and supported by the broader literature. The sequencing logic is: resolve the SHA-county financing failures that are currently destroying the returns from county innovation (Cluster A); build the digital and community health infrastructure that makes systematic UHC delivery operationally possible (Clusters B and C); reform financing structures for long-term sustainability (Cluster D); and construct the learning architecture that makes the entire system adaptive and evidence-responsive (Cluster E).

5.1 Cluster A: Close the SHA-County Innovation Gap

Recommendation A1 (0-3 months; CRITICAL): The SHA Board and National Treasury should establish a County Claims Rapid Settlement Facility to clear the claims backlog – currently averaging 34%, with 45% of primary care facilities unpaid in Q1 2025 – within 90 days, followed by real-time monthly settlement with public county-level reporting (Kawira, 2025; Kenya Healthcare Federation, 2025).

Recommendation A2 (0-6 months; CRITICAL): The SHA Board and Health Benefits and Tariffs Advisory Panel should gazette dedicated reimbursement codes for telemedicine consultations, recognising the hub-and-spoke model. SHA owes Murang'a approximately Ksh 200 million in unpaid telemedicine-related claims; without reimbursement, Kenya's most advanced county telemedicine programme faces financial collapse (Kangata, 2025; Ateng & Wanyoike, 2026).

Recommendation A3 (6-12 months; CRITICAL): A County UHC Innovation Protection Clause should be embedded in SHA regulations, requiring formal recognition of county insurance schemes (modelled on Marwa) and a mandatory 24-month integration pathway during national financing transitions. The NHIF-to-SHA transition, which destabilised Kisumu's Marwa scheme, must not be repeated with future reforms (Kisumu County Government, 2022; SPARC Africa, 2025).

5.2 Cluster B: Build National Digital Health Infrastructure

Recommendation B1 (12-36 months; HIGH): The Digital Health Agency, leveraging the World Bank's USD 215 million health systems project (World Bank, 2024), should mandate full HMIS digitisation of all public health facilities by 2028, using Murang'a's phased model – flagship Level 5 hospital first, then cascading – as the

rollout template. Annual county automation rankings (Vision 2030 Secretariat model) should be formalised as a fiscal incentive mechanism (Wanzala, 2026; Mwende & Mukii, 2023).

Recommendation B2 (12-24 months; HIGH): The Ministry of Health should develop a National Telemedicine Policy Framework modelled on Murang'a's hub-and-spoke architecture, establishing minimum standards for connectivity, specialist availability, medico-legal governance, and integration with SHA claims. The Digital Health Act (2023) provides the legislative foundation; operationalisation requires a specific national framework that counties can adapt to local disease burden (Muranga County Government, 2024; Ernst & Young, 2023).

Recommendation B3 (6-18 months; HIGH): The Digital Health Agency should ensure full technical interoperability between the national eCHIS, the M-TIBA/CarePay household registration database, and SHA's member registry – leveraging Kisumu's 273,350-household database for improved means-testing and Primary Healthcare Fund subsidy targeting. The eCHIS scale-up study (Ileri et al., 2025) documents that flexible county adoption approaches were the key success factor; this principle should be preserved in the interoperability architecture (Huisman et al., 2022).

5.3 Cluster C: Operationalise Community Health as UHC's First Mile

Recommendation C1 (6-12 months; HIGH): A minimum of 30% of Primary Healthcare Fund capitation revenues should be ring-fenced for Community Health Unit operations, covering: monthly Community Health Promoter stipends of not less than Ksh 5,000; full CHV kit provision; eCHIS-loaded smartphones; and transport. Mwenda (2023) documents the national failure – kits shared among 20 workers, absent stipends – that undermines the CHV backbone of both county models. Committee membership should be filled through genuinely community-driven selection rather than appointment by facility or county officials, addressing the capture risk identified by Ponge and Ochieng (2026). The Primary Health Care Act (2023) creates the legal mandate; capitalisation through the PHF is the implementation mechanism.

Recommendation C2 (12-24 months; MEDIUM): The Ministry of Health should mandate an eCHIS-generated electronic referral protocol creating a documented, insurance-linked pathway from CHV household visit through facility levels, fully reimbursable by SHA, with feedback loops confirming outcomes to referring CHVs. Kisumu's CHV-to-M-TIBA-to-Marwa continuum demonstrates the operational model; Karimi et al., (2025) confirms primary care network guidelines as the relevant national framework.

5.4 Cluster D: Reform Health Financing for Sustainability

Recommendation D1 (12-24 months; HIGH): National Treasury and the Council of Governors should establish a County UHC Innovation Financing Window within the conditional grant system, providing progressive matching grants to counties demonstrating HMIS digitisation, premium subsidies, or evidence-based innovation. Mugo et al., (2018) documents Kenya's persistent failure to reach the 15% Abuja Declaration target (averaging 5-7%); a matching grant mechanism creates fiscal incentives without a single large budget increase.

Recommendation D2 (24-60 months; HIGH): Kenya's UHC financing should be formally restructured as a three-tier architecture: Tier 1 (national SHA floor) – adequately funded PHF capitation for all Kenyans at primary care level, exchequer-funded regardless of contribution status; Tier 2 (county complementary financing) – county premium subsidies modelled on Marwa and ring-fenced automation revenues modelled on Murang'a; Tier 3 (strategic partnership co-financing) – time-limited development partner funding for innovation and capacity transfer. This architecture addresses the SHA paradox while creating incentive-compatible county fiscal arrangements (SPARC Africa, 2025; Nungo et al., 2024).

Recommendation D3 (36-60 months; MEDIUM): The National Assembly Health Committee should legislate a binding Health Financing Adequacy Act establishing a minimum 15% of national budget for health, with automatic escalation if targets are missed. SHA's capitalisation at 3.6% of required funding (Ministry of Health, 2025) is a structural fiscal policy failure that no governance or digital reform can indefinitely compensate for (Mugo et al, 2018; WHO, 2010).

5.5 Cluster E: Build the Inter-Governmental Learning Architecture

Recommendation E1 (6-12 months; HIGH): The Council of Governors, in formal partnership with the Ministry of Health and the Maarifa Centre, should establish a National UHC Innovation and Learning Platform with a permanent mandate for: standardised innovation documentation using the five analytical dimensions from this framework; an annual UHC Innovation Index tracking all 47 counties; structured inter-county peer learning exchanges; and direct policy briefs to Parliament on county lessons available for national scaling. Wanzala's (2026) documentation of the Vision 2030 Secretariat's call for domestic benchmarking provides both the justification and a partial institutional template.

Recommendation E2 (12-24 months; MEDIUM): All significant county UHC programmes should achieve three-layer institutionalisation: embedding in County Health Acts (as Kisumu embedded Marwa); inclusion in multi-year County Integrated Development Plans with dedicated budget lines; and formal SHA MoUs with 18-month transition clauses protecting beneficiaries across electoral cycles. Conditional grants should explicitly reward cross-electoral continuity (Kisumu County Government, 2022; McCollum et al., 2018).

Recommendation E3 (6-18 months; HIGH): The Ministry of Health, in collaboration with the Kenya National Bureau of Statistics and KIPPRA, should publish an annual publicly accessible National UHC Transformation Scorecard tracking all 47 counties across the six evaluative criteria from Table 2, plus SHA claims settlement rates and HMIS digitisation progress. Scorecard results should inform conditional grant allocation formulae. Murang'a's experience demonstrates the motivational power of transparent, comparative performance data: the Vision 2030 Secretariat ranking (98.3% score) created national reputational incentives that no directive had previously achieved (Barasa et al., 2017; Mugo et al, 2018).

Table 7. Policy Recommendations Priority Matrix: Cluster, Recommendation, Priority, Timeframe, and Responsible Actor

Cluster	Recommendation	Priority	Timeframe	Primary Actor
A	A1: SHA Claims Rapid Settlement Facility	CRITICAL	0-3 months	SHA / National Treasury
A	A2: SHA Telemedicine Reimbursement Codes	CRITICAL	0-6 months	SHA / MoH / HBTAP
A	A3: County Innovation Protection Clause	CRITICAL	6-12 months	Parliament / SHA / CoG
B	B1: National HMIS Digitisation Programme	HIGH	12-36 months	Digital Health Agency / MoH
B	B2: National Telemedicine Policy Framework	HIGH	12-24 months	MoH / KMPDC / SHA
B	B3: M-TIBA / eCHIS / SHA Interoperability	HIGH	6-18 months	Digital Health Agency / SHA
C	C1: CHV Operationalisation via Primary Healthcare Fund	HIGH	6-12 months	SHA (PHF) / MoH / Treasury
C	C2: Standardised National Referral Protocol	MEDIUM	12-24 months	MoH / Digital Health Agency
D	D1: County UHC Innovation Financing Window	HIGH	12-24 months	Treasury / MoH / IBEC / CoG
D	D2: Three-Tier Health Financing Architecture	HIGH	24-60 months	MoH / Treasury / SHA / CoG
D	D3: Health Financing Adequacy	MEDIUM	36-60 months	National Assembly / Treasury

Cluster	Recommendation	Priority	Timeframe	Primary Actor
	Act (15% Abuja)			
E	E1: National UHC Innovation & Learning Platform	HIGH	6-12 months	CoG / MoH / Maarifa Centre
E	E2: Electoral Cycle Innovation Protection	MEDIUM	12-24 months	CoG / County Assemblies
E	E3: National UHC Transformation Scorecard	HIGH	6-18 months	MoH / KNBS / KIPPRRA

Note. Priority ratings reflect immediacy of need and severity of system damage from inaction. Timeframes indicate recommended initiation-to-operationalisation periods, not completion. Cluster A recommendations are sequenced as CRITICAL to reflect that delays are actively destroying the returns from county-level UHC innovation and eroding provider, county, and public trust in SHA.

6. Discussion

This paper has developed four interrelated products – an analytical framework, a conceptual model, a comparative matrix, and a policy agenda – that together reposition county innovations at the centre of Kenya's national UHC strategy. The CINT model and the comparative analysis converge on a central finding: Murang'a and Kisumu, through entirely different pathways, have produced strategically complementary models. Murang'a's supply-side digital transformation addresses the geographic access and fiscal governance dimensions of Kenya's UHC deficit; Kisumu's demand-side solidarity insurance addresses financial protection and income equity. Neither model alone is sufficient; together, they constitute a comprehensive county-generated national solution.

The CINT model makes a theoretical contribution by foregrounding inter-governmental learning architecture as a structural pillar of health systems transformation – a dimension largely absent from the WHO building blocks model (WHO, 2010) and Rogers' (2003) diffusion framework, which treats innovation spread as a function of innovation attributes rather than institutional learning design. The model's iterative structure, feeding implementation back into policy design, advances beyond linear diffusion frameworks to reflect the political complexity of UHC reform in devolved systems (Barasa et al., 2017; Ng'ang'a et al., 2024).

The comparative analysis has significant practical implications for SHA reform. The SHA paradox documented by Kawira (2025) – millions registered, billions allocated, yet facilities financially collapsing – is not simply a transitional problem, but a consequence of designing a national financing architecture that neither built on county innovations nor adequately consulted county health systems during design. SHA's failure to reimburse Murang'a for telemedicine, and its disruption of Kisumu's Marwa scheme, illustrate a recurrent pattern: national systems designed in isolation from county realities create interface failures that undermine UHC progress at both levels (Nyawira et al., 2024; SPARC Africa, 2025).

Several limitations should be acknowledged. The analysis relies primarily on published and grey literature rather than original interviews with county officials, beneficiaries, and national policymakers, which would strengthen the empirical grounding of the recommendations. The focus on two counties, while justified by their exemplary and contrasting trajectories, has not been tested against the full range of Kenya's 47 counties; future research should apply the five analytical dimensions more broadly. The rapidly evolving SHA implementation landscape also means that findings on reimbursement gaps and claims settlement reflect conditions as of 2025 and may require updating.

Looking forward, the most important research question this paper raises is whether the CINT model's Stage 3 (Policy Translation and Adaptation) is achievable within Kenya's current governance architecture. The model requires a level of structured, evidence-responsive inter-governmental dialogue that has not historically characterised national-county health relations in Kenya (McCollum et al., 2018; Nyawira et al., 2024). The proposed National UHC Innovation and Learning Platform (Recommendation E1) is designed precisely to create

this capacity. Whether the political will exists at the national level to systematically learn from, rather than simply direct, county health systems is ultimately a question about the quality of Kenya's devolution – and about whether UHC ambition can generate the institutional architecture that health systems transformation requires.

7. Conclusion

Kenya does not need to look abroad for its national UHC model. Murang'a County has demonstrated that health system digitisation – from M-Pesa payment automation through telemedicine – converts fiscal leakage into system-building capacity, generates a self-financing revenue loop, and extends specialist care to rural populations at a fraction of the cost of facility expansion. Kisumu County has demonstrated that community-rooted solidarity insurance, anchored in digital household registration and backed by political commitment embedded in law, can extend meaningful financial protection to households the national system has repeatedly failed to reach. Together, they demonstrate that the two structural dimensions of Kenya's UHC gap – geographic access inequity and financial protection inequity – are tractable at county scale with the models that already exist.

The County Innovation-to-National Transformation model proposed here provides the conceptual pathway from these county-scale demonstrations to national transformation, and the fifteen policy recommendations provide the operational agenda. Three actions are most urgent: establishing SHA reimbursement for telemedicine to prevent the collapse of the country's most advanced digital health programme; fully capitalising the CHV/CHP workforce through the Primary Healthcare Fund to activate UHC's essential first mile; and creating a national inter-governmental learning platform so that what Murang'a and Kisumu have proven becomes the foundation of a national system, not the knowledge of two counties alone.

Kenya's UHC ambition will ultimately be won or lost at the interface between county innovation and national institutionalisation. The Vision 2030 Secretariat's assessment is unambiguous: 'the solutions are here at home' (Wanzala, 2026). The task for national policymakers is not to design new models from first principles, but to match – with legislation, financing, and institutional architecture – the innovation that counties have already built.

Conflicts of interest

The authors declare no conflict of interest.

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Data availability

All data supporting this study are available from the cited published sources.

Author Contributions

- **Dr. Awuor PONGE:** Conceptualization, data curation, formal analysis, investigation, methodology, project investigation, methodology, validation, visualization, writing – original draft, writing – review & editing
- **Dr. Ruth Nduta NGUNYI:** Conceptualization, data curation, investigation, methodology, validation, supervision, visualization, writing – original draft, writing – review & editing

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