# INTEGRATING MAASAI CULTURAL BELIEFS AND PRACTICES INTO UNIVERSAL HEALTH CARE IN KAJIADO COUNTY, KENYA

**Alexander Otieno Oketch.**
Institute of Social Transformation, Tangaza University, Kenya.
**Dr. Reginald Nalugala.**
Institute of Social Transformation, Tangaza University, Kenya.
**Dr. Stephen Ouma Akoth.**
Institute of Social Transformation, Tangaza University, Kenya.
**Dr. Shem Mwalwa.**
Institute of Social Transformation, Tangaza University, Kenya.
**Henry Katolo Mbinda.**
Marist international University College, Kenya.

## ABSTRACT

**Background:** The Maasai community in Kajiado County, Kenya, has unique cultural beliefs and practices that influence their healthcare behaviors. Integrating these cultural elements into Universal Health Coverage (UHC) programs is crucial for improving healthcare access and outcomes.

**Objectives:** This study aims to examine Maasai cultural beliefs and practices related to healthcare, with a specific focus on the role of animals, and propose methods to integrate these elements into UHC programs.

**Methods:** The study utilized a descriptive, mixed-methods approach, combining quantitative and qualitative data to understand UHC implementation in the Maasai community. Data were collected through surveys and focus group discussions in Kajiado West, focusing on five key areas: considering animals in UHC, incorporating traditions, culturally sensitive campaigns, integrating traditional healing, and involving Maasai elders.

**Results:** Participants strongly agreed that UHC should include animal health (mean score 4.58) and supported the incorporation of traditional practices (mean score 4.59). Culturally sensitive UHC campaigns received widespread endorsement (mean score 4.70). There was moderate agreement on integrating traditional healing practices (mean score 4.35), while the involvement of Maasai elders in UHC achieved a high consensus (mean score 4.66).

**Conclusions:** The findings underscore the need for culturally inclusive and sensitive UHC policies to enhance community acceptance and effectiveness. Training healthcare providers to respect Maasai cultural practices and involving Maasai elders are key strategies for building trust and improving healthcare outcomes. This approach aligns with Universal Health Care goals and Sustainable Development Goal 3, promoting equitable healthcare access.

**Keywords:** Universal Health Care (UHC), Maasai cultural beliefs, Traditional medicine, Decentralized healthcare, Cultural sensitivity, Healthcare integration

## INTRODUCTION

Universal Health Care (UHC) represents a fundamental global aspiration to ensure that every individual, irrespective of income or social status, can access high-quality healthcare services without facing financial hardship. This vision, which aims to improve health outcomes, eradicate poverty, and stimulate economic growth, resonates globally and is integral to achieving Sustainable Development Goal 3 – "Ensure healthy lives and promote well-being for all at all ages" (World Health Organization [WHO], 2020). UHC stands as a linchpin in transforming this goal from abstract ambition to tangible reality (Reich et al., 2016).

The pursuit of UHC has gained momentum globally, with a growing recognition of decentralized governance as a critical component in its implementation. The WHO underscores that decentralization can enhance health service care and quality, particularly by making health systems more responsive to local needs (WHO, 2019). Similarly, institutions such as the World Bank, UNDP, and UNAIDS emphasize the benefits of decentralized governance, including increased accountability, responsiveness, and improved access to health services, especially in low- and middle-income countries (World Bank, 2017; UNDP, 2018; UNAIDS, 2019).

In the context of decentralized healthcare systems, evidence from countries like the United States, Canada, Brazil, Germany, and Spain reveals a complex picture. Decentralization often leads to improved healthcare access and efficiency but can also result in disparities in resource distribution and health outcomes (Atun et al., 2015). Studies from these countries highlight both successes and challenges, offering valuable insights for other nations pursuing similar reforms (Saltman, Bankauskaite, & Vrangbæk, 2007).

The United States presents a unique case of decentralized healthcare with its combination of federal, state, and local systems. The Affordable Care Act (ACA) of 2010 was a significant step towards UHC, aiming to reduce the number of uninsured Americans and improve healthcare quality (Obama, 2016). States were given the autonomy to expand Medicaid, resulting in varying levels of healthcare access across the country. For example, states like California and New York, which expanded Medicaid, saw significant reductions in uninsured rates and improvements in healthcare outcomes (Sommers et al., 2014). However, states that opted out of expansion, such as Texas and Florida, continue to face high uninsured rates and disparities in healthcare access (Guth et al., 2019).

Canada's healthcare system is characterized by a single-payer model with provincial and territorial management. Each province administers its healthcare services, leading to slight

variations in care and access. The decentralization allows for tailored healthcare solutions that meet local needs. For instance, British Columbia has implemented innovative community health programs targeting indigenous populations, addressing specific health disparities (Lavoie, 2018). However, issues such as long wait times for specialist care and varying drug coverage across provinces highlight the challenges within Canada's decentralized system (Barua & Moir, 2019).

Germany operates a decentralized healthcare system funded by statutory health insurance (SHI) and private insurance. The SHI system, managed by over 100 non-profit sickness funds, ensures broad coverage and high-quality care. Decentralization allows for regional adaptation and efficiency (Busse & Blümel, 2014). For example, Bavaria has implemented successful public health initiatives addressing regional health concerns such as cardiovascular diseases and diabetes (OECD, 2019). However, the system faces challenges like rising healthcare costs and integration of care, particularly between inpatient and outpatient services.

In Africa, the need for UHC is particularly pressing due to significant health disparities and limited access to healthcare. The African Union and various development organizations have prioritized UHC as key to enhancing health and socio-economic development (African Union, 2019). However, decentralized healthcare systems in African countries, such as Ghana and South Africa, have shown mixed results. Ghana's National Health Insurance Scheme (NHIS) has improved access to healthcare, particularly in rural areas, but faces sustainability issues and challenges in covering the informal sector (Akazili et al., 2014). South Africa's district health system aims to improve primary health care delivery, yet disparities in resource allocation and quality of care persist, particularly between urban and rural districts (Coovadia et al., 2009).

Kenya's experience with UHC is a testament to both the potential and the hurdles of implementing such a system in a diverse and culturally rich context. The country's devolved system of governance, which includes 47 county governments, aims to enhance healthcare delivery by bringing services closer to communities. Devolution has led to improvements in healthcare infrastructure and increased healthcare utilization in some counties (Tsofa et al., 2017). However, challenges such as unequal resource distribution and gaps in service provision persist. Counties with better financial and administrative capacity, like Nairobi and Mombasa, have made significant strides, while others lag behind (Barasa, Cleary, & Molyneux, 2017).

A particularly compelling case is Kajiado County, where the Maasai community's unique cultural beliefs and practices pose specific challenges and opportunities for UHC implementation. The Maasai's deep-seated values related to health, both human and

animal, influence their healthcare perceptions and practices (Mbae, 2019). The innovative "Mbuzi Moja - Afya Bora" initiative, where residents exchange goats for comprehensive annual medical care, exemplifies a culturally sensitive approach to integrating Maasai values into the healthcare system (Waweru et al., 2021). Despite such innovative programs, challenges remain in addressing issues such as unequal resource distribution, cultural barriers to accessing healthcare, and gaps in service provision (Kilonzo et al., 2017).

This study aims to bridge the gap between UHC and Maasai cultural practices in Kajiado County by exploring how decentralized governance can be leveraged to enhance healthcare delivery in culturally meaningful ways. By examining the effectiveness of county-based governance and the impact of culturally tailored health programs, this research seeks to contribute to a more inclusive and equitable healthcare model. It emphasizes the need for a shift from a state-centered to a people-centered approach, one that fully incorporates rural and cultural contexts into UHC strategies (Koon, Rao, & Tran, 2018).

Ultimately, this study endeavors to align the principles of Universal Health Care with the diverse cultural beliefs and practices of the Maasai and other communities in Kajiado County, fostering a healthcare system that is both universal and culturally attuned.

## LITERATURE REVIEW

The Maasai community in Kajiado County has a unique culture and traditional beliefs related to healthcare, including the use of traditional medicine and the role of animals in healing. According to Matiru et al. (2019), the Maasai community in Kenya values traditional medicine and incorporates it into their healthcare practices. The study also found that the Maasai community considers animals, particularly cows, to be an important source of food and medicine. Kikwai et al. (2020) emphasized the importance of incorporating the cultural beliefs and practices of the Maasai community into Universal Health Care (UHC).

The study proposed the use of community health workers who are trained in traditional medicine and understand the cultural beliefs of the Maasai community.

The Maasai community has a strong cultural attachment to their animals, which are central to their livelihoods and used in many cultural practices and rituals. Shigoli et al. (2020) noted that the Maasai community places a strong emphasis on traditional medicine and healing practices, which may lead to a lack of trust in Western medicine. The Maasai community believes that traditional medicine is more effective in treating and preventing diseases and that it is a crucial aspect of their cultural heritage. Therefore, they are more likely to seek traditional medicine first before seeking Western medical care.

The Maasai community's relationship with their animals goes beyond their economic importance. They believe that their animals are gifts from God and that they are a symbol of wealth and prestige. Furthermore, the Maasai community's health and well-being are closely linked to the health of their animals. According to Koech (2019), animals are not just a source of food and income for the Maasai community, but they are also used in traditional healing practices. The Maasai community believes that animals have healing properties and that their welfare is essential to the health and well-being of the community.

For instance, cow urine and dung are used to treat various illnesses, and the Maasai community also practices bloodletting, a traditional healing practice that involves cutting the jugular vein of a cow and drinking its blood. These practices reflect the close relationship between the Maasai community's health and the welfare of their animals.

The World Health Organization (WHO) definition of UHC emphasizes access to quality health services without experiencing financial hardship. However, this definition does not take into account the Maasai community's belief in the welfare of both humans and animals. Therefore, there is a need to tailor the concept of UHC to align with their cultural beliefs and values. Odhiambo (2018) argued that this can be achieved by integrating traditional medicine into the healthcare system and involving traditional healers in healthcare delivery. This approach not only improved the Maasai community's access to healthcare but also helped to build trust and bridge the gap between Western medicine and traditional medicine. Additionally, it is crucial to involve the Maasai community in the development and implementation of healthcare policies and programs to ensure that they align with their cultural beliefs and values.

Njoroge et al. (2019) explored the perceptions of Maasai community members towards modern healthcare services and traditional healing practices. The study found that many Maasai community members preferred traditional healing practices due to cultural beliefs and the perceived effectiveness of these practices. However, the study also revealed that access to modern healthcare services was limited in many areas, leading to a reliance on traditional healing practices. Ngugi et al. (2019) examined the role of animals in Maasai culture and its implications for healthcare utilization. The study found that animals, particularly livestock, played a significant role in Maasai culture and were often used as a form of currency and status symbol. The study also revealed that animals were often used in traditional healing practices and that the perceived value of animals could act as a barrier to seeking modern healthcare services. Nkatha et al. (2020) explored the impact of cultural beliefs and practices on maternal and child health outcomes among the Maasai community in Kajiado County. The study found that cultural beliefs and practices, including the use of traditional birth attendants and delays in seeking healthcare services, were major contributors to poor maternal and child health outcomes among the Maasai community.

Overall, these studies suggest that cultural beliefs and practices play a significant role in healthcare utilization among Maasai communities and highlight the need for culturally sensitive approaches to UHC implementation.

## The Conviviality Theory

Conviviality theory, as developed by Ivan Illich, emphasizes the significance of individual autonomy, self-reliance, and meaningful social relationships in fostering a just and sustainable society (Illich, 1973). According to Illich, conviviality refers to a society where individuals have the freedom and capacity to live and interact with others in ways that are meaningful, respectful, and harmonious.

In this case, the application of Conviviality theory was observed in the evaluation of county-based governance's effectiveness in implementing UHC in Kajiado County, Kenya, with a focus on the Maasai community. The case underscores the Maasai community's unique relationship with their animals and their belief in the interconnectedness of human and animal health (John et al., 2020). However, the existing UHC framework fails to account for these cultural and social factors, rendering it inadequate in meeting the healthcare needs of the Maasai community.

Conviviality theory suggests that governance systems should respect and incorporate the cultural values and practices of different communities (Illich, 1973). In the context of UHC implementation, this would involve actively involving the Maasai community in decision-making processes, understanding their healthcare needs and preferences, and tailoring healthcare services to accommodate their unique cultural practices. Applying Conviviality theory to this case, an assessment of county-based governance effectiveness would entail examining the extent to which the governance system promotes convivial relationships between the government, healthcare providers, and the Maasai community (Smith et al., 2018). Key factors to consider include the participation and empowerment of the Maasai community in decision-making processes, cultural sensitivity in healthcare service design and delivery, equitable access and affordability of healthcare services, the quality and effectiveness of healthcare provision, and collaboration and partnerships among stakeholders (John et al., 2020).

In the book "Frontier Africa and the Currency of Conviviality" by Francis B. Nyamnjoh, conviviality is explored as a valuable social currency in African communities (Nyamnjoh, 2017). It refers to the ways in which people interact, connect, and build relationships, emphasizing mutual respect, harmony, and inclusivity. Nyamnjoh also discusses conviviality as a response to diversity, highlighting African societies' ability to navigate diverse ethnic, cultural, and linguistic groups through practices of tolerance, understanding, and empathy. Additionally, conviviality is seen as a means of social cohesion, promoting

solidarity and community bonds. Nyamnjoh's work also analyzes exclusionary practices that undermine conviviality, calling for the reevaluation of social norms and systems to promote inclusivity and equality. Lastly, conviviality is portrayed as a source of resilience and agency for African communities, enabling them to navigate challenges and assert agency in the face of adversity (Nyamnjoh, 2017).

Studies have highlighted the importance of engaging indigenous communities, recognizing their traditional knowledge and practices, and incorporating them into healthcare systems (Jones et al., 2019; Adams et al., 2021). By combining Conviviality theory with indigenous approaches, healthcare systems can become more culturally sensitive, inclusive, and responsive to the needs of indigenous communities (Smith et al., 2018; Johnson et al., 2022).

The Maasai community in Kajiado County has unique cultural beliefs and practices that significantly influence their healthcare utilization. Traditional medicine and the role of animals in healing are central to their healthcare practices, and these cultural factors must be considered in the implementation of UHC. Conviviality theory provides a useful framework for understanding the importance of incorporating cultural values into healthcare systems. By integrating traditional medicine, addressing barriers to healthcare access, and promoting culturally sensitive healthcare practices, UHC implementation can be improved, leading to better health outcomes for the Maasai community.

## RESEARCH GAP

Despite the recognition of the Maasai community's unique cultural beliefs and traditional practices in healthcare, there remains a substantial gap in effectively integrating these elements into the Universal Health Care (UHC) framework in Kajiado County, Kenya. While studies acknowledge the importance of traditional medicine and the role of animals in Maasai health practices (Matiru et al., 2019; Kikwai et al., 2020), there is limited research on practical strategies for their incorporation into modern healthcare systems to improve health outcomes. Additionally, the current UHC framework does not adequately address the interconnectedness of human and animal health as perceived by the Maasai, nor does it build sufficient trust between the community and Western healthcare providers (Shigoli et al., 2020; Koech, 2019). Empirical evidence on the effectiveness of involving traditional healers and community health workers trained in both traditional and modern medicine is lacking (Odhiambo, 2018). Furthermore, there is a need to explore barriers to healthcare access due to cultural practices and how these can be mitigated to enhance UHC delivery. Applying Conviviality Theory to evaluate governance systems' effectiveness in promoting culturally sensitive healthcare delivery remains underexplored. Addressing these gaps is crucial for developing an inclusive UHC model that respects and integrates

Maasai cultural beliefs, thereby improving healthcare access and outcomes in Kajiado County.

## RESEARCH METHODOLOGY

### Research Design and Philosophy

This study adopted a descriptive, mixed-methods approach, integrating both quantitative and qualitative data to provide a comprehensive understanding of Universal Health Care (UHC) implementation in the Maasai community. As Creswell and Plano Clark (2018) assert, a convergence design is effective in combining numerical data with contextual insights, capturing a holistic view of the UHC challenges and opportunities in this setting. The research was guided by pragmatism, a philosophical approach articulated by John Dewey (1938), which emphasizes practical consequences and real-world applications. This philosophical approach ensured that the findings would be actionable and relevant to the Maasai community. Pragmatism supports iterative engagement and adaptation, aligning with best practices in participatory research, as opined by Creswell and Plano Clark (2018) and Tashakkori and Teddlie (2010).

### Location of the Study

The study was conducted in Kajiado County, situated in the Rift Valley region of Kenya, which has a population of approximately 1.2 million people, according to the Kenya National Bureau of Statistics (2020). Despite having 26 health facilities and 874 health workers, the county faces significant challenges, including inadequate funding, staffing shortages, and infrastructural deficits, as alluded by Kaimenyi et al. (2021) and Okiro et al. (2021).

### Target Population

The target population consisted of Maasai residents in the Magadi and Oloondokilani wards of Kajiado-West Sub-County. These wards were selected for their high concentration of Maasai residents and their diverse geographical and socio-economic characteristics, thereby providing a representative sample of the broader Maasai community, as highlighted by Ng'ang'a et al. (2022).

### Sampling Design

### Sampling Technique

Purposive sampling was employed to identify key informants with in-depth knowledge of the healthcare system and Maasai cultural beliefs, aligning with qualitative research standards, as indicated by Palinkas et al. (2015). Conversely, simple random sampling was used for the quantitative component to ensure representativeness and reduce sampling bias,

according to Fink (2017). The sample size for qualitative data was determined based on data saturation, ensuring comprehensive coverage of the thematic areas, as suggested by Guest et al. (2020). For quantitative data, Cochran's formula was applied to calculate an appropriate sample size.

## Sample Size

Quantitative surveys targeted a sample size of approximately 384 individuals, as calculated using Cochran's formula (Cochran, 1977). Focus group discussions were conducted with 6-12 participants per group, and qualitative interviews included 10-15 participants per category, ensuring depth and diversity of perspectives, as proposed by Morgan (1997).

## Pretesting of Study Instruments

Instruments, including the survey questionnaire, interview guide, and other data collection tools, were pilot-tested to ensure validity and reliability. Feedback from the pilot phase informed adjustments to enhance the accuracy and consistency of the tools, aligning with standard practices in instrument development, as described by DeVellis (2016) and Streiner et al. (2015).

## Data Collection Procedure

A mixed-methods approach was utilized, incorporating ethnographic and phenomenological methods for qualitative data and structured questionnaires for quantitative data. Data collection involved in-depth interviews, focus group discussions, observations, and document analysis. Quantitative data were collected through surveys and subjected to statistical analysis to derive meaningful insights, as outlined by Creswell (2014) and Neuman (2014).

## Data Analysis

Qualitative data were analyzed using thematic analysis facilitated by NVivo software, allowing for the systematic identification of patterns and themes, as explained by Braun and Clarke (2006). Additionally, quantitative data were analyzed using descriptive and inferential statistics with SPSS software, thereby providing statistical rigor and enabling robust conclusions, as noted by Pallant (2020). The integration of both data types facilitated a comprehensive understanding of UHC implementation challenges and opportunities in Kajiado County.

## RESULTS OF THE FINDINGS

This section delves into the descriptive statistics and explores perceptions surrounding the integration of Maasai cultural beliefs and practices into the Universal Health Care (UHC) program in Kajiado West. The analysis covers five key areas: considering animals in UHC,

incorporating traditions, culturally sensitive campaigns, integrating traditional healing, and involving Maasai elders.

*Table 1: Integration of Maasai Belief*

**Descriptive Statistics**

| | | Statistic | Std. Error | Bootstrap[a] | | | |
|---|---|---|---|---|---|---|---|
| | | | | Bias | Std. Error | 95% Confidence Interval | |
| | | | | | | Lower | Upper |
| | N | 384 | | 0 | 0 | 384 | 384 |
| | Minimum | 2.00 | | | | | |
| | Maximum | 5.00 | | | | | |
| Should UHC consider Animals | Mean | 4.5755 | | .0020 | .0340 | 4.5078 | 4.6458 |
| | Std. Deviation | .68518 | | -.00316 | .02807 | .62315 | .73640 |
| | Skewness | -1.376 | .125 | -.005 | .126 | -1.647 | -1.160 |
| | Kurtosis | .680 | .248 | .029 | .457 | -.058 | 1.702 |
| | N | 384 | | 0 | 0 | 384 | 384 |
| | Minimum | 2.00 | | | | | |
| | Maximum | 5.00 | | | | | |
| Important in incorporate Maasai traditional | Mean | 4.5937 | | -.0004 | .0335 | 4.5261 | 4.6589 |
| | Std. Deviation | .67909 | | -.00090 | .03194 | .61582 | .74212 |
| | Skewness | -1.550 | .125 | .005 | .140 | -1.844 | -1.279 |
| | Kurtosis | 1.541 | .248 | -.018 | .603 | .429 | 2.855 |
| | N | 384 | | 0 | 0 | 384 | 384 |
| | Minimum | 2.00 | | | | | |
| | Maximum | 5.00 | | | | | |
| Culturally sensitive UHC campaigns | Mean | 4.6953 | | -.0009 | .0298 | 4.6328 | 4.7526 |
| | Std. Deviation | .56751 | | -.00138 | .03664 | .49659 | .63901 |
| | Skewness | -1.973 | .125 | .025 | .213 | -2.365 | -1.500 |
| | Kurtosis | 4.124 | .248 | -.153 | 1.182 | 1.654 | 6.268 |
| | N | 384 | | 0 | 0 | 384 | 384 |
| | Minimum | 2.00 | | | | | |
| | Maximum | 5.00 | | | | | |
| Integration of Maasai healing in UHC programs | Mean | 4.3542 | | .0007 | .0364 | 4.2813 | 4.4271 |
| | Std. Deviation | .75069 | | -.00195 | .02624 | .69824 | .80116 |
| | Skewness | -.871 | .125 | .007 | .102 | -1.059 | -.662 |
| | Kurtosis | -.064 | .248 | -.020 | .299 | -.620 | .551 |
| | N | 384 | | 0 | 0 | 384 | 384 |
| | Minimum | 1.00 | | | | | |
| | Maximum | 5.00 | | | | | |
| Involvement Maasai elders UHC success | Mean | 4.6589 | | .0004 | .0315 | 4.5990 | 4.7188 |
| | Std. Deviation | .61383 | | -.00216 | .03958 | .53632 | .69609 |
| | Skewness | -1.953 | .125 | .032 | .289 | -2.520 | -1.416 |
| | Kurtosis | 4.453 | .248 | -.295 | 2.057 | 1.026 | 8.548 |
| Valid N (listwise) | N | 384 | | 0 | 0 | 384 | 384 |

## Considering Animals in UHC

The mean score of 4.58 on the statement regarding the inclusion of animal health in UHC indicates a strong consensus among participants that UHC should account for the connection between human and animal health. This score reflects a robust agreement that aligns with the Maasai belief system, which places significant emphasis on the interdependence of human and animal health within their cultural framework. The

relatively low standard deviation of 0.69 suggests that most participants share a similar viewpoint, with minor differences in the strength of their agreement. The negative skewness of -1.38 indicates that a significant number of respondents expressed even stronger support, reinforcing the cultural value placed on the interconnection between human and animal well-being. For the Maasai, livestock such as cattle, goats, and sheep are not only vital for their livelihoods but also hold deep cultural and spiritual significance. Therefore, the health of these animals directly impacts the health and well-being of the Maasai people, making it crucial for health systems to consider this interrelationship.

### Importance of Incorporating Traditions

The mean score of 4.59 on the importance of incorporating traditional Maasai practices into UHC signifies a robust consensus among participants that these practices should be integrated into the healthcare framework. This high mean score reflects a strong agreement with the notion that traditional Maasai practices play a crucial role in shaping effective and culturally sensitive healthcare policies. The low standard deviation of 0.68 indicates that while there is general consensus, there is some individual variation in opinions. The tight distribution of responses around the mean score highlights a cohesive stance within the community, indicating widespread recognition and support for the integration of traditional Maasai practices into UHC. This consensus underscores the value placed on maintaining cultural traditions within modern healthcare systems.

### Culturally Sensitive Campaigns

The mean score of 4.70 on the need for culturally sensitive UHC campaigns reflects a strong consensus among participants that such campaigns are crucial. This high score indicates firm support for integrating cultural sensitivity into UHC initiatives, recognizing the importance of aligning healthcare campaigns with the cultural values, beliefs, and practices of the communities they serve. The low standard deviation of 0.57 suggests that responses are closely clustered around the average score, reflecting a high level of agreement among participants. The negative skewness of -1.97 indicates that many respondents placed even stronger emphasis on cultural sensitivity, highlighting that for some individuals, this aspect is of exceptional importance. This finding underscores the need for UHC campaigns to be deeply rooted in the cultural context of the Maasai to ensure effectiveness and acceptance.

### Integrating Traditional Healing

The mean score of 4.35 suggests moderate agreement on integrating traditional Maasai healing practices into UHC programs. The higher standard deviation of 0.75 highlights a wider range of individual opinions, indicating that while there is general agreement, there exists notable variability within the community. This variability reflects the complexity of incorporating traditional healing practices into modern healthcare frameworks. Some

individuals may strongly support this integration, while others may express more skepticism or reservation. Addressing these differing viewpoints is essential in formulating inclusive and culturally appropriate UHC policies and interventions.

## Maasai Elders' Involvement

The mean score of 4.66 on the importance of involving Maasai elders in the success of UHC highlights a strong consensus among participants. This high mean score indicates broad agreement that Maasai elders play a crucial role in the effective implementation and success of UHC initiatives. The standard deviation of 0.61 indicates some variability in perspectives, suggesting differing views on the specific nature of their involvement. While there is strong consensus on the critical role of elders, the variability points to differing opinions on the extent of their involvement. Some respondents may advocate for a more prominent role for elders in decision-making processes, while others might see their involvement as more supportive or advisory. The overwhelming agreement on the importance of involving Maasai elders emphasizes the need for incorporating their insights into UHC policies and strategies, ensuring that healthcare programs are aligned with Maasai cultural values and traditions.

## Interpretation of Findings

The findings underscore the importance of integrating Maasai cultural beliefs and practices into UHC programs. High levels of agreement on the need to consider animal health, incorporate traditional practices, and conduct culturally sensitive campaigns reflect the community's strong cultural values. The variability in opinions regarding traditional healing and elders' involvement indicates the need for nuanced and inclusive approaches in UHC policy development. By addressing these cultural factors and involving key community figures, UHC initiatives can be better aligned with Maasai values, enhancing their effectiveness and acceptance within the community.

## Discussion

The integration of Maasai cultural beliefs and practices into Universal Health Care (UHC) models represents a crucial yet underexplored dimension in healthcare delivery. While there is limited research on integrating traditional healers and medicine into UHC frameworks, emerging evidence highlights the importance of incorporating cultural practices to improve the effectiveness and acceptance of healthcare services within the Maasai community. This section examines culturally sensitive communication, community collaboration, mobile solutions, and pastoralist UHC models.

Effective communication is a cornerstone of successful UHC implementation, particularly in culturally diverse settings such as the Maasai community. The research emphasizes the need for culturally competent healthcare providers who understand Maasai customs and

speak Maa to improve patient engagement and adherence to healthcare services. According to Betancourt et al. (2003), cultural competence in healthcare providers can significantly improve patient satisfaction and health outcomes.

Cultural competence involves understanding patients' cultural beliefs and practices that influence their healthcare-seeking behavior. Shaw et al. (2019) stress the importance of cultural competence in enhancing patient experiences and outcomes. Culturally competent care not only respects patients' cultural needs but also builds trust, essential for effective patient-provider interactions (Dole et al., 2017). In addition, Beach et al. (2005) highlight that cultural competence training for healthcare providers can reduce racial and ethnic health disparities.

In the Maasai context, integrating traditional healing practices with modern medicine can create a more holistic healthcare approach. Traditional healers, who are trusted by the community, often serve as the initial point of contact for health issues. Collaborating with these healers can improve health outcomes by combining traditional practices with modern interventions (Ezeh et al., 2019). Additionally, a study by Helman (2007) indicates that the inclusion of traditional practices in healthcare can enhance the cultural relevance and acceptance of health interventions.

Training healthcare providers to understand Maasai cultural practices and traditional remedies is crucial. This training should enable providers to respect traditional beliefs while advocating for modern medical care, fostering trust and improving patient adherence to UHC services (Shaw et al., 2019). According to Campinha-Bacote (2002), cultural competence training should be ongoing and integrated into all levels of healthcare education and practice.

Focus group discussions reveal a strong willingness among Maasai community members to collaborate with healthcare providers in developing culturally relevant UHC programs. This finding aligns with research on successful healthcare interventions involving community participation, which enhances trust, ownership, and program effectiveness (Wallerstein et al., 2019). Moreover, a study by Minkler and Wallerstein (2008) supports the idea that community-based participatory research can lead to more effective and sustainable health interventions.

Mobile clinics are effective in improving healthcare access for rural and isolated communities. Research shows that mobile clinics successfully bridge gaps in healthcare delivery, especially in areas with limited infrastructure (Lasho et al., 2018). For the Maasai, mobile clinics can overcome geographical barriers posed by rugged terrain and scattered settlements. According to a study by Sacks et al. (2013), mobile health clinics can

significantly reduce barriers to healthcare access and improve health outcomes in underserved populations.

Integrating telemedicine with mobile clinics can enhance their impact by providing remote consultations and follow-up care. Telemedicine extends healthcare services by facilitating specialist consultations and ongoing patient monitoring (Smith et al., 2020). This combination ensures comprehensive care even in geographically constrained areas. A study by Kruse et al. (2018) highlights the potential of telemedicine to improve access to care, particularly in remote and rural settings.

Cultural sensitivity is crucial for mobile clinics. Ensuring that mobile clinics are staffed by culturally competent providers who understand Maasai customs and speak Maa can improve community acceptance and utilization of services (Smith et al., 2020). According to McElmurry et al. (2009), culturally tailored healthcare services can significantly enhance patient satisfaction and adherence to treatment plans.

## Pastoralist UHC Models

Exploring UHC models that leverage livestock as a contribution to health insurance premiums offers a novel approach to addressing affordability and cultural sensitivities. Community-based health insurance schemes have shown promise in improving healthcare access and affordability in rural communities (Ng'ombe et al., 2014). According to Msuya et al. (2004), community-based health insurance can effectively increase healthcare utilization and reduce financial barriers to care.

Incorporating livestock into UHC models aligns with its cultural significance for the Maasai. Livestock serves as a primary economic asset and integrating it into UHC models could enhance community acceptance and financial sustainability. However, implementing such models requires careful consideration of feasibility, ethical implications, and community involvement. A study by Chikanda et al. (2018) suggests that community involvement in the design and implementation of health insurance schemes is critical for their success.

Community participation is essential to ensure that the UHC model respects Maasai cultural values and decision-making processes. Transparency in financial management and safeguards to protect vulnerable populations are crucial for maintaining trust and addressing ethical concerns (Agyepong et al., 2018; Owino, 2019). According to Jacobs et al. (2008), transparent and accountable management of community-based health insurance schemes is vital for their sustainability and acceptance.

## LIMITATIONS

The study is limited based on the context. In the current study the focus was on a pastoralism community which is characterized by movement with the livestock from one region to another in search for pastures hence there is a possibility that the members in the sample who had better information might not have been captured by the researcher.

## RECOMMENDATIONS

To enhance the integration of Maasai cultural beliefs and practices into the UHC program in Kajiado West, several key recommendations are essential

i. **Recognition of Human-Animal Health Interdependence**: UHC policies should acknowledge the Maasai's cultural and economic reliance on livestock. This includes integrating traditional Maasai healthcare practices into UHC and training healthcare providers to understand and respect these practices, fostering trust and cooperation.

ii. **Culturally Sensitive UHC Campaigns**: Developing campaigns that align healthcare initiatives with Maasai values is crucial. Involving Maasai elders in healthcare decision-making will ensure that UHC programs are culturally relevant and widely accepted. This collaborative approach will improve healthcare outcomes and strengthen community engagement and trust in the UHC program.

## FUTURE RESEARCH

Future research should focus on

i. **Empirical Studies**: Assessing the effectiveness of integrating traditional medicine into UHC, including the role of traditional healers in healthcare delivery, to provide valuable insights for policy development.

ii. **Longitudinal Studies**: Examining the long-term impact of interventions like culturally sensitive programs and mobile clinics on healthcare access and outcomes.

iii. **Expanding the One Health Approach**: Applying this approach to other marginalized communities to offer comparative insights. Studying communities with similar characteristics can help identify best practices and adaptations, aiming to develop culturally sensitive healthcare models that ensure equitable access for diverse populations worldwide.

## CONCLUSION

Integrating Maasai cultural beliefs and practices into UHC programs can significantly improve healthcare access and outcomes for the Maasai community. Recognizing the interdependence of human and animal health and incorporating traditional Maasai healthcare practices are essential steps. Training healthcare providers to understand and

respect these practices fosters trust and cooperation, while culturally sensitive UHC campaigns ensure alignment with Maasai values.

This study underscores the importance of considering cultural factors and involving key community figures, such as Maasai elders, in healthcare decision-making. This approach enhances the acceptance and effectiveness of UHC initiatives and ensures that healthcare systems are inclusive and culturally sensitive. By respecting and integrating Maasai cultural practices, healthcare systems can achieve better health outcomes and greater community trust.

Overall, this approach contributes to the broader goal of equitable healthcare access for diverse populations, aligning with the vision of Universal Health Care. Ensuring that healthcare systems are culturally attuned and responsive to local needs is crucial for achieving Sustainable Development Goal 3 and improving health outcomes worldwide.

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