Macrothink Institute™

International Journal of Social Work
ISSN 2332-7278
2023, Vol. 10, No. 2

Power Relations and Maasai Women's Access to Social Health Security in Kajiado West Sub-County, Kenya

Peris Chepkurui Kerich (Corresponding Author)
Research scholar in Social Work
The Catholic University of Eastern Africa, Nairobi
E-mail: pkerich@gmail.com

Dr Norvy Paul
Senior Lecturer in Social Work
The Catholic University of Eastern Africa, Nairobi,
E-mail: norbypaul74@gmail.com

Dr Stephen Asatsa
Lecturer in Psychology
The Catholic University of Eastern Africa, Nairobi
E-mail: sasatsa@cuea.edu

Received: July 7, 2023 Accepted: August 28, 2023 Published: September 14, 2023
doi:10.5296/ijsw.v10i2.21316 URL: https://doi.org/10.5296/ijsw.v10i2.21316

Abstract

Health is a human right and over the years, national governments have invested heavily to provide citizens with quality, accessible, and affordable health care. Although some aspects of women's health have improved, there are still important unmet needs. The Maasai community has a patriarchal social structure, where men hold positions of power and authority. Women often have limited decision-making power and may face barriers to accessing healthcare independently. The study examined the effect of power relations on Maasai women's access to social health security in Kajiado West Sub-County,Kenya. The study employed a mixed-method sequential explanatory design. The target population were

Maasai women of Kajiado West Sub County. The sample size was 398, according to the Yamane formula. Questionnaires, interview guides and Focus Group Discussions were used in data collection. The study found a significant negative relationship between power differences and women's social security for health in Kajiado West Sub-County. In the Maasai community men are in command of family leadership and women obey decisions made by their husbands without questioning. Accessibility to health services is challenging for women since they have to walk far to access health services. The majority of the women are aware of the Linda Mama package and the National Health Insurance Fund national scheme package. The study recommends that there is a need for the government and international and nongovernmental organisations to promote gender equality to address the patriarchy and power relation disparities. There is a need for sensitisation on the rights of women, especially about health.

Keywords: Power relations, access, social health security

1. Introduction

In health literature, social health security for health is an issue that is gaining traction in countries all over the world. In many economically developing countries, health care consumes a significant portion of family income, and it is estimated that nearly half of the world's population lacks access to basic medical services (Alesane & Anang, 2018; Gyasi et al., 2018). Moreover, the World Health Organization (WHO) defines health that is a key objective of social health security as "a condition of total physical, mental, and social wellness, rather than simply the absence of sickness or infirmity". In the same vein, it states that poor health, on the other hand, has a negative impact because it forces people to incur large expenses. Similarly, most developing countries fall short of their population health potential (Fang et al., 2019). Social Health Security is said to be reliant on a wide range of financial, social, economic, and environmental, as well as committed leadership with a vision that focuses primarily on people, particularly the poor, sick, and marginalised, and encourages change in individual unhealthy behaviours through various initiatives all of which make health security difficult and complex to manage (Azevedo, 2017).

The 2030 Agenda for Social Development and the Post-2015 Development Agenda aim to achieve integrated goals and targets in the areas of social, environmental, and economic variables, with a focus on health as a priority. The World Health Organization (WHO) Assembly also coined the phrase "health for all," emphasizing the importance of nations cooperating to ensure that everyone has access to health care, enabling people to live productive lives on both a social and economic level (Doctor, 2018). The 2018 Declaration of Astana with a commitment to health for all, operationalized primary health care as central to the achievement of universal health coverage and health-related sustainable development goals through social health security. In the definition of core pillars of primary health care, the Declaration of Astana emphasizes empowering people and communities to access health care throughout their life course. In 2017, nearly half of the world's people (33% to 49%) were covered by essential services. Low-income countries saw the lowest percentage of people fully covered by essential health services in 2017 12% to 27% (Ghebreyesus, 2020).

In the United States of America, social health security is provided to the American people through government health programs or private health insurance. Changes in the prevalence and distribution of health insurance coverage are attributed to economic trends, shifts in population demographic composition, and policy changes that affect access to health care. By the same token, in the United States, government-sponsored insurance includes federal programs such as Medicare, Medicaid, and children's health insurance (Berchick et al., 2019). A little more than one out of every ten women is uninsured due to a lack of affordable health insurance programs. Ten million women are still uninsured, with the highest rates in states where Medicaid eligibility has not been expanded. Medicaid is a government-funded program in the United States of America for low-income people. Low-income earners, pregnant women, mothers of children under the age of eighteen, and people over the age of sixty-five are all eligible for the program (WHO, 2018; Taylor, 2020).

Literature states that Indonesia a middle-income country with two hundred and sixty-two million inhabitants launched a National Health Insurance system in the year 2014 most rapidly transforming societies concerning health social security. According to the World Health Organization Indonesian National Health Insurance System covered seventy percent of the population by 2017 (Agustina et al., 2019). At the beginning of 2016, the government of China made public its strategy for integrating the urban and rural resident schemes, which paved the path for the ultimate consolidation of all SHI schemes and equal benefits for all (He & Wu, 2017). The rapid and outstanding progress that China has made in constructing a comprehensive social health insurance (SHI) system stands out as particularly noteworthy. To lessen the burden of the high costs associated with medical care and to broaden people's access to it, the government of Nepal created a social health insurance program for government-run hospitals and clinics (such as the Primary Health Care Center and the District Hospital, both of which can be reached within an hour) that offer both outpatient and inpatient services. The Social Health Security Programme, also known as SHSP, is a social protection program run by the government of Nepal. Its primary objective is to ensure that Nepal's inhabitants have access to high-quality medical treatment without placing a significant financial burden on them (Shah et al., 2022).

The study of women's health in Africa is intricate and extensive. The way that women develop, become ill, recover, connect with others, reproduce, age, and receive medical treatment is influenced by thousands or possibly millions of different elements. To understand how laws, customs, and cultural beliefs impact health in women, these factors ought to be investigated. Women's life and well-being are impacted by uneven treatment in many ways. Women ought to have the same political, economic, and social rights and opportunities as men, according to feminism (Alexander et al., 2020). In many Sub-Saharan African countries social health security through either social health insurance schemes or community health schemes is expected to protect people from the burden of diseases. The introduction of social health security aimed to ensure access to health care by all people (Fenny, 2018).

According to Kenya Demographic and Health survey, one in four persons in Kenya (26% females and 27% males) have some form of health insurance. The proportion of persons covered with health insurance is higher in urban areas than in rural areas (Kenya

Demographic & Health Survey, 2022). The Maasai are a pastoralist ethnic group native to East Africa that inhabits southern Kenya and northern Tanzania. According to some scholars, around one million Maasai are living on 160,000 square kilometres of land in the Maasai community. According to studies among Maasai settlements in the Moduli and Longido regions of northern Tanzania, the bulk of the Maasai community resides in Kenya. The Maasai nomadic tribe has a cooperative land management system and rotates their herds of cattle according to the seasons (Davies, 2019).

The Kenyan government has developed and implemented national health policies and initiatives with varied partners to improve access to high-quality healthcare. It has also changed the healthcare system by courageously pursuing social cohesion and universal coverage through National Hospital Insurance Fund (NHIF). The Draft Health Bill 2015, National Health Sector Strategic Plan, Vision 2030, and Health Policy Framework Paper address improvements. Kenya's 2010 constitution provides a rights-based, all-inclusive healthcare framework. It guarantees Kenyans the best health and health care. Article 56 of the constitution requires affirmative action measures to ensure minorities and vulnerable groups have equal access to healthcare (Kimathi, 2017). The Kenya National Bureau of Statistics (2018) reported 91,237 females in Kajiado West Sub-County, and the National Hospital Insurance Fund Database on 31 August 2022 reported 48,944 females enrolled in NHIF, indicating that the study is relevant and that the problem needs to be investigated. To attain social security for women's health, social articulation and global health must be re-evaluated. Besides physical risk factors, women are systematically underrepresented in decision-making roles and overrepresented in informal caregiving. Global health strategies often overlook gender parity, which leaves women shockingly invisible.

The government, local health authorities, and international society have ignored indigenous people's health. Since the millennium development objectives did not contain indigenous group targets, a country might conceivably meet its goals while indigenous health stagnates (Mohindra, 2017). Women's rights organizations, feminist academics, and like-minded professionals have advocated for gender equality in healthcare access in global health and development, particularly during the UN decade on women. Building health charters indicated that social, political, and environmental elements were more essential than previously considered in determining health inequities (Heise et al., 2019). As previously documented, current women's health interventions do not address health issues that cause more illness. Health insurance policies don't properly address women's social health security (Habib et al., 2021). These obstacles hinder the most effective health improvement for most women. The women's health agenda's nearly exclusive focus on childbearing women is discriminatory since it excludes women who do not have children and women who are no longer reproductive (Peters et al., 2016).

Despite Kenyan Big Four Agenda programs, Mbuzi Moja, and Linda Mama for maternity services, Maasai women still have trouble accessing social health security (NHIF). Despite Maasai polygyny, the social health security program (NHIF) requires one spouse to be a dependant (Munge et al., 2018). Early marriage before eighteen, adolescent moms lacking required documentation to enrol in Social Health Security, and patriarchal oppression

preventing women from making health care decisions are cultural practices. Men own all family property; therefore, women have no economic authority (Lowe et al., 2022).

Maasai culture expresses societal norms. They are tied by cultural, familial, religious, and community norms. These factors prevent people from accessing mainstream services like education, health, economics, and politics (Esho, 2019). The Maasai community's restrictive lifestyle prevents them from achieving SDGs and Kenya's Vision 2030. Kenyans participate in NHIF, a low-cost health security program. The Maasai population's health security is only half of the total due to low literacy, economic backwardness, and substandard housing, as well as culturally and socially accepted activities like polygamy (Kamau & MacNaughton, 2019). Overall, fewer women than the national average and comparable Kenyan ethnic communities used such health services. NHIF recorded several reasons for limited access, however, these were not explored. Thus, NHIF-related research on women's social articulation and health accessibility in Maasai women is necessary.

1.1 Understanding the Research Problem

The National Hospital Insurance Fund (NHIF) in Kenya is an affordable and widely utilized health security provision that requires people's participation. However, the Maasai community, characterized by low literacy rates, economic challenges, inadequate housing, and the prevalence of cultural and social practices such as polygamy, faces significant barriers to accessing this health security benefit. The Maasai population's utilization of health security measures, including NHIF, is significantly lower than the national average (Kamau & MacNaughton, 2019).

Maasai women face challenges in making decisions regarding their healthcare due to cultural norms and power dynamics within their communities. Traditional gender roles often confine women to domestic responsibilities, leading to limited involvement in decision-making processes related to healthcare choices and access. As a result, Maasai women may not have control over decisions regarding their health, including seeking medical treatment, obtaining health insurance, or participating in health-related programs.

Additionally, patriarchal structures prevalent in Maasai society further restrict the agency of women in accessing social health security. The dominance of male decision-makers and leaders within the community reinforces gender inequalities, as women's voices and perspectives are marginalized or disregarded. This limits the representation of women's health needs in policy-making processes and impedes the development and implementation of gender-responsive healthcare services. This research aimed to comprehensively examine the influence of power relations, specifically focusing on decision-making processes, patriarchal structures, leadership dynamics, and the prevailing preference for male children, on Maasai women's ability to access social health security.

1.2 Feminist Theory and Women's Access to Health Social Security

Feminism has historically mirrored the social and political ideology of the times. Parallel to black rights movements around the world in the late nineteenth and early twentieth centuries, the first wave of feminism demanded that women be recognized as legal entities. The second

wave of feminism peaked during the civil rights movement in the 1960s and lasted well into the 1980s in the United States. During this period, the emphasis was on demanding equal rights for women, equal access and pay, control over their bodies, and the establishment of anti-sexual harassment policies (Hirudayaraj & Shields,2019). While feminist theory offers valuable insights into how gender-based inequalities impact women's access to social health security, there are also some limitations and weaknesses to this approach (Kiguwa, 2019). Power is an essential concept in feminist theory, but there are various definitions of power in feminist literature. Power was defined by radical feminism in terms of "power over," with men wielding power over women in both overt and covert ways. Economic exploitation, social marginalization, denial of autonomy, systematic violence, and the exercise of hegemonic masculinity are examples of these (Disch & Hawkesworth, 2016).

2. Methodology

The study's objective was to assess the extent to which power relations affect women's access to social health security in Kajiado West Sub County. A mixed methodological approach with a sequence of explanatory design was used. The research employed mixed methods sequential explanatory design. The research included the collection and analysis of quantitative data as well as qualitative data text, which was collected and analysed sequentially and aided in the elaboration of the quantitative results obtained. The study was conducted in the wards within Kajiado West Sub-County, which has a total area of 8519.8 square kilometres and served as the research site. The target population was the Maasai women of Kajiado West Sub-County (Krieger, 2012).

Purposive sampling, which includes a variety of non-probability sampling techniques, was used to recruit participants for the study. The researcher considered convenience sampling because it is inexpensive and simple, and the subjects are readily available respondents were targeted for the interviews. According to the NHIF Teraterm Database (2022), the total number of registered National Hospital Insurance Fund members in Kajiado West Sub-County is 113,084, with 64,140 men and 48,944 women (NHIF, 2022). The study employed Yamane statistical formula to determine the sample size of 399 participants. Data collection instruments were structured questionnaires, focus group discussions, and in-depth interviews. The quantitative tool was a five-point Likert scale that respondents indicated the extent to which they agree or disagree with the aspects of the power difference and the same was analysed using SPSS 22.0 to generate simple descriptive statistical results in the form of frequencies and percentages. Qualitative data from the structured questionnaire was subjected to content analysis and assigned codes by topic. Responses from focus group discussions, in-depth interviews, and unstructured parts of the questionnaire were replicated and used to elaborate on the analysed data. To determine the existence of a relationship between independent and dependent variables and the significance of the independent variables correlation and linear regression were used.

4. Results and Discussion

4.1 Effect of Power Relations on Women's Access to Social Health Security

In the assessment of the power relations, the study enquired on the family leadership command where most of the respondents strongly agreed that in their community men are in command of family leadership as represented by 181 (49.6%), closely followed by 169 (46.3%) respondents who agreed. Thus, in the Maasai community men are in command of family leadership. Almost half of the respondents 182 (49.9%) agreed that in their community women are not considered for leadership roles, this was strongly agreed by 79 (21.6%). The study found that close to half of the respondents 181 (49.6%) agreed that they obey decisions made by their husbands without questioning and 143 (39.2%) strongly agreed. In the same vein, the focused group discussions and interviews further determined that in the community, they view men to be domineering as they make almost if not all family decisions that are not to be disputed especially by the wives.

In a further assessment of the power relations, 181 (49.6%) of the respondents agreed that their husband makes choices on family size. This implies that the husband makes choices on family size. The women expressed that they are not permitted to use contraceptives, as their husbands expect them to give birth to as many children as possible. The study found that slightly over half of the respondents 191(52.3%) agreed that in their community women are considered weak and incompetent in family decision-making. The results demonstrate that in the Maasai community women are considered weak and incompetent in family decision-making. In a similar vein, it is noted that the Maasai are a pastoral society with a strong patriarchal structure, unequal power distribution by gender, and a general exclusion of women from leadership positions. Other studies reveal that husbands are still seen as the head of the home and have the right to rule over wives in many African cultural contexts (Massoi, 2018; Mshweshwe, 2020).

The Maasai community, according to the interviews and focus group discussions, practice nomadic pastoralism, with some not maintaining permanent camps and others maintaining a base for women and children. Men have been observed to make decisions and exert significant control over women's activities. Some of the key power relations revealed by the study included cultural norms that prioritized male leadership and the perception of women as incompetent to make decisions about their own health care and access. The findings attribute high levels of power relations to women's inability to enrol in social health security due to limited access to education, resources, and cultural norms that prioritize male economic participation in families over women. A participant had this to say;

"Men are seen as domineering in my community because they almost always decide on family matters that cannot be contested, especially by the wives. I think women should have the ability to make decisions, especially ones that affect their wellbeing" ***(P 05).***

4.2 Women's Social Healthcare Security in the Maasai Community

The study showed that 192 (52.6%) agreed that they walk very far to access health services. The findings from the interviews established due to their nomadic pastoralism life, when the

whole family has to move from one place to another the women are unable to access healthcare due to the distance between the temporary homesteads and health facilities. Moreover, 146 (40%) of the respondents and 112 (30.7%) agreed and strongly that they must get permission to enrol in social health security from their husbands respectively. Corresponding with the descriptive findings, the focused group discussions revealed that the consent of the husband and coming up with an idea of enrolling for social health security is not positively taken up by husbands as they water down any decisions made by women and that the buck should stop with them. The findings are consistent with the sentiments that the male head of the household makes decisions about household expenditure and even health. The findings also showed that most of the women are not insured because of the restriction to one wife by the insurance. In tandem with the findings from the focused group discussions, it was also clear that the restriction of one wife by the insurance limit the inclusion of women in social health security.

In addition, 129 (35.3%) disagreed that they can seek medical care without their husband's approval whenever they want and 113 (31%) strongly disagreed. The findings imply that the respondents cannot seek medical care without their husband's approval. The participants in the focused group discussions further disclosed that they cannot leave home to run their errands or access healthcare without permission from their husbands since it would result in violence. In corroboration with the findings, Citaristi, (2022) revealed that in West Africa between 2007 and 2018, only 38% of reproductive age (between 15 years to 49 years) were able to make their own decisions about their health. The findings show that 153 (41.9%) agreed that they are unable to pay their medical bills when their husband is not around. The focused group discussions further revealed that the women are not economically empowered to access healthcare without their husband's support.

The findings show that 170 (46.6%) disagreed that they can sell the family assets (livestock) to raise money for medical care without their husbands' consent and 126 (34.5%) strongly disagreed. This shows that women in the Maasai community cannot sell family assets to raise money for medical care without their husbands' consent. In tandem with the study findings, the Demographic Health Survey (2019) revealed that women had less decision-making autonomy, according to statistics from the countries studied. In addition, the interviews revealed that the Maasai community would rather see the cows die due to the harsh climatic condition than sell them to generate income that can be used to purchase food for the family or health needs. It is unacceptable to slaughter animals even when the family members are dying of hunger, especially during the drought season.

In addition, 191 (52.3%) agreed that they are aware of the Linda Mama package for expectant mothers. The findings show that the women are aware of the Linda Mama package for expectant mothers. Further, 189 (51.8%) agreed that they are aware of the NHIF national scheme package, and 58 (15.9%) strongly agreed. The findings denote that the women are aware of the NHIF national scheme package. Furthermore, the findings imply that the majority of the women are aware of county-sponsored programs such as Mbuzi Moja Afya Bora. Most women are not aware of the Universal Health Cover sponsored by the government. Women's access to social health security is hampered by a lack of material

wealth, which has resulted in a reliance on male dominance, as well as cultural ideologies that place women in subordinate positions. However, patriarchy provides legitimacy to structures of female dominance and oppression (Sikweyiya et al.,2020).

4.3 Correlation and Regression Analysis of Masai Women's Social Security Access and Power Relations

To measure the strength and direction of the linear relationship between the independent and dependent variables correlation was used. Table 2 presents the correlation findings.

Table 1. Correlation Matrix

		Social Health Security	Power Relations
Social Health Security	Pearson Correlation	1	
	Sig. (2-tailed)		
	N	365	
Power Relations	Pearson Correlation	-.861**	1
	Sig. (2-tailed)	.000	
	N	365	365

The table also shows that there is a statistically significant negative relationship between power relations and women's social security for health, [r (365) =-.861, p=.000]. This demonstrates that the increase in power relations leads to a decrease in women's social security for health. Therefore, there is a statistically significant negative relationship between power relations and women's social security for health in Kajiado West Sub-County. The findings are in tandem with the sentiments of Tandrayen-Ragoobur, (2021) who opine that in many cases, the male head of the household makes decisions about household expenditure and even health thus limiting the social health security for the women.

Table 2. Model Summary of Regression Analysis

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.861[a]	.741	.702	.20114

a. Predictors: (Constant), Power Relations.

The model summary Table 2 shows an R-correlation coefficient of 0.861. This shows that there is a positive relationship between the independent variables (power relations) and the dependent variable (women's social security for health). The coefficient of determination (R-squared) explains the variations in the dependent variable accounted for by the independent variable. The R-squared (R^2) of 0.741 implied that 74.1% of the variations in women's social security for health were explained by cultural practices power relations family practices traditional practices.

Table 3. ANOVA of Major Variables

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	32.852	1	32.852	446.723	.000[b]
	Residual	26.695	363	0.074		
	Total	59.547	364			

a. Dependent Variable: social security for health

b. Predictors: (Constant), Power Relations

From the ANOVA output presented in Table 3, the calculated F value was greater than the critical value (446.723 > 3.867). The significance F value was 0.000, indicating a significant relationship between the dependent and the independent variable. The model was thus significant and the data was ideal for making a conclusion on the population observations.

Table 4. Coefficients of Major Variables

	Unstandardized Coefficients		Standardized Coefficients		
Model	B	Std. Error	Beta	t	Sig.
(Constant)	1.053	0.203		5.187	.000
Power Differences	-0.895	0.217	-0.861	-4.124	.000

a. Dependent Variable: social security for health.

From the coefficient table 4, taking all factors to a constant at zero, the social security for health will be 1.053. Taking all other independent variables at zero. A unit increase in power

difference will lead to an 89.5% reduction in social health security. Power difference had a significant influence on social security for health as indicated by the p values of less than 0.05. There is a statistically significant negative relationship between power differences and women's social security for health in Kajiado West Sub-County. The findings are in tandem with the sentiments of Tandrayen-Ragoobur, (2021) who opine that in many cases, the male head of the household makes decisions about household expenditure and even health thus limiting the social health security for the women.

5. Conclusion and Recommendations

5.1 Conclusions

There is a significant and negative relationship between power differences and women's access to social security for health in Kajiado West Sub-County. Within the Maasai community, power dynamics heavily favour men, who assume the role of family leaders. Consequently, women are expected to comply with their husbands' decisions without question, leading to limited autonomy and control over their own health-related choices.

In the Maasai community, men hold the authority to make decisions regarding family size. This patriarchal control over reproductive choices can have profound implications for women's access to social health security. Limited decision-making power in matters of family planning can result in larger family sizes than desired, which can strain financial resources and make it more challenging for women to afford necessary healthcare services, including medical insurance.

Moreover, the cultural norms prevalent within the Maasai community undermine the role of women in leadership positions, both within the household and the broader community. Women are often excluded from participating in decision-making processes, including those related to healthcare. This exclusion reinforces the perception of women as weak and incapable of making informed decisions, further disempowering them in matters of health security.

Consequently, many Maasai women face significant obstacles in seeking medical care independently. They are required to obtain permission from their husbands before accessing healthcare services, creating dependency and limiting their ability to make timely and independent decisions regarding their health. Financial barriers further compound the challenges, as women may be unable to afford medical bills or access necessary funds for healthcare without their husbands' consent. The inability to sell family assets, such as livestock, to cover medical expenses without spousal approval exacerbates the financial limitations faced by Maasai women.

These findings highlight the multifaceted nature of power relations within the Maasai community and their adverse impact on women's access to social health security. The restrictive gender roles, lack of decision-making agency, and financial dependence on husbands contribute to significant barriers for Maasai women in seeking medical care and securing the necessary resources for their health needs. Addressing these power differences and promoting gender equity within the community is essential for enhancing women's

access to social health security and improving their overall well-being.

The social security of women may be significantly impacted by social work practices. Social workers frequently assist women who are at risk or marginalized as a result of social, economic, and political issues like poverty. The provision of social services and support networks that advance the health and well-being of women is one of the main effects of social work methods.

According to the study's findings, social work will be essential in challenging power relations that prevent women from accessing social health security. Social work practice would emphasize community engagement and involvement to identify and overcome obstacles that women face when attempting to access social health security due to cultural practices. Social work techniques would include addressing structural and systemic causes of gender inequality and disparities in women's health. In addition to working to empower women to speak up for themselves and their communities, social workers may advocate for policy changes.

5.2 Recommendations

1. The government need to intervene forcefully to address undermining factors associated with control and patriarchy, specifically power relation disparities and gender equity.

2. Access to livelihood opportunities is critical for progress, in this case, out of poverty and oppressive norms accepted by society. Increased independence will encourage women to exercise more decision-making power in the home and even in the community by electing leaders with whom they agree. The government and civil society actors should prioritize investments in such populations' empowerment.

3. Access to primary health care is a right that must be prioritized through government structures, and all women of reproductive age must have access to health care. The frameworks have been tested through the Linda Mama initiative, Mbuzi Moja, and Kangata Care; such approaches will make it easier for women to access quality, affordable, and appropriate health care; the County government can help in this area.

Through its existing structures, the government should support feminist efforts. Such arms as FIDA are critical not only to the rights associated with self-determination but also to societal priorities.

References

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K. A., Achadi, E. L., Taher, A., ... & Khusun, H. (2019). Universal health coverage in Indonesia: concept, progress, and challenges. *The Lancet, 393*(10166), 75-102. https://doi.org/10.1016/S0140-6736(18)31647-7

Alesane, A., & Anang, B. T. (2018). Uptake of health insurance by the rural poor in Ghana: determinants and implications for policy. *Pan African Medical Journal, 31*(1). https://doi.org/10.11604/pamj.2018.31.124.16265

Alexander, L. L., LaRosa, J. H., Bader, H., & Garfield, S. (2020). *New dimensions in women's health*. Jones & Bartlett Learning.

Azevedo M. J. (2017). The State of Health System(s) in Africa: Challenges and Opportunities. *Historical Perspectives on the State of Health and Health Systems in Africa, Volume II: The Modern Era* (pp. 1-73). https://doi.org/10.1007/978-3-319-32564-4_1

Berchick, E. R., Hood, E., & Barnett, J. C. (2019). *Health insurance coverage in the United States: 2018* (p. 2). Washington, DC: US Department of Commerce.

Citaristi, I. (2022). United Nations Population Fund—UNFPA. In *The Europa Directory of International Organizations 2022* (pp. 293-296). Routledge.

Davies, S. E., Harman, S., Manjoo, R., Tanyag, M., & Wenham, C. (2019). Why it must be a feminist global health agenda. *The Lancet, 393*(10171), 601-603. https://doi.org/10.1016/S0140-6736(18)32472-3

Disch, L. J., & Hawkesworth, M. E. (Eds.). (2016). *The Oxford handbook of feminist theory*. Oxford University Press.

Doctor, H. V., Nkhana-Salimu, S., & Abdulsalam-Anibilowo, M. (2018). Health facility delivery in sub-Saharan Africa: successes, challenges, and implications for the 2030 development agenda. *BMC public health, 18*(1), 1-12. https://doi.org/10.1186/s12889-018-5695-z

Esho, T. (2019). An exploration of the psycho-sexual experiences of women who have undergone female genital cutting: a case of the Maasai in Kenya. *Facts, Views & Vision in ObGyn, 4*(2), 121.

Fang, H., Eggleston, K., Hanson, K., & Wu, M. (2019). Enhancing financial protection under China's social health insurance to achieve universal health coverage. *BMJ, 365*. https://doi.org/10.1136/bmj.l2378

Fenny, A. P. (2018). Social health insurance schemes in Africa leave out the poor. *International Health, 10*(1), 1-3. https://doi.org/10.1093/inthealth/ihx046

Ghebreyesus, T. A. (2020). Strengthening our resolve for primary health care. *Bulletin of the World Health Organization, 98*(11), 726-726A. https://doi.org/10.2471/BLT.20.279489

Gyasi, R. M., Phillips, D. R., & Buor, D. (2020). The role of a health protection scheme in health services utilization among community-dwelling older persons in Ghana. *The Journals of Gerontology: Series B, 75*(3), 661-673.

Habib, S. S., Jamal, W. Z., Zaidi, S. M. A., Siddiqui, J. U. R., Khan, H. M., Creswell, J., ... & Versfeld, A. (2021). Barriers to access of healthcare services for rural women—applying gender lens on TB in a rural district of Sindh, Pakistan. *International Journal of Environmental Research and Public Health, 18*(19), 10102. https://doi.org/10.3390/ijerph181910102

He, A. J., & Wu, S. (2017). Towards universal health coverage via social health insurance in China: systemic fragmentation, reform imperatives, and policy alternatives. *Applied health economics and health policy, 15*, 707-716. https://doi.org/10.1007/s40258-016-0254-1

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., ... & Gupta, G. R. (2019). Gender inequality and restrictive gender norms: framing the health challenges. *The Lancet, 393*(10189), 2440-2454. https://doi.org/10.1016/S0140-6736(19)30652-X

Hirudayaraj, M., & Shields, L. (2019). Feminist theory: A research agenda for HRD. *Advances in Developing Human Resources, 21*(3), 319-334. https://doi.org/10.1177/1523422319851286

Kamau, E., & MacNaughton, G. (2019). The impact of SDG 3 on health priorities in Kenya. *Journal of Developing Societies, 35*(4), 458-480. https://doi.org/10.1177/0169796X19874609

Kenya National Bureau of Statistics. (2018). Kenya integrated household budget survey.

Kiguwa, P. (2019). Feminist approaches: An exploration of women's gendered experiences. Transforming research methods in the social sciences: Case studies from South Africa, 220-235. https://doi.org/10.18772/22019032750.19

Kimathi, L. (2017). Challenges of the devolved health sector in Kenya: teething problems or systemic contradictions? *Africa development, 42*(1), 55-77.

Krieger, N. (2012). Who and what is a "population"? Historical debates, current controversies, and implications for understanding "population health" and rectifying health inequities. *The Milbank Quarterly, 90*(4), 634-681. https://doi.org/10.1111/j.1468-0009.2012.00678.x

Lowe, H., Kenny, L., Hassan, R., Bacchus, L. J., Njoroge, P., Dagadu, N. A., & Cislaghi, B. (2022). 'If she gets married when she is young, she will give birth to many kids': a qualitative study of child marriage practices amongst nomadic pastoralist communities in Kenya. *Culture, health & sexuality, 24*(7), 886-901. https://doi.org/10.1080/13691058.2021.1893821

Massoi, L. W. (2018). Women in Pastoral Societies and the Church in Kilosa. African study monographs. *Supplementary issue, 56*, 77-86.

Mohindra, K. S. (2017). Research and the health of indigenous populations in low-and middle-income countries. *Health promotion international, 32*(3), 581-586.

Mshweshwe, L. (2020). Understanding domestic violence: masculinity, culture, traditions. *Heliyon, 6*(10), https://doi.org/10.1016/j.heliyon.2020.e05334

Munge, K., Mulupi, S., Barasa, E. W., & Chuma, J. (2018). A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund. *International journal of health policy and management, 7*(3), 244. https://doi.org/10.1016/j.heliyon.2020.e05334

Peters, S. A., Woodward, M., Jha, V., Kennedy, S., & Norton, R. (2016). Women's health: a new global agenda. *BMJ global health, 1*(3). https://doi.org/10.1136/bmjgh-2016-000080

Shah, S., Jha, N., Khanal, V. K., Nepal Gurung, G., Sharma, B., & Shrestha, M. (2022). Utilization of social health security scheme among the households of Illam district, Nepal. *Plos one, 17*(5), e0265993. https://doi.org/10.1371/journal.pone.0265993

Sikweyiya, Y., Addo-Lartey, A. A., Alangea, D. O., Dako-Gyeke, P., Chirwa, E. D., Coker-Appiah, D., ... & Jewkes, R. (2020). Patriarchy and gender-inequitable attitudes as drivers of intimate partner violence against women in the central region of Ghana. *BMC public health, 20*, 1-11. https://doi.org/10.1186/s12889-020-08825-z

Tandrayen-Ragoobur, V. (2021). *Building the patriarchy index for sub-Saharan Africa: Perceptions and acceptance of violence matter most. Patriarchy and Gender in Africa*. Lexington Books.

Taylor, Y. J., Liu, T. L., & Howell, E. A. (2020). Insurance differences in preventive care use and adverse birth outcomes among pregnant women in a Medicaid no expansion state: a retrospective cohort study. *Journal of women's health, 29*(1), 29-37. https://doi.org/10.1089/jwh.2019.7658

World Health Organization. (2018). Delivering quality health services: A global imperative. OECD Publishing.

Copyright Disclaimer

Copyright reserved by the author(s).

This article is an open-access article distributed under the terms and conditions of the Creative Commons Attribution license (http://creativecommons.org/licenses/by/3.0/).