

Influence of Financial Support on Access to Maternal and Child Healthcare in Narok North Sub-County, Kenya

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Abstract

Globally, access to healthcare services constitutes a fundamental social right guaranteed by international law and states' constitutions. Kenya has entrenched healthcare services in the Constitution as a right, with the national and county governments having shared roles in healthcare provision. Narok County is listed among highly burdened areas on maternal and neonatal health challenges occasioned by the high mortality rate. This study seeks to examine how financial support promotes access to maternal and child healthcare in Narok –North Sub-County. The study is guided by Andersen's Behavioural Model of Health Utilization. A concurrent mixed methods design was adopted for the study, and the target population was 59,996 households and 20 key informants in Narok-North Sub-County, Kenya. A sample size of 381 respondents participated in the study. The study employed the use of questionnaires and the interview guide as research tools for the collection of primary data, which was corroborated with secondary data. The study used simple random sampling to select participants from every household, while purposive sampling was used to select key informants. Data analysis was done using a convergent parallel mixed method where qualitative data were analyzed using thematic analysis and presented using themes, sub-themes, and narrations. Quantitative data analysis was done using descriptive statistics and presented using means, tables, graphs, and charts. The study results revealed that 57.2% of the respondents noted that there was a low budgetary allocation from the Government, and this had a negative implication on maternal and child health care in Narok North Sub-County. The study concluded that the implementation of the health policy in the Sub-county had not achieved the intended objectives and thus recommends that the Government needs to prioritize timely disbursements of funds to allow health facilities to provide consistent maternal and child health services. There is also a need to expand healthcare infrastructure and strengthen human resource capacity to tackle accessibility challenges for maternal and child healthcare.

Key Words: *Child Health Care, Financial Support, Maternal Health Care, Healthcare Accessibility, Health Policy Implementation*

1. Introduction

Globally, maternal and child health (MCH) care is a key component of the health system. It is an essential part of the 2030 Sustainable Development Goals (SDGs) proposed by the World Health Organization (WHO) in 2015, which includes targets to reduce the global maternal mortality ratio and deaths of newborns and children under 5 years of age (WHO 2015). Maternal and child health (MCH) is a global priority that has been continually discussed for many decades; it is one of the essential public health services (WHO, 2019). According to a study by the United Nations Interagency Group, 295 thousand maternal deaths per year were estimated in 2017, and there were 18 neonatal deaths per 1000 live births worldwide in 2018 (WHO, 2019). In the United States, a high-income country with advanced healthcare infrastructure, maternal mortality rates remain alarmingly high compared to other developed nations, with approximately 900 pregnancy-related deaths in 2020 (Hoyert, 2022). Racial disparities exacerbate this issue, with Black women facing up to four times higher mortality rates than White women, often due to systemic racism, provider discrimination, and socioeconomic barriers (Hill et al., 2022). Recent policy efforts, such as the Affordable Care Act (ACA) and state-level initiatives to expand postpartum Medicaid coverage, have aimed to improve MCH access. In Africa, South Africa, an upper-middle-income country, accounts for a small proportion of global maternal deaths but faces significant challenges due to socioeconomic inequalities and HIV prevalence (Tabutin et al., 2017). Policies like the National Health Insurance (NHI) framework aim to improve MCH access by expanding primary healthcare services. A study by Mureyi et al. (2023) found that NHI pilot programs increased antenatal care visits in underserved communities. Still, only 0.4% of women in a 37-country DHS study were from South Africa, indicating limited data on utilization (Yadav et al., 2023). Barriers such as staff shortages and inadequate rural facilities continue to hinder policy effectiveness, particularly for Black and low-income women (Mureyi et al., 2023).

Post-independence Kenya's approach to healthcare financing was rooted in a commitment to social equity and the elimination of disease as a barrier to national development (Shauri et al., 2024). The Sessional Paper No. 10 of 1965 on African Socialism and its Application to Planning in Kenya articulated this vision, declaring the government's aim to provide "medical and hospital services" alongside other social protections to combat poverty, ignorance, and disease (Republic of Kenya, 1965). This blueprint established healthcare as a public good, initially abolishing colonial-era user fees and funding services primarily through general taxation, with universal access as a core policy goal (Wamai, 2009). It also led to the creation of the National Hospital Insurance Fund (NHIF) in 1966, initially targeting formal-sector workers to pool resources and reduce financial barriers (Jung, 2021). For maternal and child health (MCH), these provisions laid an early foundation by prioritizing preventive and curative services within a centralized system. However, implementation was constrained by limited fiscal capacity in the nascent republic.

Subsequent decades witnessed incremental policy refinements amid economic pressures. The Kenya Health Policy Framework of 1994 and the first two National Health Sector Strategic Plans (1999–2004 and 2005–2010) shifted toward cost-sharing and greater efficiency, reintroducing limited user fees while emphasizing equitable resource allocation and private-sector involvement (Luoma et al., 2010). These reforms responded to declining budgetary shares and recognized inefficiencies in resource use, yet they often exacerbated financial barriers for vulnerable groups, including pregnant women and children (Thomson et al., 2017). By the early 2000s, MCH outcomes remained suboptimal, with high maternal and under-five mortality rates underscoring the limitations of fragmented financing.

The launch of Kenya Vision 2030 in 2008 marked a pivotal reorientation toward transformative, people-centred development. Under its Social Pillar, the Vision committed to “equitable, affordable and quality healthcare for all citizens,” explicitly prioritizing the scaling up of maternal and child health, immunization, and reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services as pathways to Universal Health Coverage (UHC) (Keats et al., 2018). This aligned with the Constitution of 2010, which enshrined the right to the highest attainable standard of health, including reproductive health and emergency treatment. Devolution in 2013 further decentralized service delivery to counties, which assumed responsibility for most primary and secondary care, while the national government retained policy, regulatory, and referral functions (Muwonge et al., 2022). This governance shift necessitated parallel reforms in financing to ensure coordinated budgetary support. In Kenya, the maternal mortality ratio stands at 355 deaths per 100,000 live births (Kilemi, 2023). Given the current annual births, this means that there are nearly 5000 women and girls dying annually due to pregnancy and childbirth complications (Harish et al., 2021). While access to skilled birth attendance has improved from 62% to about 70%, over 80% of maternal deaths are attributed to poor quality of care (Bobo et al., 2021). In Narok County, where the present study was conducted, only 18% of children are born in clinical facilities (Purity et al., 2023). Maternal health service coverage is poor: <30% of the population has access to services; 17% attend ANC; 17.6% of pregnant women have skilled assistance at delivery. In addition, the Narok County Integrated Development Plan (CIDP) 2022-2027 reports show a Maternal Mortality Rate (MMR) of 522 per 100,000 live births, an Infant Mortality Rate (IMR) of 37.2%, a neonatal mortality rate exceeding 50, and stunting levels at 22%. Against this backdrop, the study aimed to determine the efficacy of the Kenyan health policy in improving maternal and child healthcare within Narok-North Sub- County.

2. Statement of the problem

Kenya has made continuous efforts to address development challenges and improve the socio-economic wellbeing of its citizens, including the realization of health as a basic social right. The Constitution of Kenya 2010 provides a legal framework for a rights-based approach to healthcare delivery, while the Kenya Health Policy 2014 was formulated to enhance affordability, equity, accessibility, and quality of healthcare services. This study is particularly related to access to comprehensive maternal, neonatal, and reproductive health services. While there exist many studies on health reforms in Kenya, there is a paucity of such work in relation to healthcare policy enhancement of maternal and child healthcare, and particularly in Narok. Annual health reports and the County Integrated Development Plan report (2023-2027) indicate that in Narok County, only 18% of children are born in clinical facilities, and with the worst Maternal and Child Health outcomes in Kenya, including a high MMR of 434/100,000 births. Maternal health service coverage is poor, and <30% of the population has access to services; 17% attend ANC; 17.6% of pregnant women have skilled assistance at delivery, and Narok North is one of the most affected sub-counties. It is against this background that this study seeks to examine the effectiveness of Kenya's health policy implementation on access to maternal and child healthcare in Narok North Sub-County, Kenya.

3. Empirical Literature

Financial support has increasingly become a central policy instrument in improving access to maternal and child healthcare across the world. Governments and development agencies have adopted different financing mechanisms such as conditional cash transfers, public insurance

programs, free maternity services, transport subsidies, and social protection schemes to reduce financial barriers associated with pregnancy, childbirth, and child healthcare services.

In the United States, financial support through public insurance programs such as Medicaid has played a critical role in improving maternal and child healthcare access among low-income populations. Medicaid finances nearly half of all births in the country and has been associated with improved prenatal care attendance and reduced maternal and infant mortality among vulnerable populations. Research by Howell (2018) established that Medicaid expansion under the Affordable Care Act increased access to prenatal and postpartum services, especially among low-income women and racial minorities. The study further noted that financial coverage reduced delays in seeking maternal healthcare services and improved continuity of care during pregnancy and after childbirth. Similarly, Eliason (2020) found that states that expanded Medicaid experienced significant reductions in infant mortality rates compared to states that did not adopt expansion policies. Despite these gains, literature from the United States also highlights persistent disparities in maternal healthcare access. Financial support programs have not completely eliminated inequalities associated with race, immigration status, and geographical location. Declercq et al. (2017) observed that women from marginalized communities still face barriers such as inadequate healthcare facilities, transportation challenges, and limited provider availability even when insured. Additionally, studies indicate that interruptions in Medicaid eligibility after childbirth negatively affect continuity of maternal healthcare, particularly postpartum mental health services and pediatric care. In the United Kingdom, maternal and child healthcare access is largely supported through the publicly funded National Health Service (NHS), which provides universal healthcare coverage free at the point of service. Literature consistently demonstrates that universal financial protection under the NHS has substantially improved maternal and child health outcomes over time. According to Black et al. (2019), the NHS reduced financial barriers to accessing antenatal care, skilled birth attendance, immunization services, and pediatric healthcare. The authors argue that universal financing mechanisms contribute significantly to equity in healthcare access by minimizing socioeconomic disparities in service utilization.

Historical analyses also reveal that the establishment of the NHS in 1948 transformed maternal and infant healthcare services in the United Kingdom. Evidence suggests that free maternal healthcare services contributed to reductions in infant mortality and stillbirth rates, particularly among socioeconomically disadvantaged populations.

In Asia, India provides one of the most extensively studied examples of financial support interventions in maternal and child healthcare through the Janani Suraksha Yojana (JSY) program. Introduced in 2005, JSY is a conditional cash transfer scheme aimed at encouraging institutional deliveries among poor pregnant women. Numerous studies have documented the program's influence on maternal healthcare utilization. Lim et al. (2010) found that the program significantly increased institutional deliveries and antenatal care utilization among economically disadvantaged women. The study demonstrated that financial incentives encouraged women who previously delivered at home to seek facility-based childbirth services, thereby reducing maternal and neonatal health risks. Further evidence by Gopalan and Varatharajan (2012) indicated that demand-side financing under JSY reduced financial barriers associated with childbirth and improved healthcare-seeking behavior among rural women. The authors observed that financial support not only enhanced access to healthcare facilities but also reduced catastrophic out-of-pocket expenditure related to delivery services. Similarly, research by Powell-Jackson et al. (2016) established that cash transfers under JSY reduced maternal depression and debt associated with childbirth expenses.

A systematic review by Neelsen et al. (2021) indicated that financial incentives can modestly improve the utilization of reproductive, maternal, and child health (RMCH) services in low- and middle-income countries, although performance-based financing may be less effective than other methods like vouchers and conditional cash transfers. Thapa et al. (2021) highlighted the Investment Case (IC) approach in Nepal, which improved access to maternal, neonatal, and child health (MNCH) services through collaborative planning, despite challenges such as resource constraints. Aji et al. (2022) focused on Indonesia, identifying key themes for sustaining MCH programs post-donor funding, emphasizing the need for stakeholder engagement and financial sustainability. Mao et al. (2023) found that eliminating out-of-pocket costs for essential MNCH services in Nigeria could significantly reduce mortality rates and financial burdens on poorer households, suggesting that similar strategies could be beneficial in Kenya.

The Direct Health Facility Financing (DHFF) program in Tanzania demonstrated significant improvements in maternal health service delivery, although challenges like inadequate infrastructure persisted. Tsofa et al. (2023) examined the political economy of health sector planning in Kenya, revealing that while devolution has increased stakeholder participation, it has also led to inefficiencies in decision-making and fund allocation. Barmaasai (2021) established a positive relationship between healthcare budget allocations and economic growth in Kenya's North Rift Region, advocating for increased fiscal prioritization of healthcare. Mwangi and Abuga (2024) investigated the impact of public policy on healthcare devolution in Homa Bay County, finding that adequate funding and community engagement are crucial for improved service delivery. Recent studies in Narok County have underscored the importance of financial resources in enhancing MCH services, with increased budget allocations correlating with better healthcare outcomes. However, systemic challenges such as resource misallocation and inadequate monitoring remain significant barriers. The current study aimed to assess the role of budgetary allocation and financial support in promoting access to MCH care in Narok-North Sub-County, addressing existing gaps in research and practice.

4. Research Methodology

This research paper is an output of a research study that was conducted in Narok North Sub-County in Kenya between May 2025 and July, 2025. Concurrent mixed methods design was adopted in this study and the target population was 59,996 households and 20 key informants in Narok-North Sub-County, Kenya. A sample size of 381 respondents participated in the study. The study employed the use of questionnaires and the interview guide as research tools for collection of primary data which was corroborated with secondary data. The study used simple random sampling to select participants from every household while purposive sampling was used to select key informants. Data analysis was done using quantitative and qualitative methods (mixed method). Qualitative data was analyzed using thematic analysis and presented using themes, sub-themes and narrations. Quantitative data analysis was done using descriptive statistics, and presented using mean, tables, graphs and charts. Research ethics including seeking authorization from National Commission of Science Technology and Innovation (NACOSTI), seeking respondents' consent, and assurance of anonymity and confidentiality in all the information given were adhered to.

5. Findings of the study

The subsequent sections highlight the discussion of major finding of the study.

5.1 Descriptive Statistics on Financial Support and Maternal and Child Healthcare

The study sought to establish whether there was financial support in promoting access to maternal and child healthcare in Narok-North Sub-County, Kenya. The respondents were asked to indicate the extent to which they agreed with the statements using a 5 scale Likert whereby 1= Strongly Disagree (SD) 2= Disagree (D), 3 = Not Sure (NS) , 4 = Agree (A) and 5= Strongly Agree (SA). The responses were presented using descriptive analyses as show in Table 1 below.

Table 1: Extent of Financial Support in Promoting Access to Maternal and Child Healthcare

Statement	SA	A	NS	D	SD	Mean
The government provides sufficient budgetary support for maternal and child healthcare services.	(28)9%	(60)19.4%	(31)10%	(155)50%	(36)11.6%	2.64
Budgetary allocations for maternal and child healthcare have increased over the past five years.	(13)4.2%	(42)13.5%	(86)27.7%	(116)37.4%	(53)17.1%	2.50
Budgetary allocation for maternal and child healthcare is adequate	(23)74%	(14)4.5%	(76)24.5%	(165)53.2%	(32)10.3%	2.45
Funds allocated for maternal and child healthcare are used for their intended purpose	(15)4.8%	(24)7.7%	(126)40.6%	(125)40.3%	(20)6.5%	2.64
The available financial resources for maternal and child healthcare are utilized efficiently.	(26)8.4%	(19)6.1%	(104)33.5%	(134)43.2%	(27) 8.7%	2.62
The Social Health Insurance Fund (SHIF) adequately covers maternal and child healthcare costs	(25)8.1%	(39)12.6%	(54)17.4%	(156)50.3%	(36)11.6%	2.55
Mean of mean						2.57

Source: Field survey, 2025

The study assessed the extent of government funding allocations towards maternal health care services in Narok Sub-County, Kenya. The research results demonstrated varying levels of dissatisfaction where 155 (50%) and (11.6%) 36 of the respondents disagreed and strongly

disagreed respectively, that government funding of maternal healthcare services was adequate. On the contrary, 9% (28) and 60 (19.4%) of survey respondents either strongly agreed and agreed with an assertion that the funding is adequate. Furthermore, 31 (10%) of respondents were undecided possibly reflecting inadequacy or uncertainty of government provision of maternal healthcare. Majority 191 (61.6%) of the respondents established that there is inadequacy of funding, which may point to a systemic issue with respect to prioritization, or transparency from the government funding allocations towards maternal healthcare services in the study area.

On whether budgetary allocations for maternal and child healthcare have been increased over the past five years, the study results revealed that only 13 (4.2%) of the respondents strongly agreed with the statement above. These results suggest that majority of respondents lack awareness on any increase in budgetary allocation, potentially pointing to issues such as inadequate funding, ineffective communication of budget changes, or a disconnect between allocations and tangible outcomes. Furthermore, the study found out that 116 (37.4%) and 86 (27.7%) of the respondents disagreed and were not sure respectively with the statement above. The study results also established that 53 (17.1%) and of the respondents strongly disagreed that budgetary allocation had increased in the last five years. The study sought to evaluate whether budgetary allocations for maternal and child health care are adequate in Narok-North Sub-County, Kenya. The study's findings indicated that, 23 (7.4%) and 14 (4.5%) strongly agreed and agreed respectively that budgetary allocation for maternal and child healthcare is adequate. Furthermore, the findings of the study established that 165 (53.2%) disagreed and 32 (10.3%) strongly disagreed with the above statement. The study's findings also indicated that 76 (24.5%) were not sure whether budgetary allocation for maternal and child healthcare is adequate in the context of the study area.

The study examined whether funds allocated for maternal and child healthcare are used for their intended purpose. The study results revealed that 15 (4.8%) strongly agreed and 24 (7.7%) agreed that funds allocated for maternal and child healthcare are used for the intended purpose. Further 125 (40.3%) disagreed and 20 (6.5%) strongly disagreed while 126 (40.6%) were uncertain. On whether the available financial resources for maternal and child healthcare are utilized efficiently, the study results revealed that 26 (8.4%) and 19 (6.1%) strongly agreed and agreed, respectively. In addition, 134 (43.2%) disagreed, and 27 (8.7%) strongly disagreed with the statement that the available financial resources for maternal and child health care are utilized efficiently, while 104 (33.5%) were not sure, revealing an information gap on the utilization of the funds meant for maternal and child health care. The study indicates significant skepticism about the efficient utilization of financial resources for maternal and child healthcare. This shows potential issues on the information gap and lack of transparency in financial resource management in Narok-North Sub-County, Kenya. The study sought to examine whether the Social Health Insurance Fund (SHIF) adequately covers maternal and child healthcare costs. The study results revealed that 25 (8.1%) strongly agreed and 39 (12.6%) agreed that SHIF adequately covers maternal and child healthcare. Further, the study established that 156 (50.3%) of the respondents disagreed and 36 (11.6%) strongly disagreed respectively. Further analysis revealed that 54 (17.4%) of the respondents were uncertain whether SHIF adequately covers maternal and child health costs in the context of the study area. This indicates widespread doubts about the adequacy of the Social Health Insurance Fund (SHIF) in covering maternal and child healthcare costs, indicating potential gaps in coverage. The overall mean of the indicators measured was 2.57 (42.8%), suggesting a negative perception regarding the extent of financial support in promoting access to maternal and child healthcare in Narok North Sub-County. This indicates that residents view the current financial support as inadequate for improving maternal and child health services in the region.

5.2 Qualitative Findings on Financial Support and Maternal and Child Healthcare

The study sought to examine how financial support has promoted access to maternal and child healthcare in Narok-North Sub-County. This section explored community perceptions and experiences regarding government funding, focusing on the adequacy, timeliness, and management of financial resources. The study established two themes supported by qualitative data collected through interviews with local stakeholders.

5.2.1 Inadequate and Delayed Budgetary Support

Respondents consistently indicated dissatisfaction with the level and timeliness of government financial commitment toward maternal and child healthcare. Key informants expressed that the financial support from the government was inadequate and often delayed. Several interviewees stated that, although there have been official claims about increased funding over recent years, these claims did not reflect their lived realities. Most health facilities in the area were still grappling with shortages of essential medical supplies and services. One health official (HO003), for instance, observed that improvements had not been seen at the facility level and that service delivery appeared to be deteriorating rather than improving. Health official HO003 remarked that;

“.....The reality is that the funding is there on paper, but the timeliness of its disbursement is a serious challenge. The funds often arrive late in the financial cycle, sometimes months after they are supposed to be available. When this happens, we cannot procure essential supplies like drugs, delivery kits, or nutritional supplements on time. We also experience delays in paying contracted staff who provide outreach services in the community. This directly slows down service delivery because activities that require immediate financing stall until the money is released. The other issue is that delayed funds force facilities to operate on credit or postpone planned programs. For instance, we may plan to conduct a maternal health outreach in remote areas during a specific month, but if the money is delayed, we have to push the program forward. By the time the funds come in, the planned timelines have lapsed, and in some cases, the intended impact is lost. So, while the budgetary allocation is captured in the national and county budgets, its effect is not always felt on the ground because the delay disrupts the delivery chain. That is why communities feel like the funding is not translating into real services, even though it is technically allocated.” KI HO003

Another community health promoter labelled as CHP001 observed that;

“.....If there were any increases in the budget or financial support, we honestly haven't seen any difference here in the clinics or the services we provide. The supplies are still lacking, and many times, mothers come to the facility but are turned away because we simply don't have enough resources. It feels like instead of improving, the situation is actually getting worse over time.” KI, CHP001

Furthermore, there information gap between government budgeting and community awareness. AD001, CHP007, CHP004, HO001 and HO007 mentioned that they were unaware of how much funding was allocated or how it was utilized. For instance, AD001 opined that;

“.....there's a big information gap between how the government does its budgeting and what the community knows. Budgets are made every year, but the details don't reach people in a way they can understand. So, the community doesn't know how much money is allocated, which projects are planned, or when they should be done. Without that, they can't really monitor or

question what's happening. If this information was shared clearly and on time, people would have the power to oversight government work. But right now, the lack of information makes it easy for misuse to go unnoticed". KI, AD001

This lack of transparency had reportedly bred confusion and mistrust among residents and the majority of the key informants noted that there is a disconnect between policy-level promises and actual service delivery, highlighting that budget increases, if any, were not accompanied by clear communication.

5.2.2 Mismanagement of Limited Financial Resources

Another recurring concern was the perceived mismanagement or inefficient use of the limited financial resources designated for maternal and child healthcare. AD002, CHP004, HO006 and AD004 emphasized that even when funding was reportedly available, its effects were not visible at the grassroots level in terms of essential supplies and the failure of insurance schemes to cover essential aspects of maternal and child health. Many were unsure whether funds reached local health facilities or were used for the intended purposes. Reports of persistent equipment shortages and continued financial burdens on families were frequently mentioned. A local administrator labelled as AD003, while reflecting on this concern, remarked,

"We hear that money was supposed to have been allocated for maternal and child healthcare, but no one really knows what happened to it. When we ask around, there's no clear explanation or proof of how the funds were spent. It feels like the money just vanishes without reaching the clinics or helping the people who need it most."

KI,AD003

In addition, AD006 and CHP003, and HO007 noted that doubts were raised regarding the effectiveness of the Social Health Insurance Fund (SHIF). The above respondents consistently reported that SHIF did not adequately cover the costs of maternal and child health services, leading to persistent out-of-pocket expenses. For instance, a local administrator labelled AD002 recounted,

"SHIF doesn't cover all the costs involved in maternal and child healthcare. Even though it's supposed to help, many families still end up paying a lot of money out of their own pockets because not everything is included or reimbursed. This makes it really hard for us to access the care we need without struggling financially." KI, AD002

Furthermore, the health official, HO007 noted that;

".....We are struggling because the limited funds we receive are being mismanaged. Instead of channeling the resources directly to maternal and child healthcare services, a significant portion ends up tied in administrative overheads or diverted to unrelated projects. I see health facilities operating without essential supplies, no medicines, no delivery kits, sometimes not even gloves. Our maternity wards cannot function effectively when we are constantly improvising. Staff morale is low because they work under pressure, yet their needs are ignored. When funds are mismanaged, pregnant women have to travel long distances for basic care, and children miss out on vital services like immunization and nutrition support. The truth is, if we used the little money we have more transparently and prioritized maternal and child health, we could save more lives. Mismanagement is not just a financial issue it is costing us mothers and babies."

These statements underscore community frustration over financial inefficiencies and suggest that mismanagement of allocated funds may be a barrier to accessing essential maternal and child healthcare services.

5.3 Discussion of Study Findings

The study assessed the role of financial resources in promoting access to maternal and child healthcare in Narok North Sub-County and with specific focus on the extent of government funding allocations towards maternal health care services in Narok Sub-County, Kenya. The study findings established that due to low budgetary support, maternal and child health care in Narok North Sub County was heavily underperforming. This was further exacerbated by the national government's devolution of health, which complicated healthcare financing in the study area through late disbursements of funds to counties by the national treasury to enable the county governments to provide services at the grassroot level.

These findings on financial support resonate strongly with the enabling factors outlined in Andersen's Behavioral Model of Health Services Use (1995), which emphasizes the importance of personal and community resources such as financial means and funding mechanisms in facilitating access to healthcare. The study underscores how inadequate government funding, coupled with post-devolution delays in fund transfers and a lack of transparency in resource allocation, contributes to the overall underperformance of maternal and child health services. This aligns with Andersen's assertion that enabling factors, including affordability through subsidies, insurance schemes, and timely financial support, are essential for mitigating economic barriers to care. For example, key informants in the study expressed significant dissatisfaction with the untimely financial commitments from the national government to counties, illustrating how deficient enabling resources generate inefficiencies. These include budget misalignments, administrative bottlenecks, and persistent challenges that prevent effective service delivery, as supported by the research of Tsofa et al. (2023). Such issues perpetuate reliance on out-of-pocket payments and additional costs like transportation, which discourage utilization even when health needs such as routine antenatal care or child vaccinations are evident and pressing.

The health care financing process was marred by the inadequacy of funding and transparency from the national government towards maternal healthcare services in counties. The study results corroborated with the findings of Tsofa et al. (2023). They noted that inadequacy in health care financing had introduced challenges in decision-making, often leading to inefficiencies like misalignment between budgets and priority-setting, delays in fund disbursement, and administrative capacity constraints that hinder effective health service delivery. Further, key informants showed dissatisfaction with the level and timeliness of government financial commitment toward maternal and child healthcare. It also established that financial support from the national government to counties to facilitate their devolved functions, including healthcare provision, was inadequate and often delayed. Although there have been claims about increased funding over the years, these claims did not reflect the realities that people were experiencing at the grassroots levels.

Thapa et al. (2021) further noted that persistent challenges, such as resource constraints and geographical barriers, limited full implementation of the maternal and child health care across the world as it was established in the study area. The study underscored the importance of decentralized health planning, inclusivity, and functional support systems in improving MNCH service equity. While the current study focused in assessing the extent to which resource allocation had promoted access to maternal and child healthcare in Narok North Sub-County, the study

agreed with Thapa et.al (2021) that there was poor financial support from Government to support health care financing in the the study area. It was further established that in Narok North sub-county, respondents were of the opinion that there was no correlation between policy-level promises and actual service delivery, hence affecting the overall health framework in the study area. In Narok North Sub-County, respondents repeatedly highlighted that financial support for maternal and child health care remains grossly insufficient, exposing a critical gap in resource allocation that directly compromises service delivery and health outcomes for mothers and children. This inadequacy not only restricts the provision of vital interventions, including antenatal care, skilled birth attendance, and postnatal services, but also fosters widespread skepticism among community members and health stakeholders regarding the efficient and transparent use of allocated funds. Concerns about potential fund leakage, mismanagement, or the prioritization of other sectors over health were commonly raised. These local insights closely parallel and strengthen the findings from Tukay et al. (2021), who evaluated the Direct Health Facility Financing (DHFF) program in Pangani District, Tanzania.

Their analysis revealed similar hurdles, such as inadequate financing, chronic shortages of medical equipment, and unreliable supply chains from the Medical Stores Department, all of which collectively obstructed optimal maternal health service delivery. Nevertheless, Tukay et al., (2021) noted that the DHFF initiative had achieved some positive outcomes by enhancing access and quality through increased facility autonomy and more timely fund disbursements. They emphasized, however, that long-term success hinges on addressing systemic limitations in infrastructure, workforce capacity, and stable financial flows to maximize the program's potential and improve MNCH indicators in comparable resource-limited environments across East Africa. Access to maternal and child health care programme is affected by the perceived mismanagement of the limited financial resources which are designated for maternal and child healthcare. Respondents noted that even when funding was reportedly available, it was not enough to meet the needs of the people at the grassroots level. It was apparent from the respondents that they could not tell whether funds reached local health facilities and used for the intended purposes. Reports of, persistent equipment shortages, and continued financial burdens on families were frequently mentioned. The findings from Narok North Sub-County reveal a deep-seated perception among respondents that access to maternal and child healthcare is severely hampered by the perceived mismanagement of limited financial resources, with doubts about whether allocated funds actually reach local health facilities or are used for their intended purposes, resulting in persistent equipment shortages and ongoing financial burdens on families despite reported funding availability. These concerns align closely with the observations of Tsofa et al. (2023), who examined the political economy of sub-national health sector planning and budgeting in three Kenyan counties (Garissa, Kisumu, and Turkana) under the devolved system. Their study similarly identified systemic inefficiencies, including delays in fund disbursement, misalignment between budgets and priority-setting, and administrative capacity constraints, which collectively undermine effective health service delivery at the local level. Both studies highlight how devolution, while intended to enhance local accountability and responsiveness, has instead introduced complexities that foster perceptions of mismanagement and resource leakage, leading to inadequate service provision and continued reliance on out-of-pocket payments by families.

Additionally, the perceived mismanagement of funds and skepticism toward initiatives like the Social Health Insurance Fund (SHIF) and Linda Mama represent a failure in enabling factors at the organizational level. Reports from respondents about chronic equipment shortages and family financial burdens suggest that without dependable enabling support, predisposing factors such as

low socioeconomic status in rural communities intensify disparities, leading to lower service utilization rates. This is in line with Andersen's (1995) model, which posits that enabling factors mediate the link between predispositions and actual healthcare use, thereby reinforcing the conclusions from Thapa et al., (2021) and Tukay et al., (2021) that resource constraints and geographical barriers in analogous contexts obstruct equity. This dynamic creates a vicious cycle where unmet needs persist due to financial inaccessibility. In summary, these results show that weak enabling factors not only restrict access but also diminish trust, influencing behavioral choices against seeking care. In addition, local administrators raised doubts regarding the effectiveness of the Social Health Insurance Fund (SHIF) in promoting health care service delivery in Narok North Sub-County. They noted that SHIF did not adequately cover the costs of maternal and child health services, leading to persistent out-of-pocket expenses. This further impoverished many families despite the enhanced subscriptions that had been introduced by the Government. This indicated that there is frustration from many inhabitants in the Sub-County over financial inefficiencies, and this was deemed to be a barrier to accessing essential maternal and child healthcare services. Despite government assurances that Linda Mama would continue as a stand-alone initiative under SHIF to safeguard mothers and infants without financial barriers, local administrators report persistent inefficiencies, including limited coverage restricted to indigent families. These challenges in implementation undermine the program's effectiveness, perpetuating economic hurdles to essential healthcare and the very access barriers it was designed to eliminate. The study in Narok North Sub-County on SHIF demonstrated a significant gap compared to the positive projections in Mao et al., (2023), who conducted an extended cost-effectiveness analysis of public financing for essential MNCH interventions in Nigeria. Mao et al., (2023) showed that eliminating out-of-pocket costs for 18 key MNCH services could prevent catastrophic expenditures, save over 1.16 million lives, and offer substantial financial protection, particularly for the poorest households, under uniform or pro-poor scaling scenarios. In contrast, the experiences reported by local administrators in Narok North Sub-County indicate that SHIF does not deliver similar levels of financial safeguarding. The study findings revealed that the lack of sufficient funds stood out as a key challenge that impacted the availability of maternal and child healthcare services in Narok-North Sub-County. CHPs and local administrators lamented how economically straining it is to access these services in Narok North Sub-County. The results suggested that most respondents experienced financial difficulties, which underscores the severity of the situation in the Sub County. Some of the financial difficulties included exorbitant and unavoidable transport costs to health facilities, paying for services or medicine, informal costs such as unofficial consultation fees, transportation costs to the facilities, and the generally low standard of living that curtails allocable funds for healthcare. Basic transport services in rural areas made it impossible for individuals to seek care, especially for routine antenatal visits or vaccination sessions for children in the study area. These findings demonstrate a significant implementation gap between the aspirations of the Kenya Health Policy 2014–2030 and the lived realities of residents in Narok-North Sub-County. While the policy guarantees accessible, affordable, and equitable maternal and child healthcare services, persistent financial constraints, transport barriers, and hidden healthcare costs continue to hinder effective access to care among vulnerable populations. The inquiry found from Narok North Sub-County, highlight insufficient financial support as a primary barrier to maternal and child healthcare access manifesting in high out-of-pocket expenses for services, medicines, informal fees, exorbitant transport costs, and the constraining effects of low household income in rural areas corroborates strongly with the extended cost-effectiveness analysis conducted by Mao et al. (2023) on public financing of

essential maternal, newborn, and child health (MNCH) interventions in Nigeria. Both studies underscore the detrimental role of financial barriers in limiting service utilization, particularly among poorer households, where direct medical costs and indirect costs (such as transportation) exacerbate catastrophic health expenditures and impede timely access to critical interventions like antenatal care and child vaccinations.

6. Conclusions And Recommendations

The study sought to evaluate the impact of financial assistance on utilization of maternal and child healthcare services in Narok–North Sub-County. The study in Narok-North Sub-County, Kenya, concludes that there is inadequate government financing for maternal and child healthcare services attributed to lack of adequate prioritization and accountability by the both the national and county governments. The study concludes that untimely disbursements of funds from the national government further aggravated the situation, limiting the healthcare facilities' ability to offer appropriate care for mothers and children in Narok North Sub-County. The study also concludes that low budgets resulted in insufficient healthcare facilities and a shortage of healthcare professionals, which hindered healthcare service delivery. The lack of adequate funding directly affects the availability and quality of maternal and child healthcare services. Increasing and properly utilizing funds is essential to improve health outcomes in Narok-North Sub-County.

In line with the above conclusions, the study recommends that there is need to increase government funding for maternal and child healthcare in Narok-North Sub-County. The Government needs to prioritize timely disbursements so that facilities can provide consistent services for the inhabitants of the study area. There is need to implement strict accountability measures to reduce mismanagement of allocated funds since more funding will improve the availability of medical supplies and services. The study proposes further study to be done on specific obstacles in the government budgeting process to establish how they can be addressed and provide firsthand suggestions for improving healthcare financing.

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