



Different pathways of social protection reforms: An analysis of long-term institutional change in Kenya



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ABSTRACT

The potential of social protection to contribute to inclusive growth has been increasingly recognized throughout the last two decades. Social protection reforms involve comprehensive processes of long-term institutional change. Dynamics differ not only across but also within countries across social protection pillars reflecting multiple institutional trajectories and equilibria ranging from rapid and comprehensive shifts over processes of gradual change to situations of blocked reforms or reform reversals. This paper seeks to understand why reforms aiming at extending social protection coverage to the poor might differ across different pillars of social protection within the same country. Being embedded within comparative institutional analysis the paper aims at providing a systematic framework for defining and explaining variations in reform dynamics highlighting the role of uncertainty. The framework is applied to the Kenyan case. The empirical methodology employs a process tracing approach including primary and secondary data covering the time period between 2001 and 2017. The case of Kenya is one example for multiple institutional trajectories within a country: Whereas cash transfer reforms follow a pattern of cumulative incremental change, social health protection reforms reflect patterns of non-cumulative change including blocked reforms and reform reversals. The results suggest that those differences are partly explained by differences in preferences among agents or the institutional legacies within each domain. In addition, behavioral responses to uncertainty matter: Stronger information asymmetries within the cash transfer and fee waiver reform domains opened space for discretionary decision-making. Interpretations of the concept of social protection and complexity of 'insurance' facilitated processes related to cash transfers whereas providing impediments to social health insurance. Lastly, the international and socio-economic context provided focal points facilitating coordination on targeted or vertical interventions such as cash transfers or fee waivers.

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1. Introduction

The potential of social protection to contribute to inclusive growth has been increasingly recognized throughout the last two decades. However, social protection reforms involve comprehensive processes of often long-term institutional change. The dynam-

ics differ, reflecting multiple institutional trajectories and equilibria that include rapid and comprehensive shifts, gradual change or situations of blocked reforms or reform reversals. These differences are not only observed across countries. They also exist *within* countries across different pillars of social protection. To overcome the fragmentation of social protection observed in many low and middle income countries and develop integrated national social protection *systems*, it is important to move from an isolated view of single instruments towards a comparative understanding of reform dynamics across different sub-policy areas.

This paper seeks to understand why reforms extending social protection coverage to the poor might differ across pillars of social protection within the same country. It emphasizes the role of

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uncertainty. Embedded within comparative institutional analysis and framing the problem in game-theoretic terms, the objectives of this paper are twofold: (1) providing a systematic framework for defining and explaining variations in reform dynamics, and (2) applying this framework to redistributive reforms extending social protection to the poor in Kenya. The focus is on cash transfers and social health protection. It covers the period from 2001 to 2017, starting with the emergence of social protection on Kenya's political agenda.

The paper highlights (re-iterated) processes of policy formulation, policy decision-making and institutionalization and extends the existing research in several ways. A growing number of empirical studies address the political economy of social protection reforms in low and middle income countries (Abuya, Maina, & Chuma, 2015; Awortwi & Aiyede, 2017; Brooks, 2015; Fox & Reich, 2013; Hickey, Lavers, Niño-Zarazúa, & Seekings, 2019; Plagerson, Patel, Hochfeld, & Ulriksen, 2019; Yi & Koechlein, 2017). Yet, only few studies offer a comparative approach across pillars of social protection. The seminal contribution by Haggard and Kaufman (2008) provides a comprehensive long-term comparative analysis of (broader) social policy reforms in Asia, Latin America and Eastern Europe between 1945 and 2005. Considering the more recent wave of social protection reforms starting in the late 1990s and 2000s, the only studies known to the authors explicitly addressing within-country differences in social protection reform dynamics are Bekenya and Hickey (2019), Ulriksen and Plagerson (2017) and Wanyama and McCord (2017). Also, many political economy studies are empirical without an explicit conceptual background. Exceptions include, for example, Hickey (2008) and Lavers and Hickey (2016), which extend the political settlement approach by examining the interaction between elite factions and non-elites and incorporate insights from discursive institutionalism to address the role of ideas, discursive processes and non-domestic actors in shaping policy outcomes. Their approach has been widely applied, for example in Chemouni (2018) and Wanyama and McCord (2017). Leisering (2019) develops a comprehensive sociological approach rooted in constructivist institutionalism and examines how ideas constitute interests or institutions in the development of social cash transfer policies.

This paper complements existing approaches and provides an analytical framework to compare institutional change across redistributive (sub-)policy areas. First, by drawing on different strands of literature classifying either policy or institutional change the paper suggests a typology of reform dynamics. Second, to explain multiple trajectories of change, each social protection pillar is characterized as a reform domain. Reform domains are embedded within the same reform context (within-country analysis). Multiple institutional equilibria across different pillars of social protection may arise from differences in reform domains or the interaction between the reform context and the specific characteristics of a reform domain. Building on Aoki (Aoki, 2001, 2007), who emphasizes the role of bounded rationality for explaining institutional change and Dequechs' work on uncertainty (Dequech, 2011), this paper addresses the role of uncertainty in explaining change. It argues that – next to the institutional setting and preferences of players involved – information structures, i.e. the type and distribution of information, are relevant in explaining trajectories of change.

The remainder of the paper is structured as follows: Section 2 presents the theoretical background. Section 3 describes the empirical methodology. Section 4 classifies reform dynamics in Kenya for the sub-policy areas of social health protection and cash transfers and analyzes divergent reform paths in Kenya. Results are discussed in Section 5. Section 6 presents the conclusion.

2. Understanding reform dynamics – A comparative institutional perspective

2.1. Defining and classifying reforms

Various definitions of “reform”, “policy” or “institutions” exist. For example, a reform may be defined as “...a policy innovation manifesting in an unusually substantial redirection or reinforcement of previous policy” (Keeler, 1993: 434), or “...an episodic change, which reinvents institutional patterns so as to break with prevailing customs and procedures” (Cortell & Peterson, 1999: 182). Summarizing these definitions, “reform” refers to processes of change whose objects are either policies or institutions. Here, policies are defined as “a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them” (Jenkins, 1978). Institutions here are understood as “...self-sustaining, salient patterns of social interactions, as represented by meaningful rules that every agent knows and incorporated as agents' shared beliefs about the ways how the game is to be played.” (Aoki, 2007, 7). Both concepts are interrelated: Whereas “policy” focuses on the contents of actors' decision-making, “institutions” regulate decision-making and at the same time, are endogenously created, changed or sustained through the strategic interaction of players.

For a better understanding of different processes of change, a classification system distinguishing three dimensions of change is suggested (see Table 1):

Temporal baseline

Explaining reforms presupposes a dynamic perspective with at least two points in time, i.e. a change from an initial state t_0 to a new state t_1 . Thus, classifying reform dynamics requires defining a temporal baseline against which dynamics are evaluated (initial status quo).

Mode of change

The mode of change reflects the number of steps in the overall process as well as the relationship between them: Incremental change involves several steps, whereas non-incremental change involves one major step only (Howlett & Cashore, 2009).¹ Incremental processes may be either cumulative, i.e. subsequent steps built on previous steps (Hinrichs & Kangas, 2003) or, non-cumulative, i.e. subsequent steps reversing or diverging from previous ones (“back-and-forth processes”).

Scope of change

The magnitude or scope of change captures the degree to which the content of reform initiatives deviates from the initial status quo. Based on Peter Hall's (1993) classification, three orders of change will be distinguished: Third-order change refers to a major goal change or a fundamental realignment of major aspects of policy development. It is the most comprehensive type of policy change. Second-order change is a change in instruments, whereas first-order change is the smallest deviation from existing policies and refers to the calibration of existing instruments. As Hinrichs and Kangas (2003) point out, incremental first- and second-order changes may eventually imply a fundamental third-order change without receiving much attention in the political discourse. If an incremental reform process is cumulative, then small changes might eventually lead to third-order changes (“system-shifts”).

¹ Howlett and Cashore (2009) use the expression ‘paradigmatic change’ for non-incremental change. Yet, this reference to scope would indicate that paradigmatic changes involve broader scale policy change, whereas incremental change does not. Yet, as will be described below, also incremental change may lead to fundamental system shifts.

Table 1
Dimensions of change.

Temporal baseline	Analytical starting point (Initial state)
Mode of change	Incremental Non-incremental (cumulative or non-cumulative)
Scope of change (I)	1st order 2nd order 3rd order
Scope of change (II)	Displacement Drift Conversion

Source: Authors.

Further, [Streeck and Thelen \(2005\)](#) provide another approach to capture the qualities of a deviation from the status quo from an institutional change perspective: “Displacement” refers to the removal of existing rules and the introduction of new rules. If new institutions are added on top of or alongside existing institutions, this is defined as layering. “Drift” indicates a change in the impact of a rule due to changes in external conditions, while the rule itself formally stays the same. “Conversion” occurs if a rule is interpreted and implemented in new ways but formally stays the same.

2.2. Explaining reforms: Institutional change and multiple trajectories

2.2.1. Processes of change

From a game-theoretic perspective, institutional change is a collective action problem. It results from the strategic interactions of agents, implying multiple coordination and cooperation processes among those actors and their re-assessments of the game.

[Aoki \(2001\)](#), [Aoki \(2007\)](#) stresses the role of bounded rationality, information, and subjective beliefs to explain institutional change: Common knowledge of the rules of the game and the shared beliefs on their relevance for playing the game are central elements. Yet, agents may hold subjective beliefs about the game. They need not know all details on action sets or payoffs for all agents, as long as they share a rough idea, i.e. shared beliefs, about how the game is played. This shared information partition represents the relevant common knowledge ([Aoki, 2007, p. 7, 11](#)). According to Aoki institutional change occurs if “...agents’ beliefs on how the game is played are altered in a critical mass.” ([Aoki, 2001, p. 231](#)).²

Whatever the initial impetus for change³ inconsistencies may emerge: Formerly suboptimal strategies may increase in viability or new strategies might be initiated. Due to the localized nature of information distribution and bounded rationality, agents may perceive and interpret these changes differently. So different sets of beliefs may emerge and compete. This competition characterizes the transitional process. According to Aoki:

the transitional process converges when and only when (i) with the help of a system of predictive and/or normative beliefs that have guided agents’ learning, a new pattern of plays of game emerges and became to be collectively recognized as the way how the game is now being played; and (ii) agents’ new action choices based on such expectations generate satisfactory payoffs to them without a big surprise. That part of behavioral

expectations common to all the agents then emerge as a new institution” ([Aoki, 2007, pp. 24–25](#)).

As a result of this transition process, new institutions may evolve gradually or spontaneously, depending on the specifics of the process of updating and synchronizing subjective beliefs among agents ([Aoki, 2001: 242–244](#)).

Against this background the framework developed here builds on the interplay of the following elements (see [Fig. 1](#)):

- Initial institutional status quo,
- Strategic interactions of actors within a reform domain, which is shaped by their preferences
- Prevailing types of uncertainty (or “information structures”) within a reform domain,
- Environmental conditions, i.e. the reform context to which all domains are exposed alike

2.2.2. Initial institutional status quo

Existing institutions governing the reform domain represent the initial institutional status quo and define the current formal and informal rules and shared beliefs. They summarize the historical legacies influencing individual payoff structures of agents in the reform domain, define the shared behavioral and decision-making rules assigning authority at the initial status quo and represent the common knowledge. In this regard, the initial institutional status quo marks the point of departure. The entrenchment of existing institutional arrangements may obstruct change by inducing path dependencies ([Pierson, 2000, pp. 258–262](#)).

2.2.3. Preferences

A reform domain involves all domestic or international agents with identifiable interests in the reform process. This may include a wide range of agents such as policy-makers, ministry officials, public authorities, private sector agents, non-governmental organizations, professional associations or bi- and multilateral agencies.⁴ A reform domain is characterized by the strategic interaction of a set of agents (respectively players), their action choices and preferences (characterized by the pay-offs for each action choice). Here, action choices refer to supporting or opposing the reform in question. The preferences of agents are their subjective evaluations of the reform in comparison to the status quo. The subjective evaluations may, for example, relate to expected changes in the distribution of material or non-material resources (e.g. power or reputation) or may be driven by ideological considerations reflecting underlying values or morals.⁵ Preferences among agents may differ leading to conflicting point of views and different coalitions supporting or opposing change. The more homogeneous preferences are (ceteris paribus), the lower the likelihood for conflicts and cooperation problems and the higher the likelihood for change.

2.2.4. Uncertainty and information structures

As stressed by Aoki uncertainty is inherent to processes of institutional change: What information is available for whom (“infor-

² In this line of thought institutional change involves more than a mere change in formal rules. The introduction of a new law does not per se qualify as a new institution; additionally, a critical mass of agents must believe that it is relevant.

³ Aoki distinguishes between a change in environmental conditions leading to changing consequences of actions or internal shifts in the domain leading to activation of new individual action choices due to for example learning processes or both ([Aoki, 2001: 242](#), [Aoki, 2007: 22–23](#)).

⁴ International agents providing technical or financial support to domestic agents are members of the reform domain. They are considered to have and pursue their own interests in reform processes, such as preferring one policy option over another, being interested in the success of supported project or programs, or competing with other international donors over distribution of resources including reputation. Thus, they are part of the game.

⁵ The preferences reflect ‘self-interested behaviour’ (e.g. expected changes in level of individual influence or resources), but also prevailing ‘mental models’ such as values or beliefs held by actors involved ([Aoki, 2007: 4](#)). For example, attitudes towards redistribution are value-based and are influenced by individually held beliefs about the respective roles of individual and social responsibility such as for example the distinction between the ‘deserving’ vs ‘non-deserving’ poor.

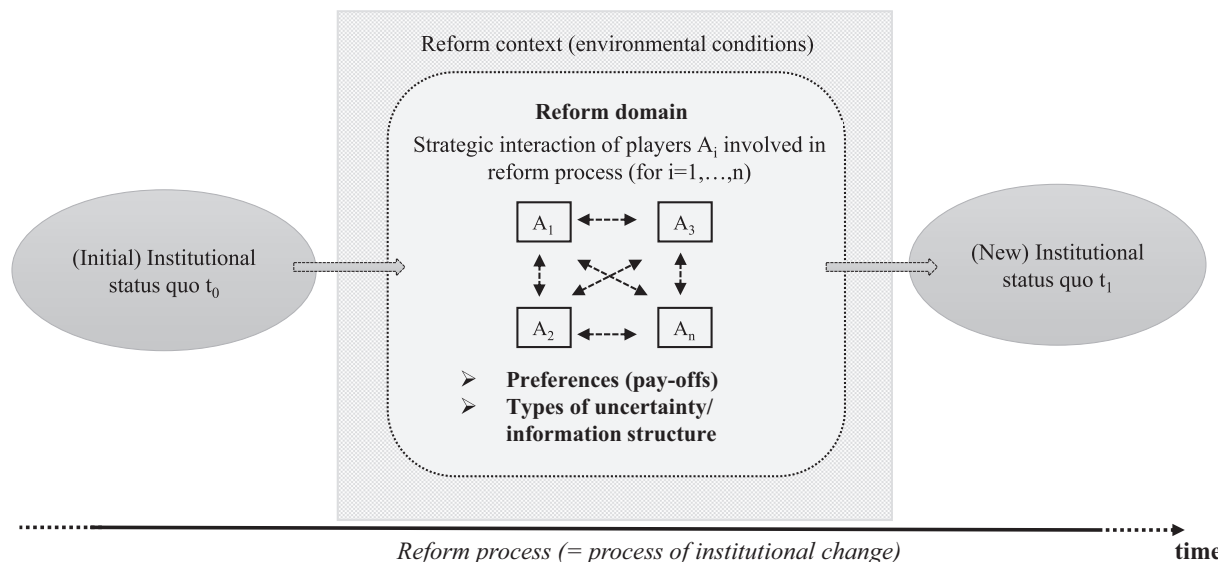


Fig. 1. Framework for institutional change Source: Authors.

mation structures”) and how it is interpreted are key to understanding resulting trajectories. However, uncertainty is not a homogeneous concept and its behavioral implications are multi-fold. This approach draws on Dequech’s typology on different types of uncertainty (Dequech, 2011) and deduces possible implications for processes of institutional changes. Two overarching types of uncertainty are distinguished in particular: weak and strong uncertainty.

“Weak uncertainty” is defined as “uncertainty about which state of the world from a predetermined list of states known to the players will occur.” (Dequech, 2011, p. 624).⁶ It characterizes situations in which information might not be accessible to everyone involved but still all relevant information exists (Dequech, 2011, pp. 624–627). Two implications for institutional change may result from weak uncertainty: First, if an agent has more information than other agents (private information) and interests between agents differ, the better-informed party has a strategic advantage to pursue its own interest. If the informational advantage is with agents supporting reform, change is more likely; if the informational advantage is with agents not supporting reform, change is less likely. Second, even without private information and leaving conflicting interests aside, agents may face a pure coordination problem if information is incomplete: Whether a reform is enacted or what policy is chosen among different policy options depends on a focal point, around which behavioral traits can coordinate (Schelling, 1960). A shared focal point requires common priors, i.e. mutually held – e.g. culturally embedded – beliefs on what is considered as relevant.

“Strong uncertainty” is related directly to bounded rationality. It originates either from the absence or paucity of information or from limited mental capacities of players (Dequech, 2011, pp. 627–633): Absence or paucity of information is captured by the term “ambiguity” (Camerer & Weber, 1992, p. 330). Limited mental capabilities of agents refer to the “complexity of the environment relative to the agents’ capabilities” (Dequech, 2011, p. 627) and

in this paper are denoted by the term “complexity”^{7, 8} In such situations, cognitive heuristics matter and subjective beliefs may substitute information in decision-making. Individuals may interpret the same information (or lack thereof) differently. Again, focal points provide a solution for coordinating actions, but differences in subjective beliefs might inhibit or delay the emergence of shared focal points, which prevents a new institutional equilibrium. Strong uncertainty shifts the focus to the transition process and the emergence and synchronizing of new beliefs highlighted by Aoki (2001). Situations of strong uncertainty are obviously relevant for policy innovations in general. In addition, the degree of complexity of policies may also impact prevailing uncertainty.

2.2.5. Environmental conditions (Reform context)

The reform context provides exogenous conditions for agents and their social interactions in the reform domain (e.g. the national or international institutional environment or country-specific socio-economic conditions). A change in the reform context (e.g. crises, elections, broader political reforms) may trigger change in the reform domain. It indirectly influences institutional change by influencing either the payoff structures of agents involved or the information structure.

2.2.6. Multiple trajectories

In the suggested framework, within-country differences in transition processes may come from two sources:

- Each social protection pillar is described by a specific reform domain and the initial institutional arrangements governing each domain. Differences across pillars may cause differences in reform trajectories.⁹
- Although reform domains are embedded within the same reform context, the impact of these exogenous conditions on institutional change may differ, if reform domains differ,

⁶ In game theoretic terms, in situations characterized by weak uncertainty all players are fully aware of the action space available to them and of all other players involved as well as on the consequences and resulting payoffs related to each action-state-profile. Players are able to or at least behave as if they build unique, additive and fully reliable probability distributions either based on known objective probabilities (‘Knightian risk’) or subjective probabilities (‘Savage’s uncertainty’). Resulting information problems are those considered in standard game-theoretic coordination or cooperation games.

⁷ Dequech (2011) uses the term “procedural uncertainty”.
⁸ Either agents cannot unambiguously assign a probability to the different states, or agents have limited capacities for consistently linking states, actions, consequences and payoffs, thus, uncertainty relates to the functional form of the game.
⁹ In this regard our approach is similar to the adapted political settlement approach suggested by Lavers & Hickey, 2016, which also allows for capturing differences in policy change across different pillars of social protection by characterizing for each policy domain as a specific political settlement.

3. Methodology

This paper presents a comparative case study analysis of two sub-policy areas, cash transfers and social health protection, within the policy area of social protection in Kenya. The case study covers the time between 2001 (social health protection) and 2004 (cash transfers), until the pre-election period in July 2017.

The paper employs a process tracing approach. Process tracing often involves detailed historical analysis. It aims to explain decision-making outcomes by identifying and exploring the mechanisms that generate them and allows for analyzing the role of timing, sequencing and interaction effects between policy stages (Büthe, 2002; Kay & Baker, 2015). Process tracing often involves detailed historical analysis. The interpretative qualitative data analysis is based on primary and secondary data. The primary data includes 25 semi-structured interviews conducted between March 2016 and January 2017 with national-level stakeholders involved in policy design or implementation, including members of parliament (3), ministries (3), other public authorities (5), non-governmental organizations (5), donors (5) and independent observers (4). A limitation of the study is that no interviews with participants from the private sector were conducted. To include their perspectives, the analysis relies on published academic literature or reports. Secondary data includes legal documents (laws, regulations, decrees and sessional papers), policy strategies, reports and evaluations as well as academic literature.

4. Institutional change in Kenya: The cases of social health protection and social cash transfers (2001–2017)

4.1. Current situation – Overview

Kenya is a lower-middle-income country with an average annual per-capita income of 1595 current USD in 2017. Kenya transitioned to a multi-party system in 1991 and has since experienced six democratic elections. In 2010, the country adopted a new constitution, which introduced checks and balances between executive and legislative, with the aim to reduce the substantial rights and powers that the presidency has accumulated over the years (Hassan, 2015). The constitution also provides for decentralization which in comparison to many other African countries is very extensive. Extreme poverty in Kenya, as measured by the international poverty line of 1.90 USD PPP per day, substantially increased since the 1990s, from 31.9 percent in 1997 to 43.7 percent in 2005. Current estimates show a decline to 36.8 percent in 2015.¹⁰ The right to social protection is enshrined in Art. 43 of the Kenyan constitution enacted in 2010. Overall social protection spending in Kenya is around 1.3 percent of GDP (including Civil Service Pensions), while spending on social assistance (excluding health programs) is reported at 0.21 percent of GDP excluding and 0.41 percent of GDP including external donor financing (Government of the Republic of Kenya 2017, pp. 62–63).

4.1.1. Social cash transfers

Since 2013, the National Safety Net Program (NSPN) is the umbrella for four cash transfer programs:

- The Cash Transfer for Orphaned and Vulnerable Children (CT-OVC) targeting families living with OVCs
- The Older People Cash Transfer (OP-CT) targeting poor and vulnerable persons over 65
- The Persons with Severe Disability Cash Transfer (PWSD-CT) targeting adults and children with severe disabilities

- The Hunger Safety Net Program (HSNP) aiming at reducing extreme hunger and vulnerability among the poorest households in four arid areas in North Kenya

Since 2016, the monthly transfer amounts to 2000 KES (18.3 USD) for the first three programs and 2700 KES (24.7 USD) for the HSNP. The OP-CT, PWSD-CT and OVC-CT are collectively known as Inua Jamii (IJP) and administered by the Ministry of East African Community, Labour and Social Protection (MoEACL&SP).¹¹ The HSNP is administered by the Ministry of Devolution and Planning (MoDP).¹²

Spending for cash transfers constituted about 84% of all social assistance expenditures (excluding health programs).¹³ Table 2 presents data on the number of beneficiaries and expenditures for the NSNP. The OVC-CT and OP-CT are the largest programs. While overall spending for cash transfers as a percentage of total GDP is still low, also relative to spending in other African countries,¹⁴ all programs have been expanding considerably since their inception, the OP-CT growing the fastest (Government of Kenya, 2017, pp. 42–43). In 2017 the Ministry of Finance announced the Inua Jamii Senior Citizens' Scheme for people aged 70 and above, which will gradually replace the OPCT.¹⁵

Total spending for cash transfers increased from 3.9 million USD in 2007/08 to 192.6 million USD in 2015/16. From the outset, the OP-CT and PWSD have been fully financed by the Government of Kenya, while the CT-OVC and HSNP are co-financed by donors. Overall, the role of the government in financing cash transfers relative to donors has been becoming more important (UNDP, 2019, p. 113; 118). In fact, the increase in overall spending has been driven by government funding rather than direct budget support from donors: The share of government funding in social assistance funding increased from 41% in 2007/08 to 74% in 2015/16. The general government budget is additionally supported by a concessional loan from the World Bank under the Program for Results (P4R) (Wanyama & McCord, 2017).

4.1.2. Social health protection

Despite advances, social health protection remains limited. The share of out-of-pocket payments in total health expenditures has decreased from 47 percent in 2000 to 33 percent in 2015. The share of external health expenditures in total health expenditures has increased from 5 percent in 2000 to 19 percent in 2015, while the share of government expenditure has declined from 37 to 33 percent.¹⁶ In 2015/16, only 19 percent of Kenyans had health insurance (Barasa, Rogo, Mwauma, & Chuma, 2018: 347). The National Hospital Insurance Fund (NHIF) is the major health insurance mechanism in Kenya. Membership is compulsory for formal-sector employees and voluntary for informal-sector workers. Since 2014, the government implements the Health Insurance Subsidy Program (HISP) through the NHIF. The program receives financial support from the World Bank and aims to extend healthcare services to the poor and most vulnerable. Beneficiaries are households registered under the CT-OVC, OP-CT and PWSD-CT. In 2016, coverage was about 170,000 households (Barasa et al., 2018: 350), which equals

¹¹ Formerly Ministry of Labour, Social Security and Services and Ministry of Gender, Children and Social Development

¹² Formerly Ministry for the Development of Northern Kenya and Other Arid Lands

¹³ Own calculations

¹⁴ Out of a total of 37 countries 14 African countries spend less, and 22 countries spend more than Kenya (UNDP, 2019, p. 115).

¹⁵ The Government of Kenya plans to gradually expand the scheme by gradually lowering the age threshold again to 65 years. It is being implemented since 2018. In total, approximately 833,000 persons aged 65 or above – about 60 percent of the population over 65 – are reported to be receiving a social pension (Chirchir & Tran, 2019, p. 3, 5).

¹⁶ Source: World Bank Health Nutrition and Population Statistics

¹⁰ Source: World Bank Development Indicators

Table 2
National Safety Net Program (NSNP).

Program	No. of beneficiary households (2015/16)	Total spending (in million US\$)		National government's percentage contribution to programs ¹		Spending as percentage of GDP (2015/16)
		2007/08	2015/16	2007/08	2015/16	
OVC	260,112	3.6	76.3	43%	84%	0.13
OP	342,660	0.03	60.5	100%	100%	0.11
PWSD	51,888	0	10.3	n.a.	100%	0.02
HNSP	98,818	0.27	45.5	100%	21%	0.08
Total	753,478	3.9	192.6	41%	74%	0.34

Sources: Data retrieved from the single registry for social protection at <http://mis.socialprotection.go.ke:20307> and Government of the Republic of Kenya (2017), p. 46, 195–196.

¹ Own calculations.

about 35 percent of all households registered under the mentioned programs. The nation-wide scaling up of the HISP, announced in late 2017, but has not been implemented to date. The HISP received (grant) funding from the World Bank (CT-OVC recipients) and the Kenyan government (OPCT and PwSD-CT recipients) (Government of Kenya, 2017, p. 61).

In addition, fee waivers for dispensaries and health centers are intended to facilitate access to essential health services, particularly for the poor. Since 2004 a policy reducing replacing user fees at government-owned health centers and dispensaries with a single one-time registration fee (10/20 policy) has already been in place. In 2013, the national government abolished all user fees at public health centers and dispensaries as well as maternal health services called “Linda Mama” at public hospitals. In 2016/17 the government allocated about 900 million KSH (7.8 million USD) and 3800 million (37.1 million USD, respectively) to these programs (Dutta, Maina, Ginivan, & Koseki, 2018, p. 51). Whereas the primary health care fee waiver is mainly funded by donors by a grant to the Kenyan government (Danish International Development Agency, DANIDA), the free maternity fee waiver is fully financed by the Kenyan government.¹⁷ Since 2017 the NHIF, manages the free maternity scheme, while the primary healthcare fee waiver is still managed by county governments with funds being channeled to counties via the County Revenue Funds (CRFs). Empirical evidence suggests that adherence to the fee waivers remains incomplete showing strong regional variations (Kabia et al., 2019; Opwora et al., 2015)

4.1.3. Institutionalization of social assistance

The establishment of the National Safety Net Program (NSNP) and the link between formerly separate policy areas (i.e. cash transfers and social health insurance through the Health Insurance Subsidy Program and the maternal health fee waivers and social health insurance through the NHIF) are important steps towards more integrated social assistance. Yet, both areas still lack an elaborated legal framework: The Social Assistance Act of 2013 is being renegotiated, whereas the Health Bill passed in 2016 formally mandates social health insurance but makes no detailed provisions.

4.2. Classifying reform dynamics

To assess reform dynamics, this section applies the three criteria described above – temporal baseline, scope of change and mode of change – to Kenya. An overview of reform phases is provided in Fig. 1 (see annex 1 for a detailed timeline).

4.2.1. Cash transfers

Temporal baseline. The CT-OVC program is the oldest among the cash transfer programs in Kenya. Discussions started in early 2004 as a response to the rising number of HIV/AIDS orphans. The first cash transfers pilot started in December 2004, after the Vice-President had approached UNICEF for jointly identifying policy solutions.

Mode of change. The reform process related to cash transfers may be subdivided into (at least) two phases (see Fig. 2). A first phase (2005–2011) involves the stepwise introduction of individual cash transfer programs, each targeted at a specific vulnerable group (orphans, the elderly, poor households affected by hunger and persons with disabilities). The second phase (2012–ongoing) comprises organizational and operational changes and is concerned with operational harmonization (phase 2a) and processes of formalization and legislation (phase 2b). In 2013, the National Social protection program was initiated. The Ministry of East African Community, Labor and Social Protection (MOEACL & SP) consolidated the Inua Jamii programs under the newly founded Social Assistance Unit. In 2016 a single registry was introduced. In 2013, the Social Assistance Act was passed by parliament, but repealed soon after and is being renegotiated since 2014/2015. A new draft bill was finalized in 2016, but it is still under debate.

Scope of change. The scope of change may at first be interpreted as a new instrument (cash transfers) added to existing instruments (in-kind transfers). In this case, cash transfers would fall into the category of second-order change. Yet, considering the entire process, the changes seem to be a typical example of cumulative change, starting with isolated and small-scale measures targeted at selected vulnerable groups and leading to the institutionalization of an increasingly integrated social assistance system. Thus, the change represents a system shift and is therefore also a third-order change.

Social assistance has been a new policy area, and monetary transfers were not in place before. Thus, from an institutional perspective, new cash transfer programs represent processes of layering, i.e. new institutions are added on top of or alongside existing institutions.

4.2.2. Social health protection

Temporal baseline. After the re-introduction of user fees in 1992, the start of the debate on extending social health protection can be traced back at least to late 2001, when the First National Congress on Quality Improvement in Health Medical Research and Traditional Medicine was convened. Back then, the president directed ministers to establish mandatory national social health insurance for all Kenyans, and a taskforce was formed that held consultations

¹⁷ Independent observer, Email conversation, August, 24 2020

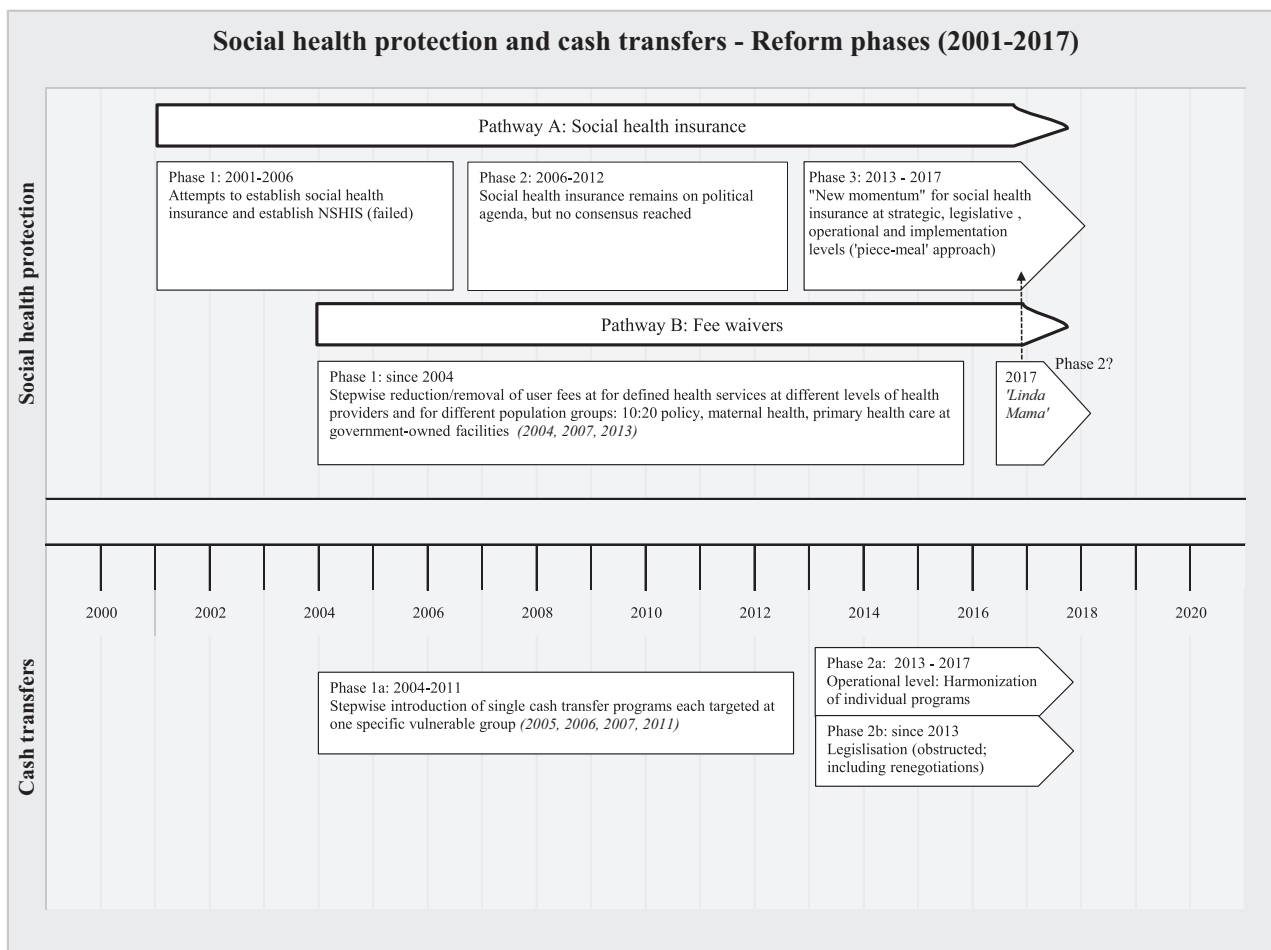


Fig. 2. Reform phases Source: Authors.

in 15 districts across Kenya. The final report recommended the establishment of the National Health Insurance Scheme (Abuya et al., 2015).

Mode of change. The trajectory of social health protection reform is complex (see Fig. 2). Pathway A includes attempts to extend social health protection by establishing a social health insurance scheme, whereas pathway B includes initiatives to extend social health protection through the reduction or removal of user fees.

Pathway A involves three phases. The first phase (2001–2006) involved activities aimed at establishing universal social health insurance. In 2001, an inter-sectoral task force was established, and in January 2002, a resolution on the establishment of a National Social Health Insurance Fund (NSHIF) was announced. In June 2003, the Ministry of Health approached GTZ and WHO for technical support to set up a social health insurance system. As a result, six technical missions were carried out in 2003 and 2004 and followed by intensive debates (Abuya et al., 2015). A bill was passed by parliament in late 2004, but the president did not sign it. Instead he returned it to parliament in 2005 with several changes, which included financial feasibility, technical design and a phased implementation (Abuya et al., 2015; Fraker & Hsiao, 2007). The unsigned bill lapsed when Parliament adjourned in 2006 (Ly, Dukhan, Feeley, Preker, & Atim, 2013). The rejection of the proposed law on the establishment of a National Social Health Insurance Fund (NSHIF) constitutes the end of the first phase:

While remaining on the political agenda, no decision was reached in phase 2 (2006–2012). In 2006 and 2007, a new multi-

stakeholder task force was established and a health financing technical working group (re-)installed in 2009. The Ministry of Health presented a draft health financing strategy in 2010, but again, no agreement was reached. In 2012 the Ministry of Health proposed a sessional paper on Universal Health Coverage (Sessional Paper No. 7 of 2012), but the paper was not passed by parliament.

This “back and forth” is also reflected in the National Vision 2030 and the first 5-year medium term plan (MTP): Whereas in the Vision 2030, which had been prepared in 2006–2007, a National Health Insurance Scheme was one of the so-called “flagship programs,” the first medium-term plan for 2008–2012 (Government of the Republic of Kenya, 2008) defined a broader flagship project including a broad choice of mechanisms to finance healthcare (Ibid: 103).

The third phase (2013–2017) seems to reflect a renewed momentum for social health insurance, including policy decisions on the strategic, legislative, organizational and operational level. Instead social health insurance being introduced in one paradigmatic step, one can observe related “piece-meal activities”: After the election and change of government in 2013, a presidential mandate on “Health Care: Towards a Healthier Kenya” was announced (Office of the President 2013). The goals include free primary healthcare for all Kenyans and reforming the NHIF. For the first time, the 2nd Medium Term Plan 2013–2017 (2013) mentions “universal access to health care” as a priority area and defines the Health Insurance Subsidy program as a flagship program. Also, in 2014, the new Kenya Health Policy 2014–2030 was issued and the NHIF Act of 1998 revised. Introduced in 2015 and passed by

parliament in 2016, the new Health Bill addresses health financing (articles 86 and 87). Without explicitly ruling out options beyond social health insurance, Art 86 (Paragraph 1) formulates the goal of universal health coverage through "...developing mechanisms for an integrated national health insurance system including making provisions for social health protection and health technology assessment" (The Health Bill 2016: 272).

The introduction of the HISP 2014 and linking it to cash transfers constituted a major step in eventually extending social health protection and moving towards a systemic approach to social assistance. Yet, while quickly reaching a remarkable coverage of 35 percent of beneficiaries in 2016, any further extension is stalling.

Pathway B involves one phase (2004-ongoing), subsequently introducing fee waiver programs for defined health services by different levels of health providers or for different population groups. In 2004 the Minister of Health introduced the 10/20 policy, which replaced user fees at government-owned health centers and dispensaries with a single one-time registration fee of 20 shillings (0.2 USD) at health centers and 10 shillings (0.1 USD) at dispensaries. To compensate health facilities for lost revenue, the government piloted a Direct Facility Fund (DFF) in the Coast Province. Based on the DFF, the Health Sector Services Fund (HSSF) fund was adopted in 2010 and implemented nation-wide. Both initiatives received financial support from DANIDA and World Bank through the Health-Sector-Wide-Approach (SWAp).

In 2007 the 10/20 policy was followed by the announcement of the health minister to remove user fees for deliveries. This announcement was not translated into a policy until June 2013, when the President of Kenya abolished all user fees for maternal healthcare and children under five as well as all services at the primary care level. The maternal health fee waiver was not backed by any direct donor funding. Their introduction coincided with the transition to a devolved system of governance, which completely changed financing structures: The Public Finance Management Act in 2012 abolished direct facility funding, and control of primary and secondary health service delivery shifted to county governments. Instead of reimbursing health facilities directly from the HSSF, funding relied on intergovernmental grants from national to county governments. In 2017 the Kenyan government relaunched the free maternity scheme under the new name "Linda Mama" and shifted management to the NHIF.

Even though both approaches – social health insurance and fee waivers – were a response to the same policy problem (improving access to health services, particularly for poor households), pathways A and B only are – if at all – loosely linked: The 10/20 policy had been introduced in July 2004, before the bill on social health insurance had even been submitted to parliament. Yet, while the Ministry of Health continued to keep social health insurance on the agenda, the 2007 fee waiver announcement and the 2013 fee waiver introduction were presidential initiatives. Yet, the recent move in 2017 – shifting the free maternity scheme to NHIF – may be a step towards linking the seemingly unrelated pathways A and B.

Scope of change. Attempts to extend social health protection in Kenya clearly involve a third-order change: Facilitating access to health services by moving from user fees to increased prepayment, redistribution and mutual risk pooling involves a change from efficiency goals to equity goals, or at least a strong balance shift between these goals. Further, attempts to introduce social health insurance can be characterized as processes of displacement, i.e. the removal of existing rules and introduction of new ones.

Table 3
Characteristics of reform dynamics.

	Social health protection	Cash transfers
Temporal baseline	2001	2004
Scope of change		
Content	3rd order change	3rd order change
Institutions	Displacement	Layering
Mode of change	Incremental: discontinuity/non-cumulative fragmented (two non-related pathways)	Incremental: continuity/cumulative

Source: Authors.

4.2.3. Comparison of reform dynamics

Reform in both policy areas is characterized by gradual and incremental institutional change and involves fundamental third-order changes (see Table 3).

However, reform dynamics differ how they deviate from the institutional status quo. Also, whereas the extension of cash transfers consists of slow yet cumulative changes, the extension of social health protection to the poor consists of non-cumulative changes, including blocked reforms or even reform reversals. Efforts to extend social health insurance have been obstructed, whereas decisions on fee waivers have been less difficult.

4.3. Explaining within-country variations in reform dynamics

The initial impetus for change was similar across both domains: Influential national-level stakeholders (president and vice president) reacted to perceived situations of socio-economic crisis, i.e. environmental conditions (low attainments of health system, HIV-AIDS epidemic). Donors offered new policy solutions to the perceived problems. Despite these similarities resulting trajectories of change evolved very differently. To explain these differences this section explores the interplay between the initial institutional status, preferences, (different types of) uncertainty and resulting information structures within the reform domains and exemplifies how the reform context influence patterns of change by shaping information structures.

4.3.1. Initial institutional status quo

When reforms started, social assistance in the form of monetary or in-kind transfers targeted at poor or vulnerable households was almost non-existent. Existing programs dealt with food security or child development (e.g. school feeding programs). Nevertheless, the institutional status quo for each reform domain provided very different initial conditions for either cash transfers or social health protection.

For cash transfers, the scope of change has been characterized as "layering": new institutions being added on top of or alongside existing institutions. Cash transfers were a new instrument in a nearly non-existent social assistance system with no specific legal provisions in place. In addition, cash transfers tended to complement existing initiatives without overlapping with any of them.

Contrary, the health sector already was highly institutionalized and included well-organized interest groups:

The health sector is a very well organized sector with an already existing legal framework and a well-defined division of labour as opposed to social assistance. These actors, such as NHIF, the trade unions, medical associations (amongst others) are partly very strong and represent their interests well; this is

why it is a little challenging to work with them and get some reforms through.¹⁸

The attempted reforms to introduce social health insurance – as processes of displacement – aimed at changing these established structures by re-defining responsibilities as well as structures for financing and delivering health services. This challenged established stakeholder constellations and spheres of influence. Agents involved in the debate on introducing social health insurance already held well-defined positions, which led to conflicting expectations on “reform winners” and “reform losers” in terms of influence or resources (see further below). These legacies also defined shared beliefs on what to expect from other agents and led to major conflicts over the suggested transition of the NHIF towards National Social Health Insurance (NSHI), as the reputation of the NHIF was low and mistrust in its capacity and compliance high.

Yet, interestingly, the initial status quo did not seem to have similar strong barriers against fee waivers, although the intended reforms also required the displacement of existing health financing rules. This is explored below.

4.3.2. Reform domains: Preferences

Preferences of agents involved in the reform domain are key to understand the formation of support or opposition to suggested reform.

Players involved during the first stage of introducing and extending *cash transfer* programs initially included the vice president, the ministries involved in administering the programs, the Ministry of Finance (MoF) and donors. For OVC-CT, donors included UNICEF, joined later by DFID and World Bank. Debates mainly revolved around the effectiveness of the instrument, questioning whether cash transfers reduce poverty or rather create dependency and reinforce poverty:

Of course there was a lot of caution even within government, is it affordable, is it politically correct, is it not creating dependencies. All those debates happened.¹⁹

It was thought that cash transfers would make the recipient lazy, just waiting to receive and to be seen to be poor and therefore they would not make any efforts to move out of the poverty cycle. Many people, including myself, were a bit in that school.²⁰

During interviews, the Ministry of Finance was frequently referred to as one important skeptic of cash transfers, but lower tiers of government also had objections:

Finance obviously was not so much for it. Even the local administration (...) when you went there you heard their sentiments that this thing is going to create dependency.²¹

Yet, these differences in ideology were no prohibitive barrier to change.

Interestingly, conflicts concerning the distribution of reform gains and losses among stakeholders – including financing – seem to be of lesser or no importance. Costs for the pilot were relatively low, and the OVC-CT, the first cash transfer program, was initially largely donor-financed (Government of Kenya (2012), p. 122, 124) which enabled or at least facilitated the first cash transfer program in 2005. Yet, only one year later, in 2006, the government of Kenya initiated the cash transfer program for the elderly, which has been fully funded by the government since its inception. As Ikiara (2009) points out, while cautious, domestic agents agreed that support for

a narrowly defined group of the hardcore poor should be affordable. He even hints at a certain reluctance towards a dependence on donor funding, given the politically sensitive nature of the policy and the unpredictability or possible instability of donor funding. Yet, any expansion should hold pace with economic development, to avoid any increase in taxes, which might endanger the political feasibility (Ikiara, 2009: 11–13). This might also explain why Art. 35 of the Social Protection Act of 2013 under “Sources of Funding” lists bilateral and multilateral donors first and avoids any direct reference to tax-based funding.

In addition, cash transfer programs were linked to different public authorities. This fragmentation possibly facilitated the proliferation of the cash transfer reform, as additional responsibilities and resulting positional gains were distributed across several public authorities. Also, cash transfers were and are considered an opportunity to win and increase influence:

They [i.e. politicians and the public] equalize it [i.e. social protection] in terms of cash transfers and some may see it as a political vehicle to gain votes or increase their political base.²²

Yet, it is interesting to note that during the second phase, harmonization and legalization of the program, more conflicting interests inhibiting the adoption of reform proposals seem to emerge. Contrary to phase 1, ongoing reforms involve processes of displacement and consequently spheres of influence for some agents: The enactment of the Social Safety Net program in 2013 led to the creation of a new stakeholder, the Social Protection Secretariat in the Ministry of Labor and Social Protection, responsible for overseeing and harmonizing the individual programs. This involves redefining and restructuring responsibilities, thus possibly introducing conflicts about influence. This indicates the emergence of path dependencies during the reform process.

The case of *social health insurance* is different. Contrary to CTs, many agents were involved and multiple sources of conflict emerged early. Main stakeholders included the president, vice president, parliament, different ministries (in particular the MoH, the MoEACL&SP former MoGCSP/MoLSSS, and the MoF), the National Hospital Insurance Fund, the private insurance sector, medical associations, trade unions representing formal-sector employees, employer associations and multiple bilateral or international donors.

Technical complexities of social health insurance are considerably higher when compared to CT and many debates were about technical conflicts, including design choices such as one single pool versus multiple pools or single versus multiple purchasers. Beyond these technical debates, many underlying conflicts over the distribution of reform gains and losses existed. As Abuya et al. (2015) illustrates, the Ministry of Health, who drove the reform proposal, faced strong opposition from various groups: Major debates centered on the financial feasibility of SHI. Estimating costs for SHI is also more complex than estimating cost for CTs. In addition, with GTZ and WHO mainly providing “only” technical support, no financial donor was available. Different cost estimates were presented, and the reform proposal was strongly opposed by the Ministry of Finance.

Trade unions, employers’ and workers’ associations were against the bill, as they feared that formal-sector employees would have to bear the major burden of financing the scheme. Major concerns related to the fact that many poor people would never be able to contribute to the fund. In addition, it was not clear how informal-sector workers would contribute to the scheme. Another key aspect was mistrust in the efficiency of the NHIF system which was widely considered inefficient (Wamai, 2009, p. 152). Interview-

¹⁸ National-level interview No. 15, Policy Planner, Kenya

¹⁹ National-level interview No. 13, Planner, Kenya

²⁰ National-level interview No. 5, Independent Observer, Kenya

²¹ National-level interview No. 13, Planner, Kenya

²² National-level interview No. 15, Policy Planner, Kenya

wees also suggested that public attitudes reflect a low acceptance of redistribution, for example:

What is important is that the political stalemate is one based on equity/financing issues: Universal health coverage in Kenya would mean that the rich and the middle-class would also need to contribute to finance such a scheme; and this still needs a wider discussion for acceptance.²³

The private-sector insurances also objected the proposal, as they expected the transition towards universal social health insurance to impair their business. As one interviewee summarized:

I think the Social Health Insurance that was being pushed by Ngilu is one of the best options in terms of being able to cover the entire population. (...) But to some extent, there was no good actor assessment and actor management, and the private insurance companies did not know how they were going to benefit from the whole thing.²⁴

Compared to cash transfers, the number of donors involved in the health sector was considerably higher, including about six bilateral donors, various international organizations such as the World Bank, WHO, different UN agencies, the European Union and international initiatives such as the Global Fund. Whereas donors supported (and financed) cash transfers unambiguously, they preferred different health policies. GTZ (now GIZ) and WHO were actively involved in developing the bill on social health insurance. Other donors (for example the World Bank, USAID or the Global Fund) focused on improving health service delivery by supporting vertical, non-systemic approaches focused on specific diseases (e.g. HIV/AIDS) and/or strengthening a decentralized provision of (selected) health services.²⁵ The establishment of a social health insurance included several features – system approach, comprehensive benefit package and a strong role for the central level – contrary to the pursued vertical approaches. *Abuya et al. (2015)* report that donors opposing social health insurance formed coalitions with the private insurance sector to campaign against SHP.

Despite the polarization, the topic was not off the political agenda and policy formulation continued. In 2007, supporters of social health insurance successfully used the development of the national strategy “Vision 2030” to keep the topic on the agenda (*Abuya et al., 2015*). Yet, only after a change in strategy (phase 3) switching from a comprehensive approach to a piece-meal approach – progress was achieved: The Health Insurance Subsidy Program described above separates the inclusion of poor households from other health financing concerns (e.g. reform of the NHIF) and links coverage of poor households to an existing social assistance framework (cash transfers). This piece-meal approach possibly helps to disentangle the conflicting interests. In addition, with the World Bank having changed its approach and now supporting social health insurance, reforms of the NHIF and financing the HISP program, the conflicting interests of the first phase abated.

Very similar to cash transfers, only few agents – mainly the Ministry of Health, Ministry of Finance and donors – were involved in formulating the original 10/20 fee reduction policy. In terms of financing, Direct Facility Funding (DFF) by DANIDA was set up in 2005 to support the 10/20 policy, followed by the HSSF supported by DANIDA and the World Bank in 2010. No major conflicting interests in policy decision-making are discernible. The financial support probably facilitated initial decision-making. However,

the 2013 maternal health waiver has been introduced without any financial support.

4.3.3. Reform domains: Uncertainty, private information and emerging beliefs

Weak uncertainty has been defined to characterize situations in which information might not be accessible to everyone involved but still all relevant information exists.

The initial group of decision-makers on cash transfers or fee waivers was small, the resulting information asymmetries facilitated policy change in these domains: The piloting of the CT-OVC program and its first scaling up were mainly discussed among the leading ministry, the MoGCSP, donors and the MoF, the latter being less concerned since donors provided most funding. For example, as one interviewee, pointed out:

It was very silent, because they didn't want to raise expectations, so they were trying to hold it small.²⁶

Likewise, fee waivers were directly announced by newly elected president after he won the elections in 2013. Even the Ministry of Health had not been involved or consulted, but – as indicated during the interviews – had been “warned” shortly before that “something was coming.” Non-governmental agents were completely left out:

Were there stakeholders involved in this fee waiver policy? Nobody. That thing was a political thing and as I was saying it was being costed while being implemented. (...) This is an ad hoc kind of policy to achieve a political objective.²⁷

Again, the case of social health insurance was different. The bill was preceded by a report of the inter-sectoral task force and six subsequent technical missions during 2003 and 2004 by GTZ and WHO, which included interviews with and presentations to stakeholders (*Abuya et al., 2015*). The technical discussions raised awareness among a broader group of stakeholders and enabled the formulation of alternative views.

Strong uncertainty influenced trajectories too. This type of uncertainty draws attention to differences in individual beliefs, subjective interpretations, emerging shared beliefs and focal points. Ambiguity was present as the concept of social protection had been newly introduced in Kenya. Also, social protection is a broad term and multiple definitions are available. Interviewees repeatedly mentioned that awareness of social protection is low and a narrow understanding of social protection as cash transfers only is widely held:

One big issue is the narrow view of social protection that especially some politicians and some relevant stakeholders have; they view social protection mainly as cash transfers, because it gains them political mileage. There is low awareness on the complexity and magnitude of the issue.²⁸

Against this framing of social protection as cash transfers, the controversial concept of social health insurance falls further behind in the public discourse, while – positively connoted – cash transfers receive more attention.

In addition, social health insurance is characterized by complexity: The concept of social insurance is highly abstract and seems not to be generally understood:

And then getting the Kenyans to understand what it [social insurance] means. You cannot accept it when you don't know

²³ National-level interview No. 15, Policy Planner, Kenya

²⁴ National-level interview No. 22, NGO representative, Kenya

²⁵ For example, from 2000 to 2007, the World Bank financed the “Decentralized Reproductive Health and HIV/AIDS – DARE” Program.

²⁶ National-level interview No. 4, Implementer, Kenya

²⁷ National-level interview No. 24, Independent Observer, Kenya

²⁸ National-level interview No. 15, Policy Planner, Kenya

what it entails, and that has been a big problem. Most people don't understand what NHIF is all about.²⁹

They [Kenyans] do not believe in paying for something they are not seeing. (...) The opportunity costs are considered too high because they can use that money for something else now. They do not look at the uncertainty, because they look at their current consumption.³⁰

So unlike the more straightforward concept of cash transfers, the complexity of "insurance" led to mutually held beliefs hampering social health insurance reforms.

4.3.4. Reform context: Uncertainty and focal points

Both, weak and strong uncertainty point to the relevance of focal points around which new behavioral traits coordinate. One such focal point was the HIV/AIDS crisis, which since the 1990s had been severely affecting Kenya leaving many children orphaned.³¹ In 1999, President Moi declared HIV a national disaster. In addition, Kenya was performing poorly with respect to child and maternal health. In 2015 Kenya barely reached MDG 4 on reducing child mortality. For maternal mortality, Kenya failed to reach the respective MDG 5.³² During interviews, it was repeatedly mentioned that this background – the perceived HIV/AIDS crisis, serious problems in child and maternal health and the high likelihood of not meeting the MDGs – served as an instigator for the introduction of the CT-OVC program and the introduction of free maternal healthcare:

The government was concerned about the growing number of orphans from HIV/AIDS and the other causes of death of parents, and for many of them there was no support structure. (...) There has been a lot of pressure, for example from NGOs, which felt that this needed to be handled.³³

(...) But other than the initiatives by the African Union and the governments of Africa, HIV/AIDS and its impact in terms of orphans, played a major role in pushing government to do something about it. There were several campaigns, especially organizations that were working with older persons and organizations that were working with children. (...) But also there has been a momentum moving across Africa. If you look at what is happening in the southern Africa region which has been leading in most of the social protection work, they were declaring HIV/AIDS a national disaster. So it has been a movement cutting across Africa and I think that's how Kenya also got into the bandwagon to do something in that regard.³⁴

And again, the other motivation was the issue of MDGs and all that, and especially related to maternal mortalities, we realized we cannot achieve that unless we address the financial barriers, and that was one of the interventions that was put in place ensuring that all maternal related services are free, starting with the ANC (Ante Natal Clinics).³⁵

Thus, the initial international and national reform context provided focal points for coordination and selecting policy options. It fostered a shared understanding of underlying problems within the reform domain of cash transfers and fee waivers. Against the background of inefficient health systems and the MDG agenda vertical interventions for maternal and child health represented the "spirit of the times." However, they provided counter-incentives for systemic approaches such as social health insurance, which require longer-term institution-building.³⁶

Over time, the reform context changed. Throughout the last decade, policy goals such as "universal health coverage" or "extending social protection" were firmly embedded on the international agenda and systemic approaches were emphasized. These changes are also reflected in the discourse in Kenya:

But again, that is where the world is headed, health coverage. Looking at Kenya's situation, the need is big. There are a lot of people suffering out there without access to essential services in health.³⁷

Globally if you look at the SDG now, social protection is featuring in so many of those goals, so there's been a lot of progress nationally, and also globally on issues of social protection,³⁸

It remains to be seen how these international changes – the new "spirit of the times" – will impact social protection reforms in Kenya. However, they already produced a "new momentum" for social health protection reforms: The World Bank – initially opposing social health insurance – decided to support the reform of the NHIF and the extension of social health insurance to the poor via the contribution-free "Health Insurance Subsidy Program".

5. Discussion

Despite similar initial triggers for change, resulting trajectories developed differently in each of the domains. Several interacting factors contribute to this outcome. Table 4 summarizes the main results.

First, the above analysis demonstrates that, in comparison to cash transfers and fee waivers, the number of agents initially involved in policy formulation and decision-making on social health insurance was higher and their interests were considerably more conflict-laden. With respect to cash transfers, conflicts were mainly ideological and pertained to the perceived adequacy of the policy, whereas for social health insurance, ideological conflicts about adequacy and design of the policy came on top of fundamental distributional conflicts about reform benefits and costs, financing in particular.³⁹ Also, reform benefits of cash transfers ("political mileage") were perceived to be higher and more evenly distributed among agents. In addition, by aggravating conflicting interests and shaping expectations on what to expect from key players, existing institutional arrangements produced stronger barriers against social health insurance than against cash transfers. Similar comparative patterns have been found by [Ulriksen and Plagerson \(2017\)](#) and [Bekenya and Hickey \(2019\)](#) for South Africa and Uganda. The extension of social health protection generally seems to be a highly contested area ([Yi, et al., 2017](#), pp. 19–21)

³⁶ Interestingly, the perception of MDGs seems to be selective. In none of the interviews was reference made to MDG 1 (reducing absolute poverty by 50%), although Kenya performed poorly in this respect.

³⁷ National-level interview No. 18, Donor, Kenya

³⁸ National-level interview No. 2, NGO representative, Kenya

³⁹ [Yi, Koehlein, & de Negro Filho \(2017\)](#) also stress the political nature of financing: "Whether or not there are sufficient financial resources for health coverage tends to be subjective, determined by institutional capacity, political will and the politics of reform." (p.19–21).

²⁹ National-level interview No. 17, Donor, Kenya

³⁰ National-level interview No. 24, Independent Observer, Kenya

³¹ The HIV-AIDS prevalence rate reached its peak at 11.1% of the total population between 15 and 49 in 1997, slowly decreasing to 7.4% in 2005 and remaining at a comparatively high level of 5.6% in 2015. The cumulative number of children orphaned by HIV-AIDS increased to 1.5 million in 2005 and 2006. Data: Health Nutrition and Population Statistics, World Bank.

³² Under-5-mortality rose from 98.1% in 1990 to 100.8% in 2000 decreasing to 50.1% in 2015. Maternal mortality numbers increased from 687 in 1990 to 768 in 200 and remaining at a high level of 510 in 2015. Data: Health Nutrition and Population Statistics, World Bank.

³³ National-level interview No. 5, Independent observer, Kenya

³⁴ National-level interview No. 2, NGO representative, Kenya

³⁵ National-level interview No. 25, Independent Observer, Kenya

Table 4
Sources of reform dynamics.

	Cash transfers	Social health protection	
		Social health insurance	Fee waivers
Institutional status quo	conducive	adverse	no impact discernible
Initial interests among agents	slightly heterogeneous (minor conflicts)	heterogeneous (major conflicts)	homogeneous
Weak uncertainty			
Distribution of information	conducive	adverse	conducive
Coordination and focal points	conducive	adverse	conducive
Strong uncertainty			
Ambiguity, complexity and emerging shared beliefs	conducive	adverse	no impact discernible

Source: Authors.

Second, initial policy formulation and decision-making processes on cash transfers and – even more so – fee waivers were exclusive, and the initial group of agents was small. The exclusion of other players caused information asymmetries (“weak uncertainty”) and reduced the opportunities for expressing opposition. Information on the social health insurance reform proposal was more widely disseminated *ex ante*, which enabled the formulation of alternative views. These information asymmetries may also help to explain why the institutional status quo within the health sector inhibited decision-making on social health insurance, but not on fee waivers.

Third, the general concept of social protection as well as measures such as cash transfers and social health insurance were new to Kenya. Over time, emerging shared beliefs in response to ambiguity and complexity (“strong uncertainty”) affected both reform domains differently, creating an imbalance against social health insurance. On one hand, the widespread narrowing-down of social protection to cash transfers, in combination with the promise of added political mileage, ensured the instrument’s prominence in social protection discourses and commanded political attention. On the other hand, “insurance” being a more complex construct than cash transfers or fee waivers helped sustain critical (and hampering) views on the fundamentals of social health insurance. Interestingly, these results seem to complement in part ideational institutional perspectives. For example, [Bekenya and Hickey \(2019\)](#) also highlight the role of simplicity/ complexity of policy solutions. [Surender \(2017\)](#) argues that continuous debates on the meaning of universal health services are a major barrier to extending social health insurance in South Africa.

Fourth, the reform context provided focal points for selecting policy solutions with differing meanings for the respective domains: Domestic factors (HIV-AIDS crisis) and the international institutional environment (MDGs) facilitated programs targeted at specific vulnerable groups (such as cash transfers and fee waivers for maternal healthcare) during the early reform process, while systemic and horizontal approaches, such as social health insurance, were less popular.

Yet, whereas initial conditions shaped institutional trajectories, it is interesting that reform dynamics are not time-invariant or completely path-dependent: While recent efforts to create an integrated and institutionalized cash transfer system may potentially reduce reform dynamics, the change towards a more “piece-meal-approach” of social health protection may add a new momentum for change. Reasons for these (possible) changes in reform dynamics include the development of defined interests and stakes in the

reform of cash transfers and new focal points for social health protection coming from the international discourse on universal health coverage.

A growing body of research discusses the role of international interdependencies for social protection reforms, including the interplay between domestic and international agents.⁴⁰ Although the role and level of influence of international agents on domestic policy making varies (for example [Chinokya 2017, 2019](#)), they cannot simply impose any policies. Their influence is mediated by domestic agents and policy processes ([Weyland, 2005; Fox & Reich, 2013; Lavers & Hickey, 2016; Seekings, forthcoming](#)). The comparative analysis of social protection reforms in Kenya mirrors the multifaceted nature of donor involvement: First, in both domains, the combination of a perceived problem, a domestic political agent ready to act and donors offering a policy solution provided the impetus for change. Second, not surprisingly, donors do have their own political agendas. Also, donors are not a homogeneous group and interests within the group of donors may conflict.⁴¹ Hence, donors may contribute to either facilitating or stalling social protection reforms, the latter being amply demonstrated by the case of social health insurance. Third, the comparative cases seem to suggest that donor funding facilitates change by mitigating distributional conflicts amongst domestic agents. Change occurred when external financial support was available (e.g. OVC-CT, HISP, 10/20 policy) and stalled if not (social health insurance). However, the relationship between donor funding and policy change is not straightforward: The OP-CT and later the PWSD-CT were introduced without any direct budget support from donors. Likewise, the 2013 maternal health fee waiver was introduced without any direct backing from donors. Thus, for the Kenyan case, external funding is not a sufficient or necessary condition for policy decision-making. Fourth, the analysis of long-term institutional change in social health protection highlights that donor involvement also is context-dependent: International discourses and paradigms change over time and so do donors’ preferences.

Finally, the focus of this paper is on processes of policy formulation, policy decision-making and institutional change. Yet, the political economy of policy *implementation* is equally important for understanding the dynamics of institutional change.⁴² It is relevant to all domains discussed in this paper, but it is particularly exemplified by the fee waiver programs: Although changes in policy formulation and adoption were quickly achieved, reforms are stalling, as implementation remains a challenge.⁴³

6. Conclusions

The paper offered a theoretical framework for characterizing social protection reform dynamics and explaining within-country differences across different pillars of social protection. It extended current discussions by exploring the role of different types of uncertainty for institutional change in social protection.

The case of Kenya illustrates that while cash transfer reforms in Kenya follow a pattern of cumulative incremental change, social health protection reforms show patterns of non-cumulative change, including blocked reforms and reform reversals. Important

⁴⁰ A recent contribution is for example [Schmitt \(2020\)](#).

⁴¹ Competition among international agents is explored further for example in [Seekings \(forthcoming\)](#).

⁴² For a broader discussion of the political economy of implementation see for example [Fox and Reich for social health insurance \(2013\)](#) or for a general discussion the classical contribution by [Grindle and Thomas \(1991\)](#).

⁴³ Although a detailed analysis is beyond the scope of this paper, empirical evidence suggests that contributing factors include inadequate financing and multiple governance problems ([Opwora et al., 2015; Okech and Lelegwe \(2016\)](#), p. 223; [Vilcu, Mbutia, & Ravishankar, 2020](#)). Devolution exacerbated problems as it required substantial changes in existing rules, procedures and behavioral traits.

contributing factors are stronger conflicting interests and institutional legacies within the area of social health insurance. However, these constitutive constellations are either shaped or intensified by uncertainties. Weak uncertainty, involving asymmetric information and the presence of focal points, facilitated decision-making on cash transfers and fee waivers. Strong uncertainty depicted by ambiguity and complexity led to mutual beliefs increasing the focus on cash transfers and exacerbating critical views on social health insurance.

The paper is a first attempt to address the role of uncertainty for institutional change in social protection. More research is required to deepen the understanding of the complex interplay between interests, institutional status quos and uncertainties. Also, the Kenyan case illustrated that paths may change, and reform dynamics may accelerate or decelerate over time. As discussed, changes in the reform context over time may change conditions within the reform domain. The concept of strong uncertainty points to the relevance of endogenous sources of change within a reform domain. This may include the implications of complexity or ambiguity, and the emergence of new shared beliefs or learning processes among agents involved. Addressing those sources of changes

seems another novel area for research into institutional change in social protection and developing strategies for integrated social protection systems.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Annex 1.: Social protection Kenya – Timeline (2001–2017)

Year	Cash transfers	Social health protection
before 1989:	2001 Introduction of user fees 1991: Suspension user fees 1992: Reintroduction user fees	<i>Before 2004: limited number of in-kind transfers to the poor</i> <i>2003: reintroduction of the universal free primary education program</i>
2001	1st National congress on quality improvement in health, medical research and traditional medicine Establishment of Inter-sectoral Taskforce on Extending Social Health Insurance	
2002	Resolution Establishment NSHIF (January)	
2003	Economic Recovery Strategy (ERS) for Wealth and Employment Creation (2003–2007) aimed at transforming the existing NHIF into a NSHIF MoH approached GTZ/WHO for technical support to set up national health insurance	
2004	Idea CT for OVC emerging/being discussed: former VP Wood Awori approached UNICEF for support	Proposed law on NSHI (rejected) Introduction of 10/20 program
2005	Pilot OVC-CT started	Direct Facility Funding (DFF) (late 2005, to support 10/20)
2006	National Social Protection Committee installed (direct commitment from Livingstone, i.e. to do something on SP) OP-CT started	Parliament adjourned without an amended NSHI bill being presented
2007	HSNP-CT (funded by DFID)	Abolishment of user fees for deliveries at public health facilities (July): Announcement by former MoH Ngilu; but not backed by a written policy
2008		
2009	WB and DFID started supporting the OVC-CT program	Health Sector Services Fund (HSSF)
2010	Constitution of Kenya (Art. 43: Right to social security)	National Health Financing Strategy (Draft)
2011	GoK – National Social Protection Strategy 2011 National Social Safety Net program and National Social Protection Secretariat founded PWSD-CT started	
2012	Urban food cash transfer program (Mombasa/Nairobi)	Sessional paper No. 7 on Universal Health Coverage (failed to pass through parliament)
2013	Social Assistance Act 2013 New Ministry of EAC, Labour and Social Protection National Safety Net Program (NSNP); attempt to	Presidential mandate on “Healthcare: towards a healthier Kenya” announced; goals include: Achieve free primary healthcare for all Kenyans; Reform of NHIF

(continued on next page)

Annex 1: (continued)

Year	Cash transfers	Social health protection
	harmonize existing programs (co-funded by WB 2013–2018)	(<i>Social Assistance Act 2013</i>) Removal of user fees at lower healthcare level and free maternal healthcare
2014	Renegotiation of Social Assistance Act 2013 Sessional paper 2014/2 on the National Social Protection Policy Draft of National Social Protection Council Bill, 2014 Health Insurance Subsidy Program for the Poor (pilot) - > linking OVC and SHP	Sessional paper 2014/2 on the National Social Protection Policy Draft National Social Protection Council Bill, 2014 Kenya Health Policy 2014–2030 Revision of NHIF Act of 1998 Health Insurance Subsidy Programme for the Poor (pilot)
2015	1st National Social protection Conference (27–30 January 2015) Renegotiation of Social Assistance Act 2013 Urban food cash transfer program abolished	1st National Social Protection Conference (27–30 January 2015) Health Insurance Program for the elderly and people with severe disabilities
2016	Zero Draft National Social Protection Bill Single Registry Changing structure of the SP secretariat	Zero Draft National Social Protection Strategy Health Bill 2016 (passed by National Assembly 30 March 2016; published in National Gazette in 2015)
2017	Linking CT-SHP via HISP	Roll out of HISP Linking of CT-SHP via HISP Free maternity healthcare administered by NHIF; renamed (Linda Mama)

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