THE CATHOLIC CHURCH'S EFFICACY IN ALLEVIATING NORMATIVE CHALLENGES IN HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

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A thesis submitted in partial fulfillment for the award of Master of Arts Degree in Religion at Masinde Muliro University of Science and Technology

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DECLARATION

This thesis is my original work with no attempts to obtain any other degree, honor, or professional certification.

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance of MasindeMuliro University of Science and Technology a thesis titled '*The Catholic Church's Efficacy in Alleviating Normative Challenges in Healthcare Provision in the Catholic Diocese of Kericho.'*

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DEDICATION

This thesis is dedicated to the Sigei's: Joseph, Ann, Dr. Fancy, Nancy, Liner, Vincent and Davis. To my lovely nephews: Ethan and Adrian. Their moral and financial support throughout the study period was immeasurable.

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ABSTRACT

A comprehensive goal of the United Nations' Sustainable Development Goals of 2015 was to ensure healthy lives and promote wellbeing for all ages. The divide between the haves and the have-nots is, however, rapidly expanding as the global society changes, notably in terms of access to healthcare services. In addition, the Catholic Church as a social institution has a social and moral obligation to participate in the provision of healthcare. The main problem of this study therefore, was to examine whether the catholic church's teachings and obligation on healthcare have an impact on its provision of healthcare in the Catholic Diocese of Kericho. The specific objectives that guided the study were: First, to evaluate healthcare provision as a contemporary phenomenon and explore the normative challenges related to it in general. Second, to examine the Catholic Church's position on healthcare provision in general. Third, to examine the success of the catholic church in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho. The liberation theology theory, which relies on the synthesis of Christian teachings and socioeconomic analysis that promotes social concern for the poor and freedom for the oppressed people served as the study's interpretational lens. In so doing, the theory guided this study in exploring the relationships between Catholic church Christian positions with particular regard to economic justice, poverty and healthcare provision human rights. Additionally, the research design used in the study was descriptive. The respondents for the study were chosen using simple, purposive, and snowballing samplings. In this study, both primary and secondary data were used. While secondary data was gathered by conducting a critical study of pertinent secondary sources such as books, journals, and magazines, primary data was gathered via questionnaires, interview schedules and focus group discussions. Utilizing frequency distribution tables and percentages, the quantitative data was presented in a descriptive manner with the goal of illuminating the study's response pattern. Qualitative data collected was analyzed thematically by describing the findings of each objective. Ethical considerations such as seeking permission from relevant authorities, maintenance of utmost confidentiality and seeking respondents' consent were built to safeguard the respondents. From the study, it was clear that Catholic Church teachings and obligation has great influence in healthcare provision. However, findings in support of the study revealed that challenges bound to socio-economic attributes are still witnessed in the accessibility and the practice was bound to affordability, healthcare technology divide and geographical location among others. In this way, it could be argued that the catholic church has not been adequately effective in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho. The study therefore recommends the Catholic Church to have a dialogic posture with the world from perspective of the poor if indeed it must play a bigger role in redefining human dignity, defending human dignity and liberating people from oppression of human values related challenges in healthcare provision in a more functional way.

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ACRONYMS AND ABBREVIATIONS

AIDS- Acquired Immunodeficiency Syndrome

CDK- Catholic Diocese of Kericho

FBOs- Faith Based Organizations

FGD- Focus Group Discussion

HIV- Human Immunodeficiency Virus

LMICs- Low and Middle-Income Countries

MOH- Ministry of Health

NHIF-National Health Insurance Fund

OOP- Out of Pocket

PHC- Primary Health care

REACH- Regional East African Community Health policy

TB- Tuberculosis

UHC-Universal Health Care

WHO- World Health Organization

DEFINITION AND OPERATIONALIZATION OF KEY TERMS

Catholic Church- refers to the visible community of Catholic faithful who practice the same faith and are governed by the visible head, the Pope, and the bishops, as well as the invisible head, Jesus Christ. In this research, it refers to an organization that routinely spreads religious doctrine based on the Bible through its projects, programs, and lectures, such as through the delivery of healthcare.

The Catholic Diocese of Kericho- refers to the group of churches that a bishop supervises. In this study, it refers to all the residents within the religious jurisdiction supervised by the Catholic bishop of the Catholic Diocese of Kericho. That is, Kericho and Bomet counties of Kenya

Efficacy- the ability to produce a desired and intended result. In this study, it refers to the ability of the Catholic Church healthcare provision to produce the result that is wanted by the Catholic Church and that looks at healthcare provision as a basic human right.

Effectiveness- the degree to which something is successful in producing a desired result. In this study, it encompasses the degree to which Catholic church healthcare facilities offer healthcare provision desired and advocated for by the Catholic Church.

Healthcare provision- encompasses actions of providing, giving healthcare service, the furnishing of medical, nursing, hospital service, optometric service, complementary healthcare service and other healthcare related services aimed at improving one's health (WHO, 1948)

Healthcare access- ability to access healthcare services such as disease prevention, diagnosis, treatment, and management, as well as other situations that may have a negative impact on health (WHO, 2006).

Equity- means the quality of being fair and impartial. In this study, it refers to exhibiting fairness and justice in healthcare provision set up

Inequity- means unfairness or injustice. In this study, it refers to existence of imbalances in healthcare provision set up

Healthcare Provision inequity: Existence of unequal and avoidable or correctable disparities in the delivery of healthcare among population groups classified according to social, economic, demographic, or geographic factors (WHO, 2006).

Healthcare Provision equity- in this study, it involves creating equal *opportunities* in healthcare provision by bringing healthcare provision differences down to the lowest level possible.

Healthcare Personnel- are persons who have special education on healthcare and who are directly related to provision of healthcare services. In this study, it refers to any individual offering healthcare service such as those offering home-based care

Healthcare facility- in this study, it refers to the location where healthcare service is provided.

Normative challenges - challenges in the nature of values, arising as a result of not confronting to or reflecting an established norm in healthcare provision set up that considers the same as a human right. Deviating from a specific

standard particularly a standard determined by moral ideals of how things should be. That is, deviating from the healthcare provision standards as influenced by socio-economic considerations in healthcare provision going against established human rights criteria as espoused by the Catholic Church.

Out of Pocket Payments- direct outlays of cash for the purposes of healthcare services which is not reimbursed at all. This is a big barrier to accessing health services by the poor as it drives them to further poverty (Musango, 2013)

Isomorphism- the idea that an organization would mimic other organizations in its environment or in a location where similar environmental pressures exist (DiMaggio & Powell, 1983). In this study, it refers to the idea that Catholic church healthcare facilities tend to imitate secular healthcare facilities and are almost operating like them.

Non-Catholic Church healthcare facilities- in this study, it refers to other healthcare facilities available within the geographical region occupied by the Catholic Diocese of Kericho

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter covers the technical aspects of the study that includes introductory background to the study, statement of problem, research objectives, research questions, scope and limitations, significance of the study, literature review, theoretical framework and justification of the study. This was crucial in laying the foundation under which the entire study was hinged.

1.1 Background to the study

The United Nations General Assembly of 2015 adopted the 2030 Agenda for Sustainable Development: Transforming our World. The Sustainable Development Goals (SDG) unveiled a new healthcare target; universal healthcare which aimed at ensuring that everyone has access to the promotional, preventative, curative, rehabilitative and palliative healthcare services they require without facing financial hardship is a key component of universal health coverage.

Faith-based service providers play a significant role in efforts to achieve Sustainable Development Goals and promote integral human development. Catholic social thought understands sustainable development as the development of each and the whole person (Wodon, 2022).

Globally, the Catholic Church oversees 26% of all healthcare institutions (Agnew, 2010). The Catholic church healthcare network is the largest non-profit healthcare provider organization in the United States, with one in every six patients being treated at a Catholic church hospital. With over 600 hospitals, 1,400 long-term care homes, and

other healthcare-related facilities, Catholic healthcare has long been a dominant presence in the United States (King, 2015).

In Africa, the Catholic Church is very visible in healthcare services. Out of all the religious organizations and for-profit organizations involved in the continent's healthcare sector, Catholic church operates the greatest number of hospitals and clinics offering medical care and, occasionally, free medical care to those with HIV/AIDS, pregnant women, and malaria patients. Even in African nations where the Catholic Church is not the majority, this nevertheless occurs. Catholics, for example, make up around 30% of the population in Ghana but run more hospitals than any other organization. In total, works in 16,178 health centers, including 1,074 hospitals, 5,373 out-patient clinics, 186 leper colonies, 753 homes for the elderly and physically and mentally less able brothers and sisters (Parry,2011).

Through the Catholic Health Commission of Kenya, the Catholic Church oversees around 30% of all medical institutions in Kenya. The Church has a huge network of 451 health facilities (including 69 hospitals, 117 health clinics, 14 medical training colleges, and 251 dispensaries), 46 community-based health programs, and programs for orphaned and vulnerable children (OVC). The Catholic Church provides mobile clinics for nomadic populations in arid and semi-arid locations when other entities, such as the government, are unable to provide health treatment (KCCB, 2015).

The Catholic Diocese of Kericho is one of the 22 Dioceses in the republic of Kenya (National Council for Law, 2013). According to the Catholic Diocese of Kericho statistics of 2019, the Diocese has a population of 1,777,466 residents with a total of 10 healthcare facilities. The statistics point out an inadequacy with the urgent need for more attention on the healthcare sector. The biggest challenge remains to be

accessibility and the quality of healthcare service available in the Catholic church healthcare facilities. According to the mission of Catholic church health department, the department is committed to excellence in all they do by providing healthcare that is up to date, compassionate, and patient centered. Yet the statistics as already mentioned and third worldliness of the region may not rule out the fact that occasionally the medical facilities may be overwhelmed.

Furthermore, the Catholic church's social teaching on healthcare access is based on the idea of human dignity. It focuses on the significance of ensuring that everyone has access to high-quality medical care (USCCB, 1997). The doctrine of a right to healthcare access implies that the community has an obligation to provide healthcare to whoever needs it, even if the recipient cannot pay for it. The Catholic church community has a duty to uphold justice for everyone by guaranteeing that anybody in need of medical care gets access to it, even if they are unable to pay for it. (USCCB, 1997). Obligation therefore is mandatory rather than voluntary irrespective of race, gender, denomination, ethnic background or affordability.

Despite the various efforts towards universal healthcare access, evidences suggest that healthcare provision is still not accessible for all. World Health Organization (WHO) reported that the global society of today is rapidly changing and the disparity between the haves and have-nots in healthcare provision is growing. WHO noted further that presently, at least half of the population in the world do not receive the healthcare services they need and each year, large numbers of households are pushed into utmost poverty because of out-of-pocket payments for healthcare service access (WHO, 2017).

Access to healthcare remains the most difficult barrier in Africa, with half of the population still unable to obtain the services they require (Clausen, 2015). Financial

barriers to healthcare services, as well as high rates of out-of-pocket expenditure, are also prevalent throughout Africa, owing to inadequate national health insurance systems and insufficient service integration (Peterson et al., 2017). The majority of people experience financial challenges since out-of-pocket costs are required before medical care can be provided, even in emergency situations, and many insurance plans exclude the poor. As a result, in many Sub-Saharan African countries, the poor bear the largest burden of illness and face financially crippling healthcare bills. Non-implementation of major laws, initiatives, and agreements between the government and various healthcare professionals has frequently resulted in staff strikes and the unwillingness to provide healthcare services to the sick in countries such as Nigeria (Oleribe et al., 2016).

Kenya consistently has high levels of healthcare access disparities, according to a study by Ilinca, et al, (2019) on socio-economic disparities in the use of healthcare services. Poorer people not only have lower health than wealthy ones, but they also have more difficulty getting the necessary healthcare services. Similarly, a study done in Kenya by KEMRI-Wellcome Trust Research Programme revealed that socio-economic disparities in healthcare provision have persisted and the primary determinants include overall household spending, educational attainment, household characteristics and living standards. Access to healthcare service is tied to affordability which disadvantages other people especially among the poor, low-income people and the uninsured (KWTRP, 2019). This is partly an indicator that healthcare provision system is broken.

In the Catholic Diocese of Kericho, many communities lack access to basic healthcare services and up to 60% of the households are living below the poverty line according

to a reported by an NGO, Brighter Communities Worldwide published in 2021. Furthermore, access to healthcare service is difficult particularly for communities living in rural and remote areas. The report further indicated that approximately 95% of the people live in rural areas. In a nutshell, biggest challenge remains to be accessibility and the quality of healthcare service.

These studies suggests that healthcare provision system generally confronts a range of economic, technological, social and moral challenges. In light of these, this study posits that the Catholic church agenda on healthcare provision appears to be at cross purpose in practical terms with a world that is highly polarized with the haves and have-nots even in healthcare provision both in Kenya and elsewhere thereby necessitates a quest for examining the effectiveness of catholic church in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho.

1.2 Statement of problem

The United Nation's 2015 adoption of the Sustainable Development Goals (SDGs) accelerated global progress towards attaining population healthcare goals in low- and middle-income countries. Catholic church is one of the faith-based service providers playing a significant role toward achievement of sustainable development goals particularly healthcare access for all. Pope John XXIII made a pronouncement that healthcare is a fundamental right for all and not a privilege for the rich while the poor and disadvantaged are left to the wayside. The doctrine of a right to healthcare access as a basic human right implies that the catholic church community has an obligation to provide healthcare to whoever needs it, even if the recipient cannot pay for it.

Despite the various advances, there exist disparities in healthcare availability and accessibility in Kenya and elsewhere in the world and is mainly evidenced by the gap

between the wealthy and the poor citizens. The wealthy in society can pay a premium to have their healthcare requirements fulfilled adequately and quickly, whilst the poor have little choice except to take whatever care they receive at whatever time it is available. Access to healthcare service is tied to affordability which disadvantages other people especially among the poor, low-income people and the uninsured.

It is on the backdrop of the Catholic Church's teachings and obligations on healthcare provision as captured in part in the foregoing introduction and the complicated capitalistic polarization of the haves and have nots dominating healthcare provision that this study sought to examine the Catholic church's efficacy in alleviating the resultant normative or human values related challenges in healthcare provision in the Catholic Diocese of Kericho as it advocates for healthcare as a basic human right with a view of ensuring healthcare accessibility for all.

1.3 Objectives of the Study

The overall objective of this study was to examine the Catholic Church's efficacy in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho.

The specific objectives were:

I. To evaluate healthcare provision as a contemporary phenomenon and explore the normative challenges related to it in general
II. To examine the Catholic Church's position on healthcare provision in general.
III. To examine the Catholic Church's success in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho

1.4 Research Questions

I. What is healthcare provision as a contemporary phenomenon and what are the

normative challenges related to it in general?

II. What is the position of the Catholic church on healthcare provision in general?

III. Has the Catholic Church been successful in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho?

1.5 Significance of the Study

Healthcare is pertinent determinant in attainment of Sustainable Development Goals that aims at ensuring a people-centered healthcare that offers universal access, social equity and financial protection among other global commitments on healthcare provision. A study such as this was of great importance in diverse ways:

First, the findings of the study aimed at ensuring healthcare access for all with the kind of dignity that befits a human person. Stakeholders in healthcare provision are given guidance by the issues mentioned which can help develop plans for solutions pertaining challenges related to human values bordering on morality that are increasingly associated with healthcare provision in the contemporary society. This is beneficial in the attainment of Kenya's Vision 2030 of high-quality life for all its citizens when the divide between the haves and have nots play increasingly less significant role.

Second, is that the findings of this study can help humanity in reinstating the deteriorating value of human dignity in healthcare provision and society at large.

Lastly, the findings of this study will be useful to the Catholic Church in understanding the impact of contemporary environment on catholic church healthcare provision thus identifying the reasons why Catholic church healthcare provision have remained distinctly Catholic or are slowly shifting to match its non-Catholic church counterparts.

1.6 Scope of the study

This study was focused and confined to the Catholic Diocese of Kericho and the area bound by it as the main geographical consideration. In terms of themes, the main concern was bound under healthcare provision and the resultant human values challenges related to ethics of socio-economic attributes in healthcare provision with reference to the Catholic church social teaching on healthcare provision. In terms of theories, the study adopted liberation theory which proposes fight for the alleged sources of oppression in order to achieve liberation.

1.7 Limitation of the study

Data gathering for the study was hampered by the vastness of the study area. Although the study area was vast, that is, Kericho and Bomet counties, through purposive sampling and parishes and respondents were earmarked for the study.

1.8 Literature Review

This section deals with the review of literature related to healthcare provision as a contemporary phenomenon in general and normative challenges related to it. It also covers the Catholic church's social teachings on healthcare provision in general and the effective role of the Catholic church in healthcare provision. The literature reviewed enabled the researcher to interrogate the written works and identify gaps to be filled by the study. This literature was reviewed under the following sub-topics: healthcare provision as a contemporary phenomenon, normative challenges related to healthcare provision, social teachings of the Catholic Church on healthcare provision and role of Catholic Church in healthcare provision.

1.8.1 Healthcare Provision as a contemporary phenomenon

WHO (2016) defined healthcare as including all services dealing with disease prevention, diagnosis, and treatment as well as health promotion, maintenance, and restoration. Provision deals with the way inputs such as healthcare financing, healthcare personnel, drugs and healthcare equipment are used together to deliver healthcare interventions. In conclusion, the objective of providing healthcare is to enhance healthcare outcomes and meet people's expectations in a way that lessens disparities in both the delivery of and response to healthcare (Adams et al., 2002).

Chirwa (2016) writing on a historical perspective of healthcare in sub-Saharan Africa remarked that home remedies gave rise to the modern healthcare sector. It began as a reactive medical practice in which individuals recorded their trial-and-error learning of a plant's therapeutic characteristics and transmitted it to others. The healthcare sector experienced a sea change in the 19th century. Numerous developments in the realms of technology, chemistry, and biology also allowed doctors the chance to study diseases better and develop more effective treatments. Chirwa added that colonialism as a historical stage had an impact on healthcare industry. Colonialism facilitated the spread of illnesses as well as trade and other products. Doctors were now also worried about the diseases that were appearing as a result of urbanization and increasing population density. New innovations including immunizations, preventive, and therapies started to take shape.

The 20th century saw a shift in emphasis away from generalized pathology and toward individual disorders. It was believed that this time period, also known as the therapeutic revolution, marked the beginning of the practical application of medicine. The Industrial Revolution saw the emergence of health as a distinct economic category. Additionally, health was linked to Darwinian notions of fortitude and survival of the

fittest, in which the purpose of life was dependent on one's capacity for physical survival. During this time, it was thought that one's capacity for adapting to environmental stimuli was a sign of good health (Donev, 2000).

Wamaitha and Adam (2016) in a journal of Ethics and medicine remarked that in Kenya, like in many African countries, prior to the advent of the colonial era, life was communally structured, and healthcare was frequently left to the family or to medicine men or women who had some familiarity with the human body, herbal medicine, and simple surgery. Ailments were frequently linked to demonic spirits or seen as the ancestors or God expressing their anger. In such cases, rituals or sacrifices for healing would be offered by mediums, priests, elders, or witch doctors. African colonial governments set up and oversaw hospitals and healthcare facilities during the colonial era. Churches like the Catholic Church and Christian missionaries were also actively involved in the delivery of healthcare at the same period.

Media (2017) supported the foregoing discourse that During the Middle Ages, religion and the church significantly influenced how people saw health. The church, which provided healthcare for the public and gathered knowledge about treatments like herbs grown in monastery gardens, was the only significant institution standing after the fall of the Roman Empire. The "forgotten" knowledge of antiquity was recovered and reframed for use in the modern era during the Renaissance.

The above cited works gave an historical account of healthcare provision in a historical context. These works gave valuable insight to the study on the changes experienced in healthcare provision over time. This study however was concerned with the impacts these changes have on the value of human dignity as far as healthcare service accessibility is concerned.

1.8.2 Normative Challenges related to healthcare provision in general

Healthcare provision in the world today is faced with various challenges resulting to poor healthcare outcomes. Crowley et al., (2020) note that globally, millions of people face poverty due to their healthcare expenses each year. The first criterion for healthcare accessibility is affordability, which is a critical factor in determining whether the average adult decides to pursue or forego healthcare. Evidence suggests that the average household of four with a "employer-sponsored" insurance plan will spend more than $28,000 on healthcare in 2020. According to one survey, one-third of persons in the United States avoided medically prescribed healthcare due to cost constraints (Osborn, 2016). Clearly, self-sought healthcare is a financial burden for the majority of the general population. Furthermore, because many of the country's hospitals are for-profit enterprises, revenues are the driving force. When a hospital's financial viability is jeopardized, quality suffers as a result.

The second category in a global analysis of healthcare accessibility is gender, which is frequently the cause of indirect healthcare restriction. Some studies, such as one published in the journal *Nature Communications*, noted gender differences in diagnosis and therapy. One Danish study found that over 700 disorders were detected earlier in males than in women, demonstrating how delayed diagnosis in women contributes to gender disparities in healthcare accessibility (Alcalde-Rubio et al., 2020).

Aside from affordability and gender, one's race can have an impact on the quality of healthcare they receive. According to data from a 2012 survey, localities with mostly Black residents were more than 50% more likely to have a shortage of primary care physicians (Rees, 2020). There is unequal distribution and, as a result, unequal access to healthcare services among races and ethnicities. In agreement with the

aforementioned scholar, Deacon (2000) noted in an article titled *Racism and Medical Science in South Africa's Cape colony in the mid- and late 19th century* that due to the fact that medical services and resources were typically solely provided to fulfil the requirements of Europeans, colonial healthcare and public health programs in Africa never provided enough care for Africans. For instance, prejudice permeated every aspect of the medical community in South Africa's Cape Colony. Because of this, South African natives received medical care of a much lower calibre than Europeans.

Another factor to consider while assessing one's global access to healthcare is one's place of living. Economically depressed areas with residents that share comparable socioeconomic statuses, such as low income, education quality, and employment rates, frequently lack access to healthcare facilities. Economic disadvantage, for example, is associated with increased mortality, asthma, heart disease, and premature deliveries (Silva, 2006). According to studies, hospitals in impoverished neighbourhoods are more likely to close than hospitals in wealthy communities. This leads to unequal distribution of healthcare facilities and shows that facilities confronted with challenges such as limited finance and employment are frequently placed in poor areas (Silva, 2006).

As the types of illnesses change across the continent, half of the population still lacks adequate healthcare services, with fewer than 50% of Africans having access to modern health facilities (Clausen, 2015). Corruption in the public sector is one of the contributing factors. Corruption, according to Clausen (2015), diverts critical resources away from healthcare delivery and decreases patient access to services. Examples include medical workers in public sector healthcare institutions selling pharmaceuticals that should be free, as well as drug and supply theft (for personal use) or diversion (for

private sector resale) at government storage and distribution points. Furthermore, bribes to obtain medication registration permission or to pass drug-quality inspections result in bogus drugs "legitimately" entering markets.

A darker side effect of technology's rise in Africa is that it allows counterfeiters to run even more sophisticated operations and produce counterfeit drugs that are harder to detect. An example of this can be found in Nigeria, where, despite regulators' adoption of counterfeit drug "track and trace systems," there is evidence that some of these systems are being successfully "copied" by counterfeit drug producers.

Another challenge that dominates healthcare service in Africa is changing population healthcare needs. The current focus of healthcare delivery in Africa is primarily on traditional and visible variables such as HIV and malaria. However, changes in lifestyle and an expanding middle class are making noncommunicable diseases such as cardiovascular disease, cancer, and diabetes major public health concerns. Rapid urbanization and greater Westernization of middle-class lives are increasing the risk factors for noncommunicable diseases. People eat more fast food and packaged meals with high sodium levels; they participate in less physical activity, sitting in vehicles and buses on their route to work; and they are more prone to consume alcohol in their free time. An increase in smoking rates among communities is another risk factor (Clausen, 2015).

Similarly, a study done in Africa by Oleribe et al., (2016) established that inadequate healthcare staff, inadequate funding, bad leadership, and poor management of healthcare providing systems are the main issues facing the industry. The incapacity of the healthcare delivery system to adequately and effectively respond to public health

emergencies, such as the breakout of infectious illnesses and pandemics, which increased mortality and morbidity in these countries, was another issue identified.

Access to excellent healthcare services in Kenya continues to be a concern for many people, particularly those living in rural and marginalized communities. A dearth of healthcare workers, particularly in rural regions, is one of the major difficulties confronting Kenya's healthcare system. This scarcity has resulted in many Kenyans lacking access to essential healthcare treatments (Ehagi, 2023).

Another difficulty confronting Kenya's healthcare system is the high expense of healthcare. Many Kenyans cannot afford the expense of healthcare services, which has resulted in many people delaying getting treatment until their condition becomes critical (Ehagi, 2023). Kenyans face access challenges to healthcare because 80% do not have insurance. A huge portion of the country's population struggles to afford health care, despite private hospitals making billions of dollars in profits and the majority of Kenyans lacking health insurance (Mwita, 2021).

Another issue confronting Kenya's healthcare system is a lack of infrastructure and medical equipment. Many Kenyan healthcare institutions lack basic equipment and supplies, making it difficult for providers to offer appropriate care. As a result, patients have been driven to seek medical treatment abroad or rely on traditional healing procedures (Ehagi, 2023).

Gender disparity is another key concern for Kenya's healthcare system. When it comes to receiving healthcare services, particularly reproductive healthcare, women in Kenya confront distinct hurdles. Women are frequently excluded from healthcare decision-making processes due to cultural conventions and gender stereotypes. (Ehagi, 2023)

The primary healthcare system in Kenya is insufficiently developed to cover the entire country. People in rural areas dwell all over the region, whereas health care is concentrated in towns and cities. This suggests that rural residents must travel considerable distances to access healthcare services. Many disabled persons have difficulty walking long distances, which means that healthcare services are only available to those who can afford to pay for transportation, resulting in significant financial hardship for the poor. As a result, many either do not seek healthcare or arrive at the hospital too late. Even when the family is able to obtain funds for transportation, the endeavor is not always fruitful. When they get at the hospital, there is no guarantee that there will be healthcare workers available to assist them (Grut et al., 2011).

Kenya Healthcare Federation (2018) published an article on key challenges faced by Kenyan healthcare provision. The article unraveled that limited access to healthcare facilities, a lack of sufficient healthcare personnel and healthcare personnel specialists to address special healthcare needs, and poor infrastructure where most healthcare facilities lack the necessary healthcare facilities and equipment to address the healthcare provision challenges are some of the major challenges faced by Kenya's healthcare system.

Another significant barrier to care is the unequal distribution of health workers across urban and rural areas (Turin, 2010). Individuals must have physical access to a health facility and the health facility must be able to give service in order to get health care. The top two "key challenges to achieving better health status in Kenya" identified in the 2005/2006 Kenya National Health Accounts (KNHA) are "inequitable access to health services" and "shortages of qualified health workers with appropriate skills" (Turin, 2010).

Kenya consistently has high levels of health and access disparities, according to a study by Ilinca, et al, (2019) on socio-economic disparities in the use of healthcare services. Poorer people not only have lower health than wealthy ones, but they also have more difficulty getting the necessary healthcare services. Socioeconomic disparities for a variety of healthcare services, such as reproductive, maternal, and child care, preventive care and vaccination, urgent care, inpatient, and outpatient treatment, have been identified within this context. Low demand and availability for formal, high-quality healthcare services were found to be substantially correlated with poverty levels. Poorer communities have lower-quality service providers and people from poorer households have been shown to be less likely to seek care in medical facilities when they are ill or have health issues. Ilinca et al., (2019) further revealed that In Kenya, there were socioeconomic disparities across the healthcare industries. While those from affluent households tended to rely on public care providers or use lower standard, frequently unlicensed care, the private sector was more varied in terms of the sorts of care providers and predominantly served wealthy persons. This is partly an indicator that healthcare provision system is broken.

A study done in Kenya by KEMRI-Wellcome Trust Research Programme revealed that socio-economic disparities in healthcare provision have persisted and the primary determinants include overall household spending, educational attainment, household characteristics and living standards. Access to healthcare service is tied to affordability which disadvantages other people especially among the poor, low-income people and the uninsured (KWTRP, 2019).

Similarly, Kabia et al., (2019) conducted a study in Kenya on the experiences of the poor with health financing reforms that target them. The findings were given in four

categories: geographical accessibility, affordability, availability, and acceptance. Some of the health facilities contracted to deliver healthcare services under pro-poor health finance policies were inaccessible, according to the findings. Some health facilities' continued imposition of user fees hampered access to healthcare services. Due to the great distances between health care providers, rural communities faced hefty transportation costs. Long distances to healthcare facilities, particularly in rural areas, resulted in high transportation expenses, creating an access barrier for recipients of pro-poor health financing programs.

According to a 2021 report by Brighter Communities Worldwide operating in Kenya's Kericho county, communities lack access to essential amenities such as water, sanitation, energy, and health, and many households (up to 60%) live below the poverty line. Access to critical healthcare services is difficult, particularly in rural and remote communities (due to, among other things, poor infrastructure, geography, and education). Maternal mortality is common (about 500 per 100,000 live births). The county's perinatal death rate is 63 per 1,000, which means that one out of every 15 infants dies after birth or within the first seven days of life. Children endure obstacles from birth and frequently do not reach the age of five (child death rate is around 55 per 1,000) due to a lack of vaccines, poor environmental circumstances, uneducated parents, and so on. 16% of Kericho County citizens have no formal education, while 22% have a secondary degree of education or higher. Gender inequality is widespread. Women and girls perform the majority of unpaid labor (such as childcare and household activities) and have limited access to vital services such as reproductive health, education, and maternal health. Girls and women are more likely to be victims of physical, sexual, or emotional violence, which can range from female genital mutilation

(FGM) to unwilling prostitution to domestic violence and early marriage (Ballantyne, 2021).

The above scholars are in agreement that healthcare provision system in the world and elsewhere is faced by a lot of challenges. Their ideas were relevant to this study in establishing that healthcare provision system is broken. They unravelled the challenges related to healthcare provision in general. This study however dwelt in examining challenges linked to norms and values and whether these challenges are prevalent in the catholic church healthcare provision given that catholic church considers access to healthcare as a basic human right.

1.9 Catholic Church's teachings on healthcare provision

Social teaching on healthcare provision is an area of Catholic Church's doctrine which addresses healthcare provision as a contemporary phenomenon within the political, economic and cultural structures of society. *Catholic social teaching: Precepts for healthcare reform* by Condit (2016) offers a magisterial gift to every generation to support the creation of a just society. Condit in this article notes that the principles of Catholic social teachings propose a moral criterion for responding to the neighbors' needs such food, shelter, healthcare and education.

Condit (2016) lays up four guiding principles for enhancing the crisis-ridden healthcare system within the Catholic Church. The essential idea is that every human being is entitled to dignity. It is founded on the Catholic Church's commitment to defend human life from conception until natural death. The moral requirement to respect each person's dignity as a child of God and as someone whom God made in His own image and likeness forms the basis of this idea (USCCB, 2015). Genesis 1:27 states that "God created mankind in his image, in the image of God, male and

female." The study's emphasis on the duty of every member of the medical community to prevent any treatment or procedure that immediately ends a person's life was guided by the principle of the dignity of the human being. Normative challenges related to healthcare provision which was the issue of concern of this study are profoundly grounded on human dignity which according to Catholic Church teaching is inviolable.

The common good is the second guiding principle. Condit points out that the common good principle recognizes that because people are social creatures, they exist in groups where everyone's rights and obligations are honored. In line with the idea of Condit, Catechism Catholic Church defines the collective of social conditions that make it possible for people to more fully and simply achieve their goals, whether they do so as a community or an individual, is referred to as the common good (The United States Conference of Catholic Bishops 1997, n. 1906). For common good to be achieved, the society should create institutions and policies that are safe and protective to individuals and families in the society. Therefore, it is everyone's responsibility to promote the common good and foster conditions that enable both themselves and their neighbors to succeed. This principle of common good guided the study in the sense that the institutions society make ought to be for the common good for everybody in the society. Condit does not describe how these institutions such as healthcare facilities are made for the common good for everybody which this study did by examining the position of the Catholic Church in shepherding the society and enhancing good relationships and interdependence. This help in ensuring healthcare provision is for the good of all members in the society.

The third principle as postulated by Condit is solidarity. According to him, solidarity involves following Christ's teaching to "love your neighbor as yourself" and the

responsibility to help others. According to the bishops of the Catholic church, a society's treatment of its most vulnerable members serves as a fundamental moral yardstick. (USCCB 2015, no. 53). Those suffering from illness are among the vulnerable in society. Condit notes further that Solidarity demonstrates the innate social nature of humans, their equality before the law and in human decency, and their shared journey towards a more cohesive society. In resonance with Condit, Goodill (2006) notes that solidarity must be seen as a priority in human values and as a moral virtue which above all in its value as a moral virtue establishing order in societal institutions such as in healthcare institutions. Normative challenges related to healthcare provision looked at in this study possibly arise as a result of broken healthcare provision. Due to this, the study therefore examined the efficacy of the Catholic church healthcare facilities to meet the healthcare needs for all members of society.

The societal organization of institutions is guided by the fourth subsidiarity principle. Pope Benedict XVI agreed with Condit that We don't need a state that dominates and regulates everything, but rather one that generously accepts and encourages initiatives brought about by various social forces and combines spontaneity with a concern for people in need (Pope Benedict XVI 2005, no. 28). The principle of subsidiarity was beneficial to the study in pointing out the responsibility of the Catholic Church to order society. Condit explained how the Catholic Church should order the society in general. This study however examined how the Catholic Church through the principle of subsidiarity should order healthcare provision society. One way of ordering the healthcare provision society established by this study is fundamental option for the poor since the poor in society are the ones closest to the need.

Kammer (2020) in his work titled, *Catholic Social Thought and HealthCare* gives a discussion of Catholic church social teaching on healthcare provision. He notes that Catholic Church's discussion of healthcare provision begins with the teaching that healthcare is a basic human right. A right to the means for the healthy development of life, such as adequate healthcare, is included in the first human right, which is the right to life (USCCB, 2009). Given that people are created in God's likeness and in the sanctity of human life, they have a claim to respect and dignity. The implication is that everyone, regardless of their economic, social, or legal position, must have access to healthcare services, which are essential for healthy growth and maintenance of life (NCCB, 1981). This discussion was beneficial in building introductory background to the statement of problem where the entire study was hinged. Access to healthcare service is a basic human right. Therefore, it is ironical to encounter challenges in accessing a basic human right for reasons such as economic, social and legal status.

The Catholic Church asks for healthcare reform that incorporates fundamental principles that uphold basic human rights, reflect the dignity of the human person, and address the individual needs of each person, particularly the underprivileged and vulnerable (Kammer, 2020). While stressing that the country's healthcare delivery system ought to be rooted on values that respect human dignity, preserve human life, and address the needs of all populations, for a country to undertake healthcare reform, Kammer suggests eight essential characteristics. These include respect for human life, prioritizing the needs of the poor, ensuring that everyone has access to healthcare, providing comprehensive benefits, and promoting pluralism, which includes the participation of voluntary, religious, and non-profit healthcare providers in government and business while upholding moral and ethical standards in healthcare

delivery.

Kammer notes further that one of the fundamental means to safeguard human life and healthcare as a basic human right is through provision of affordable and accessible healthcare. Kammer's sentiments helped in building the problem of this study as the study emphasized on religion as conscience of society. Religion ordering the society in the sense that human values are put at the top of everything.

According to Kammer (2020), implementing new public healthcare policies is insufficient to address the healthcare crisis. Instead, each party involved in the delivery of healthcare must consider how their actions and attitudes contribute to the issue and how they undermine the worth of all people and their own health. Kammer's work was relevant in exploring how humans are contributors of their own crisis though he does not show how these humans can be contributors to resolve this crisis. This study came in handy to fill this lacuna by examining individual responsibility on healthcare provision.

1.10 Role of the Catholic church in healthcare provision

In an article titled *Church and Healthcare: Time for a New Debate*, Lategan (2017) reaffirmed the church's position that it should take part in the discussion of ethically-informed healthcare. Foster's (2016) arguments that the church has a duty to advance just healthcare are important to Lategan's work. Foster makes the implication that a large number of publicly professing Christians cannot also struggle to find appropriate solutions to healthcare issues. While emphasizing public theological responsibility of the Church of promoting just healthcare, Foster comments that the engagement between the church, healthcare and society should not be limited.

According to Lategan, the primary focus of healthcare is on a person's vulnerability, and it is the Church's duty to care for society's most vulnerable members. Furthermore, the church should step outside its comfort zone when it comes to healthcare. It is well-known that the Church's involvement in healthcare is limited to forbidding actions related to bioethics, such abortion. The church's involvement in providing healthcare is extensive. With the intention that people should live to the fullest extent possible, church teaching must strike a balance between the significance of pain and human dignity. The state's obligation to provide healthcare and uphold human rights should be under church scrutiny. As a fundamental human right, access to healthcare is something that the church has a responsibility to impact (Lategan, 2017). The Church must deal with the difficulties in providing healthcare, such as the fact that this fundamental entitlement is becoming increasingly expensive and, in some cases, prohibitive.

Lategan arguments were pertinent to this study in highlighting the church's calling to offer revival to vulnerable persons in healthcare. The sick, the medical staff who perform their duties under difficult circumstances, and the neighborhood where the patient lives are all examples of vulnerable people. In general, Lategan underlined that the role of the church is to foster a sense of community, to uphold justice, and to advance wellbeing not only for churchgoers but for the entire society that works in and benefits from the healthcare industry.

Lategan however didn’t explore the approaches the church should employ to bring revival to vulnerable people in healthcare and which church in particular. This study identified that one of the ways the Church can bring revival in healthcare is through liberation approach. This study acknowledged that poverty and ill-health are some of the things that puts man down. Liberation theology advocates for human freedom.

Therefore, Catholic Church sampled out in this study have a role in freeing man from all forms of oppression in healthcare provision set up.

Nthamburi (1995) in the book, *The African Church at the Crossroads: strategy for Indigenization* portrays the Christian Church in Africa as a growing force that needs to be harnessed to maturity. The paradoxical situation in which the Christian culture finds itself in Africa is as a result of uncritical assimilation of Western culture in the name of Christianity. Nthamburi is convinced that the gospel has enriched human values in Africa to such an extent that even the tidal wave in Western culture has not undermined the human underpinning of the traditional values. He further argues that the church must communicate the gospel in metaphors that can be understood and appreciated by the hearers. He noted further that the relevant gospel to be preached to African people in the African continent should be a holistic gospel and the gospel of liberation. This is due to the fact that African men are desirous of independence because they are oppressed, underprivileged, marginalized, and economically exploited. The church must support the impoverished since good news is the most priceless gift to give to the underprivileged. This comprises not just declarations but also one's own way of living, one's own deeds, and collective corporate action for justice. During the period of resistance to colonial rule, Christians understood their liberation to be not only political, but socio- economic as well. It was liberation from all that dehumanized the community. It was liberation from poverty, disease, broken relationship brought about by ethnic rivalries, and liberation from sin. Church lives in the real, concrete practice of human freedom.

Nthamburi's ideas were relevant in giving a clear background on the duties of the Church though he does not give a clear framework on what the Church should do so as to liberate man. This study filled this gap by identifying ill-health and poverty as

sources of oppression in society and hinders man from realizing full potential. The study examined further the effectiveness of the Catholic Church in liberating man from healthcare provision struggles.

A Theology of Liberation by Gutierrez (1988) offers a meditation on the liberation process based on the gospel and the experiences of human oppression and exploitation in Latin America. According to Gutierrez, theology of liberation is a theological reflection of oppression and exploitation faced and the initiatives made to create a different, more liberated and humane society. While emphasizing the need in the present times of constructing a just society where persons can live with dignity and be the agents of their own destiny, Gutierrez remarked that the current emancipation process is so serious that it is seriously challenging both the church and the Christian faith. They are starting to understand how liberation affects social revolution and upending the existing quo. According to Gutierrez, the church has a responsibility to expose serious injustices, take on oppressive institutions, and promote justice. He continues by saying that the entire gospel is a constant demand for the right of the underprivileged to speak up, to be given preference by society, and a demand to put their needs before their own. The church is obligated by its core mandate to care about the rights, freedom, and individual dignity of people. His arguments guided this study in identifying the role of the Church of denouncing grave injustices and constructing a just society.

Guttierez does not confine his argument to particular type of injustice. This study examined role of the Catholic Church in denouncing social injustices and all dehumanizing elements in healthcare provision and constructing a just healthcare provision system.

In resonance with Gutierrez, Mugambi (1995) adds to this study with his observations

on liberation and reconstruction in the book *From Liberation to Reconstruction: African Christian Theology after the Cold War*. According to him, Liberation Theology was the major theme in African Christian Theology in the Twentieth Century with emphasis on liberty from bondage. He argues that African Christian Theology in the twenty first century should focus more on transformation and reconstruction rather than mere deliverance from bondage. He adds that the Exodus motif of Liberation emphasized in earlier periods should be complemented by other biblical motifs such as reconstruction motif. identifying alternate social structures, symbols, rituals, and interpretations of the social realities of Africa made by Africans themselves, independent of what foreigners think of the continent and its inhabitants, are all part of this theology of change and reconstruction. It follows from his arguments that such a theology calls for a change in African people's social, economic, political, and religious realities. He adds that the implied transformation calls for clarity in the relationship between Gospel and culture, Church and Society, secularization and religious pluralism and communication and witness. Mugambi's contention then is that Liberation includes transformation and reconstruction of social, political, economic and religious institutions in the society. This was relevant in this study as the study examined how the Catholic healthcare provision can be reconstructed and transformed to satisfy the healthcare requirements of every community member through liberation approach.

The Catholic Church's mission regarding the provision of healthcare is described by Putney (2004) in a journal article titled Health Care and the Catholic Church's Mission. He observes that the Catholic church provides healthcare to the sick and the afflicted in a way that invites people to recognize God's presence in their illness or suffering. In other words, the Catholic Church, through its healthcare mission, has

compassion for the ill, the troubled, and the weak in society.

Putney recognizes further the role played by the Catholic Church in promoting access to healthcare. This is due to how it views the value of the human person, its dedication to justice, and its preference for the underprivileged. Because of this, the Catholic Church opposes any medical methods, procedures, or policies that disadvantage and oppress some individuals while favoring others. Putney's ideas were relevant in uncovering effective responsibility of the Catholic Church in advocating for equitable healthcare provision though he does not provide a clear framework of what the Catholic Church should do to ensure equitable healthcare. This study filled this gap by examining the position of the Catholic Church towards attaining equitable healthcare.

In resonance with Putney, Naumann and Finn (2009) highlight the mission of the Catholic Church on healthcare provision that Catholic church healthcare ministry is called to respond to healthcare needs of a person with compassion and in obedience to the healing mystery of Jesus Christ.

To Naumann and Finn, a fuller articulation of the vision of Catholic church healthcare provision is expounded on the apostolic exhortation, *Ecclesia in Oceania* (Church in Oceania). Pope John Paul II stated in the exhortation that Jesus came to heal the sick and comfort the suffering. Through individuals who convey God's compassion to others in their times of need and suffering, the risen Christ continues his ministry of healing and consolation. Naumann and Finn draw the conclusion from the exhortation that, despite the current healthcare finance crisis, the Catholic church's engagement in healthcare provision is a "fundamental" obligation that must not be compromised. In Christ, there is a church. By bearing testimony to the special nature of the human

person and the ethical values that are fundamental to Catholic church tradition, Catholic church healthcare supports the church's mission. The foundation of ethical positions is a certain understanding of the human person, an understanding. These arguments were relevant to the study in unravelling the need for understanding human person and his ethical positions in society. Putney argued that ethical positions of understanding human person should be valuable and liberating. This study therefore dwelt in understanding ethical positions of human person in healthcare provision with the aim of liberating human person from those challenges that seem to demean the dignity and value of human person.

Another scholar, Gordon (2021) in his work, *The distinctive role of the Catholic Church in development and humanitarian response* explains the Catholic Church's organizational structure and its contribution to humanitarian aid and development. The unalienable dignity of the human person and the equality of all people form the foundation of the Catholic Church's vision for development, which is for the full person and all people.

Gordon notes that the Catholic Church is obligated to assist everyone, with a special focus on the underprivileged and marginalized groups that have often been left out, persecuted, or victims of injustice. Regardless of ethnicity, gender, or creed, the Catholic Church provides for the needs of all individuals. Gordon notes that, while acknowledging the Catholic Church's contribution to society's transformation, one way the Catholic Church might effect change is by condemning oppression and injustice. The Catholic Church continues the prophets' history of criticizing injustice, persecution, and suffering in both the Old and New Testaments through this. In the gospel of Matthew, Jesus uses the analogy of “salt and light”

“You are the salt of the earth…You are the light of the world” (Matthew 5:13–16). Christians should contribute to the preservation of the good in Christian culture and add the special flavor of God's ideals to all aspects of life, just as salt preserves food. As Salt is used as a food preservative so as Christians are tasked to preserve the catholic church culture of defense of human dignity. As salt is important in food so do every human life is of great value to the world. Light of the world means Christians should touch the lives of everyone around them. Touching the lives of everyone involves caring for their needs such as healthcare. Gordon ideas were relevant in establishing the calling of the Catholic Church of denouncing all forms of injustices and oppression in society. Gordon emphasized denouncing injustices and oppression generally in the society whereas this study confined itself to the calling of the Catholic Church in denouncing injustices and oppression in the healthcare provision.

The Roman Catholic Church is the world's largest non-government supplier of health care services. It has over 18,000 clinics, 16,000 residences for the elderly and those with special needs, and 5,500 hospitals, with approximately 65% of them located in developing nations. According to Agnew (2010), the Pontifical Council for the Pastoral Care of Health Care Workers, the Church oversees 26% of the world's health care institutions. Even in wealthy countries such as the United States, the Catholic Health Association is the largest non-profit health care provider, with over 600 hospitals and 1,600 long-term care and other health institutions spread across all 50 states. Catholic Health Australia is Australia's largest not-for-profit healthcare grouping, with 75 hospitals and 550 residential and community care services (Moran, 2023). Catholic church healthcare facilities were specifically designed to care for persons no one wanted to touch, sometimes in difficult circumstances (Moran, 2023).

Catholic healthcare facilities offer a wide range of treatments to patients of all ages, races, and religious beliefs, from conception to natural death. Catholic healthcare providers are frequently the "safety net" for thousands of patients in the communities they serve who cannot afford health insurance. Catholic healthcare systems and institutions can be found in all 50 states, including acute care, skilled nursing, and a variety of ancillary services such as hospice, home health, assisted living, and senior housing (Brockhaus, 2017).

Catholic religious congregations and their hospitals provide outstanding medical care that puts the human person first in nations with competent public healthcare systems, as well as doing scientific research that completely respects life and Christian moral ideals. In nations where health-care systems are insufficient or non-existent, the Catholic Church works to enhance health, eradicate infant mortality, and combat widespread disease. The church emphasizes on caring for the ill in both rich and poor countries, even when a cure is not attainable (Brockhaus, 2017).

Furthermore, the Catholic Church is particularly visible in African healthcare services. Among all religious and for-profit groups participating in the continent's healthcare sector, the Catholic Church manages the most hospitals and clinics that provide free medical care to people living with HIV/AIDS, pregnant women, and malaria sufferers. Even in African countries where the Catholic Church is not the majority, this occurs. Catholics, for example, make up approximately 30% of the Ghanaian population but run more hospitals than any other organization. In total, Parry (2011) operates in 16,178 health centers, including 1,074 hospitals, 5,373 out-patient clinics, 186 leper colonies, 753 homes for the elderly, and 753 homes for physically and mentally challenged siblings and sisters.

Through the Catholic Health Commission of Kenya, the Catholic Church oversees around 30% of all medical institutions in Kenya. The Church has a huge network of 451 health facilities (including 69 hospitals, 117 health clinics, 14 medical training colleges, and 251 dispensaries), 46 community-based health programs, and programs for orphaned and vulnerable children (OVC). The Catholic Church provides mobile clinics for nomadic populations in arid and semi-arid locations when other entities, such as the government, are unable to provide health treatment (KCCB, 2015). The healing apostolate is especially important for Catholic hospitals in Kenya because of the Church's long history of participation in this field. Furthermore, the Catholic Church regards healthcare as a basic human necessity that stems from the sacredness of human life. All healthcare practitioners are called to be guardians of life culture, and thus of human dignity and the right to life (Kiragu, 2021).

Kenya's government has complimented the Catholic Church for its contributions to the country's health-care system. The Catholic Dioceses of Kenya are actively involved in social ministry through a variety of projects, particularly in the health sector, and the church works with the government to provide healthcare services to millions of Kenyans (Ndaga, 2015).

The Catholic Diocese of Kericho is one of the 22 Dioceses in the republic of Kenya (National Council for Law, 2013). According to the Catholic Diocese of Kericho statistics of 2019, the Diocese has a population of 1,777,466 residents with a total of 10 healthcare facilities. According to the mission of Catholic church health department, the department is committed to excellence in all they do by providing healthcare that is up to date, compassionate, and patient centered.

The above scholars were in agreement that catholic church involvement in healthcare provision is visible everywhere in the world, the position adopted by this study as well. However, they did not unravel whether its involvement has been effective in ensuring healthcare accessibility for all which this study unravelled by examining the catholic church effectiveness in alleviating human values related challenges in healthcare provision set up.

1.11Summary of Literature Review

Available literature pointed to various scholars addressing healthcare provision as a phenomenon in general and human values related challenges, teachings and roles of the Catholic Church in healthcare provision. Healthcare provision as a basic human right is a concern for the Catholic Church. The Catholic Church teaches that human dignity is the core principle in healthcare provision. Therefore, it must be respected and valued. Furthermore, the Catholic church is against any medical procedure that directly or indirectly takes away human life it. The Catholic Church condemns socio-economic attributes in healthcare provision thus the quest for this study to investigate the effectiveness of the Catholic Church in alleviating human values related challenges arising as a result of socio-economic attributes impacting healthcare provision.

1.12 Justification of the study

From the analysis of related literature, it is clear that the reviewed works are in one way or the other linked to healthcare provision as a concern, human rights values as affected by healthcare provision in what the study called normative challenge, and the role of the Catholic Church in alleviating normative challenges in healthcare provision. It is equally clear that none of the reviewed works have connected the three variables which this study did.

1.13 Theoretical Framework

The study used liberation theology theory popularized by Catholic priest Gustavo Guttierrez, who first used the phrase in his 1971 book *A Theology of Liberation* as its main analytical lens. As many countries in Latin America started to seek freedom from the increasingly restrictive political and economic systems that emerged after the continent's decolonization, liberation theology emerged inside the Catholic Church in the 1960s (Gutierrez, 1988). It developed primarily as a moral response to the area's deprivation and social injustice.

This method of theology has developed to stand out for its foundation, applications in the real world, and ultimate objectives. Theology, according to Gutierrez (1988), is a critical reflection on praxis, or a meditation on social practice in the context of scripture. Christian theology and socioeconomic studies are combined in the concept of liberation, which emphasizes social concern for the underprivileged and emancipation for those who are oppressed.

Catholic theologies have traditionally started with the Gospel and explained experience in the context of the Catholic Church (Boff, 1990). Liberation theology, on the other hand, starts with the people's lived experiences, especially those of the poor and most vulnerable, and proceeds on to an understanding of the gospel within the context of their lived experiences. Praxis, a term used to describe this practice, entails ongoing reflection and theory adaption based on the situational setting in which one finds oneself. Liberation theology's ultimate goal is to comprehend the gospel in light of the poor and oppressed people's lived experiences so that one may analyze that specific situation and work to end oppression while continuously pursuing God's kingdom on earth (Turner, 1994).

By inferring to liberation theology, the study identified ill-health and poverty in the society as the sources of oppression. Therefore, getting the lived experience of the poor and society in general involved examining healthcare provision as a contemporary phenomenon in general and in the Catholic Diocese of Kericho and exploring the normative challenges related to it thereby drawing out social analysis of the lived experience. Emerging data showed that healthcare provision is faced with human rights values related or normative challenges despite the common knowledge in the public domain that healthcare access is a basic human right. This helped the study achieve objective one which sought to examine healthcare provision as a contemporary phenomenon and explore the normative challenges related to it in general.

Liberation theology advances to an understanding of the gospel in the perspective of that actual experience. This involved relating the lived experience to scriptural or biblical interpretation. After understanding the healthcare provision as a contemporary phenomenon and normative challenges related to it, the study sought out the will of God as found in the Bible and Catholic church Christian traditions by asking questions such as: What does the social teachings of the Catholic church teach on healthcare provision? If Jesus was here today, how would He respond to the phenomena of healthcare provision? From Jesus' incarnation and teaching, what should we do in order to transform the societal mistreatment of people in healthcare provision? The study established that Catholic church in general and in the Catholic Diocese of Kericho have social teachings governing healthcare provision. These include the option for the poor, the common good, solidarity, subsidiarity, and respect for human dignity. Also, Ethical and Religious directives for the Catholic church healthcare portrays the stand for the Catholic Church on healthcare provision of

defense for human dignity. This helped the study achieve the second objective which sought to establish the Catholic Church's position on healthcare provision in general and in the Catholic Diocese of Kericho.

Liberation theology suggests addressing the purported cause of oppressive forces in order to combat them. After understanding the lived experience in light of the gospel, liberation theology proposes working towards elimination of the oppression. The study sought the success of the Catholic Church in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho. This helped the study to achieve the third objective.

Gutierrez (1988) considered the church to be the "sacrament of history" for liberation. That is to say, the church plays a significant role in attainment of liberation. Gutierrez emphasized practice or more technically, praxis over doctrine. Catholic church has a role of liberation, liberating society from all sources of oppression such as ill-health and poverty. Using this idea, the study examined the liberative mandate of the Catholic Church in healthcare provision as part of its mission and not a form of charity it offers to the society. Three stages of liberation are described by Gutierrez (1988): the emancipation from sin, the liberation of the human conscience, and the freedom from political oppression. Liberation from societal contexts of oppression and marginalization that cause many people—indeed, all people—to live in ways that are at odds with God's plan for their lives is how Gutierrez describes liberation from political oppression. The study recognized poverty and ill health as societal oppressive situations that drive people to live in ways that are against God's purpose. By doing this, it investigated how Christian theology and political activism interacted, particularly in regards to issues of economic justice, poverty, and human healthcare

rights.

In part, Gutierrez contends that the Church has failed to adopt a theological position that acknowledges the necessity of a total commitment to the oppressed peoples, which has contributed to injustice. Overcoming political, social, and economic shackles is only one aspect of liberation. To view the evolution of humanity as a historical process of human emancipation means, in a deeper sense, to view humankind as becoming. It is to observe mankind seeking a fundamentally new society in which it will be free from all servitude and in which it will be the architect of its own future.

In sum, the study acknowledged the fact that Catholic Church had not officially accepted liberation theology. Still, liberation theology is closely linked to the teachings upheld in the Catholic church and opposition to it was majorly tied to political reasons rather than theological. Liberation theology forever linked the church to the fate of the oppressed and allowed for the poor to take part in the future of the Catholic Church, even if the Catholic church rejected it due to its radical viewpoints rather than theological. Liberation theology is closely linked to the teachings upheld in the Catholic Church. Opposition was majorly tied to political reasons rather than theological.

1.15 Research Methodology

The research design, study area, study population, target population, sampling technique, sample size, and data collection tools are all covered in this section. It also covers data analysis and presentation procedure as well as ethical considerations sought after in this study.

1.16. Research Design

This research employed a descriptive research design. Descriptive design was used to get the people's feelings and experiences in relation to Catholic church healthcare

provision. Descriptive research design was ideal for this study since the study described the variables as they are. It gave an opportunity to the respondents to describe their ex of healthcare provision in the Catholic Diocese of Kericho, the normative challenges, the teachings and the effectiveness of the Catholic Church in healthcare provision.

The study employed a mixed method where both quantitative and qualitative data was collected. While qualitative data was gathered through focus group discussion and interviews, quantitative data was gathered using closed items in the questionnaires. This was ideal in understanding better the phenomena under study. According to Hadi and Closs (2016), mixing qualitative and quantitative data enhances the quality of research by fostering a deeper comprehension of the generated data. This will address the research issue and provide a better response to the research queries.

1.16.1 Study area

The study was conducted in the Catholic Diocese of Kericho. The Diocese covers Kericho and Bomet counties in the formerly Rift valley Province of Kenya. The Catholic Diocese of Kericho was chosen as a representative of the country Kenya as communities in the area lack access to basic healthcare services, and up to 60% of households live below the poverty line. Furthermore, access to healthcare is problematic, especially in rural and distant regions (Ballantyne, 2021).

Catholic Church is purposely sampled because of its long-term involvement in healthcare provision since it is the oldest institution in the Western World and the originator of "hospitals" and it considers healthcare as a basic human right which flows from the sanctity of human life (Kiragu, 2021). Furthermore, the Catholic Church's commitment to healthcare entails caring for a large number of impoverished patients

while upholding the life ethic and regard for human dignity upon which it was built (Guinan, 1998).

The Catholic Diocese of Kericho has established ten working healthcare facilities as shown in the table 1.1below

Table 1. 1: Catholic Church healthcare facilities in the Catholic Diocese of Kericho

St Clares kaplong mission hospital
Kipchimchim mission hospital
Our lady of Guadalupe, Roret
St.Lukes Matobo
Kaplomboi health centre
Mercy Dispensary
St. Francis Monastry clinic
St. Ann's Kapsorok dispensary
Mercy secondary school clinic
Mercy mobile clinics
Total 10

Source: Researcher, 2022

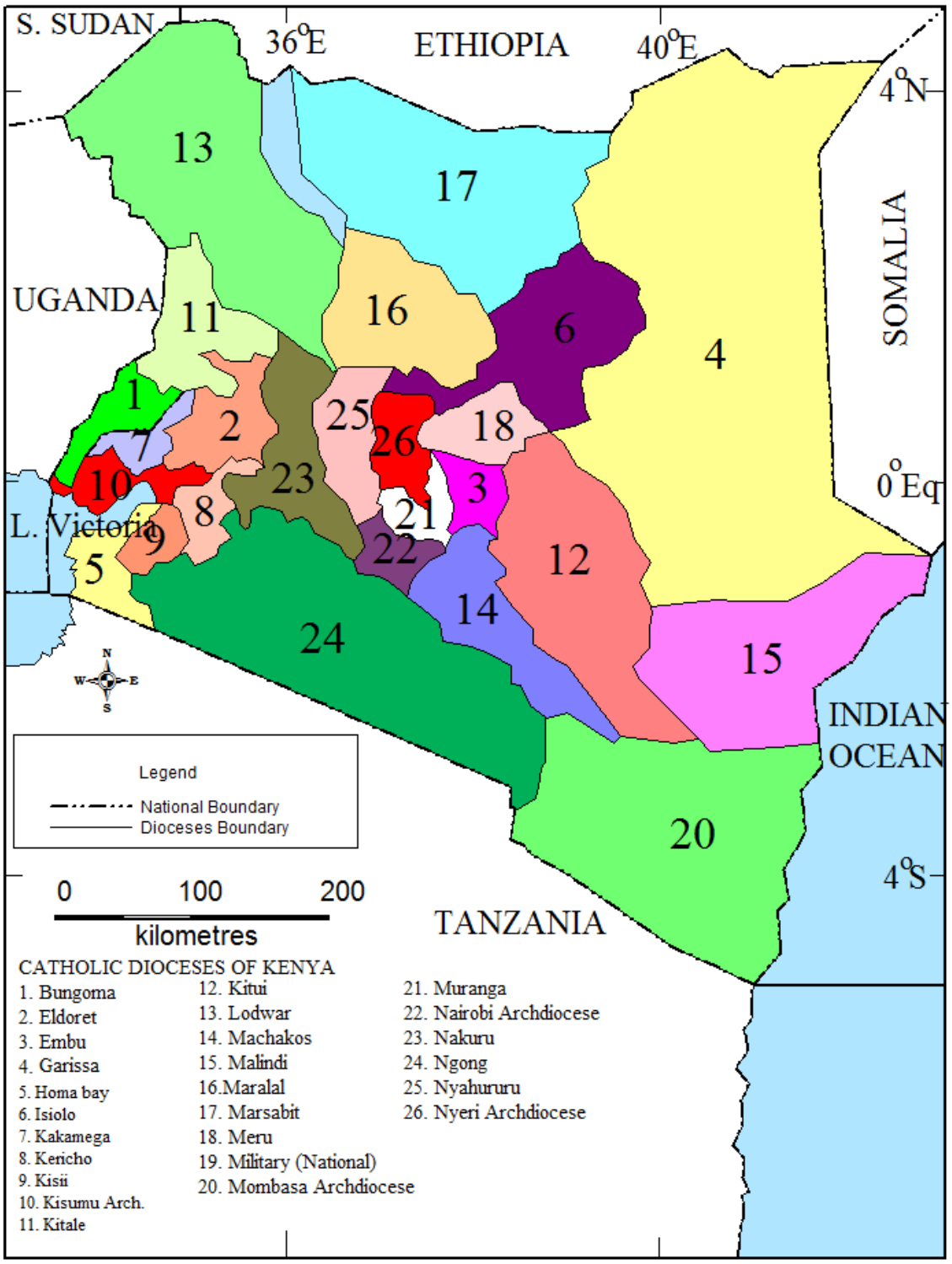

Figure 1. 1:Map of Kenya showing Catholic Dioceses of Kenya

Source: Moi University Geography Department GIS Laboratory

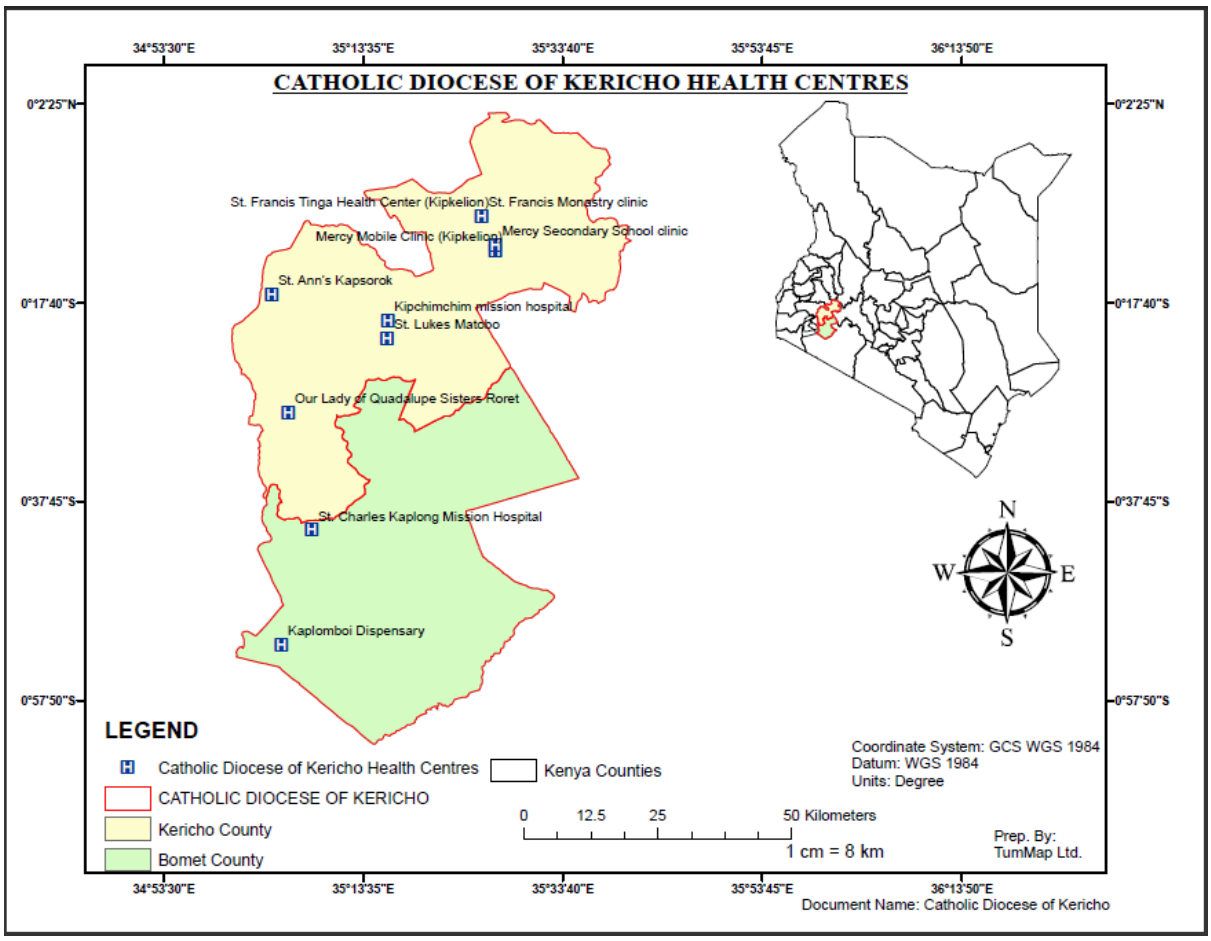

Figure 1. 2: Map of Catholic Diocese of Kericho showing Catholic church healthcare facilities

Source: Moi University Geography Department GIS Laboratory

1.16.2 Target Population

The study examined the Catholic Church's efficacy in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho.

The target population were catholic church healthcare personnel, recovered patients from catholic church healthcare facilities, Catholic Church leaders, Catholic church faithful and non-Catholic church faithful of the Catholic Diocese of Kericho.

According to the Catholic Diocese of Kericho statistics report 2019, the diocese had 48 parishes as indicated in table 1.1 below.

Table 1. 2: Parishes in the Catholic Diocese of Kericho

S/No.	Parish	Location	S/No.	Parish	Location
1	Sacred Heart Cathedral	Kericho	25	Holy Trinity Kimatisio	Bomet
2	Our Lady of Fatima	Kericho	26	St.John Bosco Kimugul	Bomet
3	St. Kizito Londiani	Kericho	27	Holy Spirit Catholic church Segemik	Bomet
4	Our Lady of Mercy Kipkelion	Kericho	28	St Mary's Matobo	Kericho
5	Holy Family Siongiroi	Bomet	29	St. Francis-Kiptere	Kericho
6	St. Joseph The worker	Bomet	30	St. Benedict Kobel	Bomet
7	St Catherine of Siena Tegat	Bomet	31	St. Barnabas of Kapsigiryo	Bomet
8	St Stephen Sironet	Bomet	32	St. Mark's Litein	Kericho
9	St. Michael Bomet	Bomet	33	St Michael's Teganda	Bomet
10	St John's Chebangang	Bomet	34	St. Raphael Longisa	Bomet
11	Mary Mother of God Chebole	Bomet	35	St. Paul's Makimeny	Kericho
12	St John's Chebunyo	Bomet	36	St. Joseph, Marinyin	Kericho
13	St Paul Catholic Kapsebetet	Bomet	37	St. Mary's Matobo	Kericho
14	St. Timothy Tebesonik	Kericho	38	St. Teresa Mogogosiek	Bomet
15	St Paul siomo Embomos	Bomet	39	St Michael's Nyambugo	Bomet
16	St. Martin's Fort Ternan	Kericho	40	St Peter's Mugango	Bomet
17	St Michaels Nyabugo	Bomet	41	St Theresa-Ndanai	Bomet
18	St. John Paul Kabianga	Kericho	42	St. Matthew's Ndaraweta	Bomet
19	Holy Cross Kaboloin	Bomet	43	St. Philomena siret	Kericho
20	St. Peter/Paul Kaplong	Bomet	44	Good Shepherd Roret	Kericho
21	St. Bartholomew Kapsang'aru	Bomet	45	St. Jude Thaddeus Kapkatet	Kericho
22	St. Barnabas Kapsigiryo	Bomet	46	St. Padre PIO Telanet	Kericho

23	St Thomas Kebeneti	Kericho	47	St Augustine Sotik	Bomet
24	St Patrick's Keongo	Kericho	48	Holy Spirit Kaplomboi	Bomet

Source: The Catholic Diocese of Kericho, 2019 statistics

According to the 2019 Census, Kericho County had a population of 901,777 people, while Bomet County had 875,689 residents. The two counties of Kericho and Bomet make up the Catholic Diocese of Kericho. The total population of the two counties is therefore the study's target population. There were 1,777,466 persons in total. The data for the analysis were gathered from this population.

1.16.3 Sampling Procedure

Stratified sampling was used to group the respondents into five groups: Catholic Church leaders, Catholic church healthcare personnel, recovered patients from catholic church healthcare facilities, Catholic Church faithful and non-Catholic church faithful. Purposive sampling was used to select 10 parishes out of 48 parishes in the Diocese as shown in table 1.3 below.

Table 1. 3: 10 Parishes purposively sampled for the study

S/NO.	Parish	Location	S/NO.	Parish	Location
1	St. Peter-paul Kaplong	Bomet	**6**	St.Mary Matobo	Kericho
2	St. Raphael longisa	Bomet	**7**	St Kizito Londiani	Kericho
3	Holy spirit kaplomboi	Bomet	**8**	Our Lady of Mercy kipkelion	Kericho
4	Our Lady of Assumption Sigor	Bomet	**9**	Our lady of Fatuma kipchimchim	Kericho
5	St Theresa's Ndanai	Bomet	**10**	Good Shepherd Roret	Kericho

Source: Researcher, 2022

The 10 parishes above were preferred and selected purposively because of the availability of a healthcare facility as this mitigated against the vastness of the area under study. Simple random sampling was used to select Catholic Church faithful

with the aim of gathering information about their perception with regard to the understanding of healthcare provision as a phenomenon and the prevalence of normative challenges in healthcare provision in the Catholic Diocese of Kericho. Snowballing sampling was used to select the recovered patients to participate in the study. This was ideal in understanding the actual normative challenges in healthcare provision in Catholic church healthcare facilities.

Key informants with vital information for in depth analysis with respect to the study objectives were chosen via purposeful sampling. For this study, key informants were: Diocesan Medical Coordinator, Catholic church healthcare personnel, recovered patients and Catholic Church leaders (Diocesan Bishop and Priests with a healthcare facility in their parish).

1.16.4 Sample size

According to Mugenda & Mugenda (1999), 384 respondents should be included in the sample if the target population is larger or more than 10,000 individuals. The sample size at this point of the study therefore consisted of 390 respondents in the quantitative aspects of this study which is slightly more than Mugenda's recommendation. The 390 respondents however ensured equal treatment of the ten selected parishes.

Simple random sampling was used to select the 390 respondents involved in the quantitative aspects of this study. These were divided into three categories: men, women and youth where 130 in each category was selected. The 130 in each category were drawn from the ten already mentioned parishes where thirteen participants were randomly chosen from each category from the ten parishes.

390/10/3=13 where three stands for the three categories: men, women and youth and 10 are the purposely selected parishes thus 13 men, 13 women and 13 youth from

each of the purposely chosen 10 catholic church parishes.

For qualitative aspects in this study, 61 respondents were chosen. Purposive sampling was used to select one healthcare personnel from each catholic church healthcare facility in the diocese giving a total of 10 healthcare personnel. Diocesan Bishop and Diocesan medical coordinator were purposely chosen. 10 Catholic church priests from the 10 purposely chosen parishes were also purposely chosen to participate in the study.

Snow balling sampling was used to select the 24 recovered patients who received healthcare services from the catholic church healthcare facilities to get their experiences while accessing this service. Out of these, 11 were catholic church faithful, and 13 were non- Catholic church faithful. At these 24 respondents the saturation point had been reached since the elicited responses were becoming repetitive. Convenient sampling was used to select 15 Non-catholic church faithful.

Table 1. 4 Sample Population and Sampling Techniques

Target Population	**Sample Size**	**Sampling Technique**
Bishop	1	Purposive
Priests	10	Purposive
Diocesan Medical Coordinator	1	Purposive
Healthcare personnel	10	Purposive
Recovered Patients	24	Purposive
Catholic church faithful	390	Simple random sampling
Non-Catholic church faithful	15	Convenient
Total	**451**	

Source: Researcher, 2022

1.16.5 Data collection instruments

Both primary and secondary sources were used to gather the data.

1.16.6 Secondary Data

With regard to secondary research, a desktop study was conducted at Masinde Muliro University of Science and Technology Library. At this stage, content analysis from relevant sources to this study was undertaken. The secondary sources were purposefully chosen and it included information from books, journals, pastoral letters from bishops' conferences and internet sources on healthcare provision as a contemporary phenomenon in general, challenges related to human values in healthcare provision and the teachings of the Catholic Church on healthcare provision. The secondary data collected were used to supplement primary data.

1.16.7 Primary Data

Focus group discussions, interview schedules, and questionnaires were used to collect primary data.

1.16.7.1Questionnaires

Face to face administration of open and close-ended questions were done with respect to the availability of the respondents. In addition to providing their own ideas in response to some questions, the respondents had to make a choice from a list of alternatives. Questionnaires were administered to the catholic church faithful and the items in the questionnaires examined healthcare provision as a contemporary phenomenon and existence of catholic church healthcare facilities in the Catholic Diocese of Kericho. They also examined the prevalence of normative challenges in Catholic church healthcare facilities.

1.16.7.2 Interviews

Key informants were interviewed orally, and notes were taken, to get detailed information about the research issue. Key informants for this study were: Diocesan

Medical Coordinator, Catholic Church leaders, catholic church healthcare personnel and recovered patients from catholic church healthcare facilities in the Catholic Diocese of Kericho. Interviews were also conducted to the non-Catholic church faithful members. The interviews sought to gather information concerning experiences of normative challenges in healthcare provision. They also examined the teachings and the position of the Catholic Church on healthcare provision in the Catholic Diocese of Kericho. They were conducted in Kiswahili, English and local dialect depending on the convenience of the interviewee.

1.16.7.3 Focus Group Discussions

The focus group consisted of twelve members brought together and a moderator who was the researcher employed a focus group discussion guide. The session took half a day. According to Barbour (2010), the number of participants in a focus group discussion rarely exceeds a minimum of four and a maximum of twelve per group. The participants were purposely chosen and it encompassed healthcare officials: County Health officer of Bomet and Kericho, catholic healthcare facility administrator from one of the ten catholic healthcare facilities in Catholic Diocese of Kericho, one community health worker, one member of: Catholic Men Association (CMA), Catholic Women Association (CWA) and Young Christian Association (YCA) selected from the 10 ten purposely chosen parishes, one catholic church healthcare personnel, one recovered patients from catholic church healthcare facility, one non-Catholic church faithful community member and the diocesan medical coordinator. The focus group engaged 12 participants as shown in the following table 1.5

Table 1. 5 Target Population and Sampling Techniques

Target Population	Sample Size	Sampling Technique
CMA	1	Purposive
CWA	1	Purposive
YCA	1	Purposive
Healthcare Administrators	1	Purposive
Community healthcare workers	1	Purposive
Kericho County health officer	1	Purposive
Bomet County health officer	1	Purposive
Catholic church priest	1	Purposive
Diocesan Medical Coordinator	1	Purposive
Catholic church healthcare personnel	1	Purposive
Recovered Patients	1	Purposive
Non-Catholic church faithful	1	Purposive
Total	**12**	

Source: Researcher, 2022

The information gathered clarified what arose from questionnaires and interview schedules. It gathered information on how the Catholic church healthcare facilities respond to the contemporary hospital market environment, how poverty was a source of oppression in society and opinions on whether liberation theology made sense in the scheme of Catholicism. This tool was ideal as it allowed the researcher to ventilate on the arising issues and it sharpened well data obtained through questionnaires and interview schedules.

1.17 Validity

When a research instrument's contents are pertinent and relevant for the study's goals, it is deemed valid. The researcher developed the research instruments with items based on study objectives in order to ensure face and content validity in this study. The

researcher also sought opinions on the usability, clarity, and readability of the data collection instruments from the supervisors as well as specialists in the field of study, particularly the lecturers in the department of Social Science Education and they were satisfied. This made it easier to revise and modify the study instrument as needed, increasing validity.

1.18 Pilot Study

To ensure reliability, a pilot study was conducted before the actual one in the Catholic Diocese of Eldoret which was not the actual area of study. According to the Nandi County Integrated Development Plan of 2018/2019, the report noted that access to healthcare in the county is a challenge and is more severe to the poor since they do not have the healthcare service they want because of the inability to afford the healthcare service. It was undertaken using few subjects whose characteristics were similar to those in the target population. This helped identify vague questions, incorporation of vital comments and suggestions from the respondents and inadequate items in the research instruments.

Reliability of research instruments was achieved through test and retest method and was conducted in an interval of two weeks. This helped realize the ability of the research instruments to produce similar data when subjected to similar target population under the same methodology.

A correlation was then calculated between from the two results to assess the consistency of the respondents across time. A test–retest correlation of 0.80 was obtained and this provided evidence of the tool's reliability (Cozby & Bates, 2012).

1.19 Data Analysis and presentation

Data collected was coded and the codes used to organize and analyze the data. Quantitative data was analyzed descriptively using frequencies and percentages aimed at depicting the pattern of response in the study. Qualitative data on the other hand was analyzed thematically. This involved coding the data by attaching the descriptive summaries of chunks of textual materials obtained from the recorded data and putting them into matching categories. From the categories, inductive and deductive analysis were used to interpret the data into meaningful themes. The themes provided basis for presenting and discussing data in line with study objectives. Thematic analysis was used in analyzing data where major concepts or themes were identified and discussed. Narrations and explanations were made based on the depicted pattern of response in the study and the existing knowledge from secondary sources. Additionally, qualitative data was presented using illustrative quotes with explanation.

1.20 Ethical Considerations

The study involved human subjects. Caution therefore was observed and reasonable safeguards were built to protect the participants. To do so, the nature and purpose of research was explained to all the concerned participants and thereafter their consent was sought. The participants were requested to sign a consent form that was attached to every questionnaire. For the instruments that did not have a questionnaire to be filled such as interviews and Focus Group Discussion, the researcher provided a separate consent form to participants. The information received by the researcher during the study period was treated with utmost confidentiality and purely for academic purposes. Primary data collected was presented actually as they are without manipulation.

Additionally, the researcher sought research permission from relevant authorities such as Directorate of Post-Graduate Studies of Masinde Muliro University of Science and Technology and National Commission for Science, Technology and Innovation (NACOSTI).

CHAPTER TWO

HEALTHCARE PROVISION AS A CONTEMPORARY PHENOMENON AND NORMATIVE CHALLENGES RELATED TO IT IN GENERAL

2.0 Introduction

This chapter examines healthcare provision as a contemporary phenomenon in general in the society. To do so, it explores the meaning of healthcare provision in the middle of several initiatives and suggestions as to what the right to healthcare access may or should be, it also illuminated the right to healthcare access in international human rights law as it presently stands, highlighting its implications for certain people and groups. The chapter also explores the normative challenges in healthcare provision from the global view and in relation to the prevailing condition in healthcare status such as the COVID-19 pandemic. Additionally, it echoes on the various manifestations of normative challenges in healthcare provision. This is done with the aid of liberation theology propagated by Gustavo Guttierez (1988), which proposes to fight oppressive forces by addressing its alleged source. This then serves well in explicating ill-health and the normative challenges related to healthcare provision as forms of oppression in society.

2.1 Meaning of Healthcare Provision

WHO (2016) defined healthcare as including all services dealing with disease prevention, diagnosis, and treatment as well as health promotion, maintenance, and restoration. Provision deals with the way inputs such as healthcare financing, healthcare personnel, healthcare equipment and drugs are combined to allow the delivery of healthcare interventions. In conclusion, the objective of providing healthcare is to enhance healthcare outcomes and meet people's expectations in a way that lessens disparities in both the delivery of and response to healthcare (Adams et al., 2002).

For the purpose of this study, and in a relevant research item, the respondents were required to provide their opinion on their understanding of healthcare provision. The figure 2.1 below illustrates their responses:

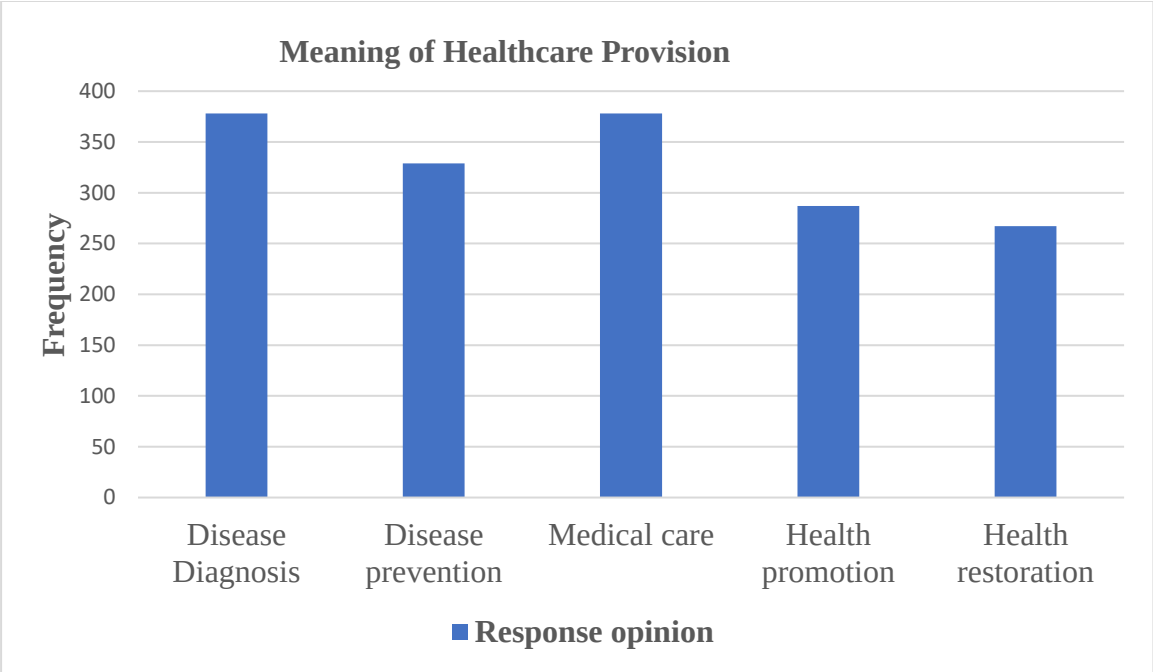

Figure 2. 1: **Meaning of healthcare Provision**

Source: Field Data (2022)

All the respondents (100%) were in agreement that healthcare provision entails diagnosis of disease and medical treatment. 329 (87%) of the respondents noted that disease prevention is part of healthcare provision. 287 (76%) of the respondents affirmed that any activity pertaining health promotion is part of healthcare provision while 302 (80%) asserted that restoration of one's health is a form of healthcare provision. Generally, the responses given revealed that healthcare provision is more than the common idea of medical treatment. It encompasses prevention, diagnosis, recovery and any practice related to healthcare matters.

The respondents were further asked to give explanation for their responses. From the elicited responses, the respondents felt that healthcare provision involves any

healthcare activity done with the aim of improving healthcare outcome irrespective of the place where the healthcare activity takes place. The respondents described healthcare promotion as designing the social and physical environment to protect individuals and population health by preventing the root causes of ill-health. Some of the interventions mentioned included: healthcare communication aimed at raising awareness about healthy behaviors such as mass media campaigns, provision of requisite knowledge, skills and information to make healthy choices for example unhealthy food to be avoided such as those of high fat levels like pork, making changes on the environment to enhance healthy choices such as setting rules and regulations pertaining quality health like aligning tax policies on unhealthy products like alcohol, wearing of seat belts and helmets during travelling.

The respondents further described healthcare restoration to be more than diagnosis which only ends disease symptom or rather providing temporary relief. They explained that healthcare restoration in most cases entails lifestyle changes such as taking a healthy balanced diet, regular exercise and even enough sleep.

Among other explanations given in support of the meaning of healthcare provision included healthcare education and counselling.

Of similar opinion, a respondent denoted:

> Healthcare providers must also offer counseling and education to their patients. They include having a positive view of oneself, having respect for and taking care of one's body, exercising regularly, dealing with the health effects of alcohol, drugs, and other drug misuse, and practicing food hygiene, among other things (non-Catholic church faithful, 2022).

According to the respondent, healthcare education and counselling is part of healthcare provision as it provides knowledge on how one can take care of their self-health. It

takes place in a particular institution or home setting, and it leads to the delivery of various healthcare interventions. Healthcare provision in a healthcare facility entails all types of healthcare such as primary care, secondary and tertiary care. Healthcare provision in home setting involves healthcare service outside healthcare facility such as home based and community care for terminal ailments and even self-quarantine during outbreaks such as during COVID-19 pandemic. It also involves rehabilitatory practices for drug and substance addicts and re-integration back to society after a long time of ailment.

Catholic church faithful and non-Catholic church faithful described rehabilitative practices to encompass all healthcare interventions set to enhance normal functioning among individuals within their environment. Among the practices cited by the respondents included: physical exercise training to improve muscle strength and modifying home environment for elderly people to improve their safety for instance levelling their compound to reduce their risk of falls.

Of similar opinion, one respondent noted that,

> Healthcare rehabilitation involves procedures and services aimed at supplementing or restoring loss of function which arose from diseases or movement disability (Catholic church faithful, 2022).

According to the respondent, rehabilitative practices involve practices aimed at developing new compensatory skills of what was lost during the ailment. Rehabilitation is patient-centered since the interventions designed for each individual patients targets to mitigate their healthcare risks. The opinion of respondents on rehabilitative practices as part of healthcare provision is in resonance with WHO (2017) that, for a healthcare delivery system to reach its full potential, rehabilitation procedures need to be

strengthened. In order to achieve this, rehabilitation must be integrated into all tiers of care and be supported by universal health coverage.

Generally, the opinions of the respondents on the meaning of healthcare provision resonated with the WHO constitution of 1948, where healthcare is defined as the preservation or enhancement of health through the avoidance, recognition, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in humans. Healthcare experts and specialists in related sectors provide it. It includes work done in the areas of public health, primary care, secondary care, and tertiary care.

2.2 Healthcare Provision as a contemporary phenomenon

Regardless of one's age, gender, socioeconomic status, or ethnicity, healthcare is a daily issue and a basic requirement. On the other hand, poor health prevents a person from reaching their full potential and actively contributing to society (WHO, 2008).

The right to good health serves as a model for comprehending a dignified existence. According to the preamble of the 1946 World Health Organization (WHO) Constitution, everyone has the fundamental right to the best feasible standard of health, regardless of their race, religion, political convictions, economic status, or social circumstances. Access to healthcare denotes the ability to utilize a service when necessary. The utilization of the service rather than the mere existence of a healthcare institution serves as the proof of access. Achieving a sufficient level of health knowledge increases personal responsibility.

The dignity of the human being lies at the heart of the right to health (WHO, 2017). This assertion aligns with the position of this study that recognition of the dignity human person provides the most important reason for advocating for patient-centered

healthcare provision. Social services, such as healthcare services, play a crucial role in preserving and advancing human dignity and resolving ongoing issues of extreme inequity and disparity. This implies that human dignity is a priority in healthcare provision.

The notion of the right to health must be inclusive calls for appropriate healthcare education, expertise, and equity in the provision of healthcare. This includes the right to a healthcare delivery system that ensures everyone has an equal chance to achieve the highest level of health, the right to disease prevention, treatment, and control, access to necessary medications, maternal, child, and reproductive health, and quick, equal access to basic healthcare services; the provision of adequate healthcare-related education and information; and population participation in decisions related to healthcare provision. Participation is the process of making sure that all national stakeholders, including non-state actors like non-governmental organizations, faith-based organizations, and churches, are actively involved in all stages of programming, including assessment, analysis, planning, implementation, monitoring, and evaluation of issues relating to healthcare provision (WHO, 2008). This explains the assumption of this study that the Catholic Church qualifies to participate in healthcare provision as it strives to provide equal opportunities for everyone to enjoy the highest attainable standards of health.

Non-discrimination is a core human rights principle that is necessary for the exercise of the right to the best reasonably attainable state of health (WHO, 2008). All healthcare facilities, services, and products must be universally accessible, acceptable, and of high quality. Everyone, including children, teenagers, the elderly, people with disabilities, and all vulnerable groups, must be able to access them. Accessibility also refers to the

freedom to ask for, receive, and share information about healthcare services. This means that the inability to acquire healthcare services owing to financial issues and a lack of health literacy is discriminatory in and of itself. Medical ethics, gender sensitivity, and cultural norms should all be respected by the healthcare facilities and services. Therefore, they ought to be seen as acceptable from both a medical and cultural perspective. Additionally, they must be of the highest caliber and fit for use in science and medicine. This necessitates the use of thoroughly screened medical professionals, drugs that are still effective and have received scientific approval, modern hospital supplies, and clean, safe drinking water.

In a research item in this study, the Catholic church faithful and non-Catholic church faithful were asked to agree or disagree whether access to healthcare service is a basic human right or not. Their response in this regard was as shown in table 2.1 below:

Table 2. 1: Healthcare service access as a basic human right

Response	Frequency	Percentage (%)
Yes	378	100%
No	0	0%

Source: Field Data (2022)

The respondents (100%) overwhelmingly agreed that access to healthcare is a basic human right and therefore everyone is entitled to it. Their assertion was in tandem with WHO (2017) that the principle of universal access to healthcare is that everyone should be able to receive the care they need whenever and wherever they need it without incurring financial hardship. Every human being has a fundamental right to health. Nobody should be afflicted by an illness and perish away solely because they couldn't afford the treatment they needed.

This study made the case that a rights-based approach to healthcare provision calls for healthcare policies, programs, and all stakeholders to prioritize the needs of those who are most disadvantaged, such as the poor, in order to move towards greater equity. This idea has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage (WHO, 2017). The study established that human dignity is the core of the right to health and is a common knowledge nationally and internationally. Therefore, right to health should entail the right to value of human dignity in healthcare provision set up.

2.3 Components of Healthcare Provision

This includes all parties involved in the promotion, maintenance, and restoration of health, as well as services for both personal and non-personal healthcare, as well as the diagnosis and treatment of disease. According to Fellie & Shortell (2001) access to healthcare involves four elements namely: patient, care team, organization and environment. They have represented these elements in a model as follows:

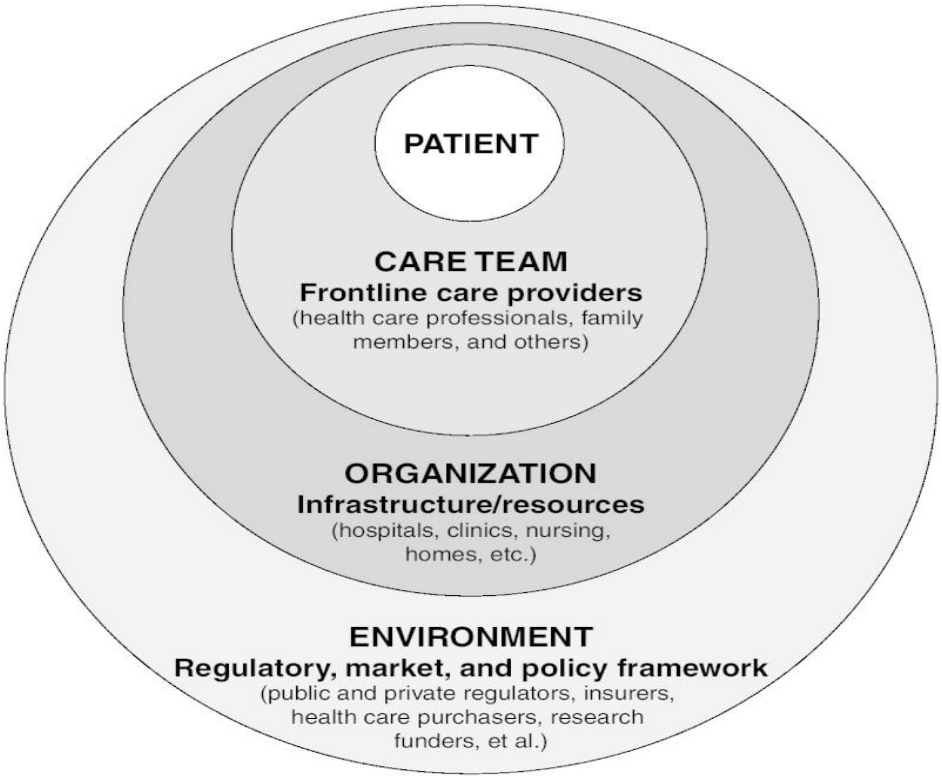

Figure 2. 2: **Conceptual model of four elements of healthcare delivery**

Source: Fellie & Shortell (2001)

2.3.1The Individual Patient

The model demonstrates that a patient-centered healthcare delivery system starts with the patient as an individual, whose wants and preferences serve as its defining characteristics. This implies that the entire healthcare system is guided and driven by the needs and preferences of the patients.

2.3.2 The Care Team

This is the second level of the healthcare delivery system. It is made up of the individual doctor and a team of healthcare professionals, patients' families and the community, whose combined efforts lead to the provision of care to a patient or population of patients. This level essentially includes all qualified employees who possess the necessary knowledge and abilities to adequately fulfill and satisfy the patients'

healthcare needs. The goal of the care team should be to standardize healthcare whenever possible and adapt it to the needs of the patients. This will improve healthcare that is efficient, inexpensive and sustainable.

2.3.3 The Organization

This is the third level of the delivery system for healthcare. It includes any hospital, clinic, healthcare facility, or nursing home that offers healthcare services, infrastructure, or additional resources to assist the efforts necessary for the satisfaction of patient's healthcare needs. The organization is a critical lever for change in the healthcare delivery system because it may foster a general environment and culture for change through its numerous operating systems, decision-making processes, and human resource practices (Ferlie & Shortell, 2001).

Ideally, this is the level that dictates the activities and decisions made in the care team and has influence in healthcare service delivery. It determines if the patients' needs and preferences as presented in the first level are going to be met or not.

Additionally, Ferlie and Shortell (2001) identifies this level as a business level. It is well-known that businesses often strive to maximize profits. As a result, what was once a right and a basic need becomes a commodity with an eye toward producing money. This appears to authorize the healthcare institution to operate as a corporate organization. The lives of people are sacrificed in order to make these gains. This study however maintained the position that human beings must enjoy the right to have their inherent human dignity respected and protected. Healthcare facilities making profits at the expense of human life is a possible violation of human rights.

2.3.4 The Environment

The environment is the fourth level of the healthcare delivery system. This includes the ethical, political, and economic environments. The environment controls the entities, regulatory, financial and payment systems that have an impact on the design and functionality of healthcare organizations. The political and economic context for healthcare is influenced by a wide range of actors. The federal government has an impact on healthcare through the Medicare and Medicaid reimbursement procedures, the regulation of private payer and provider organizations, and its support for the development and use of particular diagnostic and therapeutic interventions like drugs, devices, equipment, and procedures. Large enterprises that directly contract with healthcare provider organizations and third-party payers like healthcare plans and insurance companies, as well as the private sector's purchasers of healthcare, are both significant environment-level actors.

The Church is not left behind. It forms the conducive ethical environment necessary for healthcare access. It has an influence in the decisions made in the organization based on norms or ethics. This position however is coming under much challenge in a world that has become increasingly secular and capitalistic. All in all, the church still claims that it is still solely responsible for discerning what is morally right to be done and what is morally wrong to be avoided. In other words, the church still maintains that it is mandated to instill and uphold human values. It therefore influences the decisions made pertaining the dignity of human person in any healthcare organization (Ferlie & Shortell, 2001). This possibly explains why the Catholic Church in particular has an Ethical and Religious directives mandated to govern catholic healthcare institutions and in particular respect for human dignity.

According to Schotsmans (2012), the church community demonstrates responsibility in providing healthcare as well as doing so. The church's positive involvement in the healthcare industry is a component of its commitment to humanity. It seems obvious that the church should be involved in healthcare and medical ethics. The study also revealed that healthcare provision should benefit from a just, righteous and equal society and world. Part of the church's role to secure unity and to promote holiness, is to actively engage with the society to promote human dignity, righteousness and equity. This position aligns with Lategan (2017) argument that the role of the church includes campaigning for food security and safety, access to high-quality healthcare, and fostering a sustainable society. The study in this regard reads and justifies the involvement of the Catholic Church on healthcare provision as part of its calling.

2.4 Healthcare provision stakeholders and delivery

The study explored the entities that are integrally involved in healthcare provision and whose involvement affect the process of healthcare provision and delivery. In a research item in this study, the respondents were asked to give their opinions on whether the listed key stakeholders affected healthcare provision and delivery. The following table 2.2 illustrate their response in this regard.

Table 2. 2: Healthcare provision stakeholders

Component	Frequency	Percentage
Patients	378	100%
Healthcare Personnel	378	100%
Community	378	100%

Source: Field Data, (2022)

The respondents overwhelmingly agreed that patients, healthcare personnel and the community are key stakeholders that significantly influence healthcare provision and delivery. Patients were described as any recipient of healthcare services. Healthcare personnel was described as anyone who delivers healthcare services to the sick either directly as doctors and nurses or indirectly as aides or helpers. That is, whoever provides healthcare service to the patient. Community was described to encompass healthcare partners who collaborate in enhancing healthcare provision. They included just as we have seen above in the category of environment and organization (see conceptual model already discussed): healthcare facility, home, government, church, insurance company and pharmaceutical firms. This was important for this study as it informed the assumptive basis of this study that the patient, healthcare personnel and community are the key stakeholders responsible for healthcare provision and delivery. This is in tandem with Lubbeke and the colleagues (2019) who posited that in healthcare provision, the main stakeholders are patients, providers (professionals and institutions), payers, and policymakers.

2.5 Responsibility of Healthcare Stakeholders

Interview responses from the healthcare personnel mainly confirmed that healthcare provision stakeholders have a role to play for effective healthcare provision. The responsibilities as mentioned for each stakeholder are discussed as follows:

2.5.1 Patients

Patients were described to be responsible for making choices concerning their own health. That is, living healthy lifestyles. For instance, avoiding drug and substance abuse. Additionally, patients were also termed responsible for seeking medical attention and controlling healthcare costs. This is because healthier living would lead to lower healthcare costs. Therefore, personal healthy lifestyle is a way of controlling healthcare costs and it is an individual responsibility.

In an interview, one of the healthcare personnel affirmed that:

> Patient is responsible to take care of his or health by providing correct and complete information about their health, reporting changes in their general health conditions and symptoms of any illness. Furthermore, they are responsible for following recommended treatment plan they have agreed to with the healthcare personnel (Catholic church healthcare personnel, 2022).

According to the respondent, patients play a vital role in one's healthcare by seeking treatment as well as following recommended treatment. Therefore, patients have an individual responsibility to care for his or her own health especially through seeking treatment as well as maintaining healthy lifestyle.

2.5.2 Healthcare personnel

Healthcare personnel were described to be responsible for alleviating suffering, ending pain, providing proper and suitable medicines and instructions to patients

regarding prescribed drugs on the usage as well as the side effects if any.

Furthermore, the healthcare personnel were reported to be liable for offering guidance and counselling on various illnesses such as stress management as well as living with diseases such as HIV/AIDS and even general healthy lifestyles such as eating a balanced diet and regular body exercises

Finally, creating public awareness on the matters pertaining health such as outbreaks of diseases, ways of spreading as well as containment measures of the diseases was reported as a mandate of healthcare personnel. The foregoing cited responsibilities of healthcare personnel aligns with the Hippocratic Oath taken by all healthcare personnel which states every healthcare personnel is entitled to serve humanity through caring for the sick, promoting good health, and alleviating pain and suffering (Haring, 1974).

In an interview, a healthcare personnel opined that;

> Healthcare workers are essential to maintaining human life because they give patients preventive medication, stop diseases from spreading, teach the public about disease prevention and treatment, and convey knowledge about how to lead healthy lifestyles (Catholic church healthcare personnel, 2022).

According to the respondent, healthcare personnel is responsible for disease treatment as well as prevention through healthcare education and counselling. In a nut shell, healthcare personnel are responsible for alleviating human suffering pertaining health.

2.5.3: Community

Community was described by the respondents to encompass the healthcare facility, insurance company, government, church and even pharmaceutical companies. Healthcare facility was reported to be responsible for facilitating provision of all

types of healthcare services: preventive, curative and rehabilitative services**.** The government was termed responsible for employing healthcare professional, building government owned healthcare facilities, financing and running the operations in healthcare facilities and remuneration of healthcare personnel. The church was described to be liable for building of healthcare facilities, running the operations in the healthcare facilities, helping the poor and the vulnerable access healthcare service and upholding the healthcare facility norms. Insurance company was termed liable for offering healthcare coverage. Pharmaceutical firms were described responsible for manufacturing and marketing drugs which doctors prescribe to treat patients and produce medical equipment such as the laboratory testing kits. Lastly, a home was termed accountable for offering care especially for terminal illnesses such a HIV/AIDS, Diabetes since the family members are responsible for financial support necessary to meet the cost of healthcare service

One of the respondents denoted that:

> Community involvement in healthcare provision is key for the attainment of universal coverage because of the common interest of healthcare for all. Viewing healthcare provision through the lens of community entails bringing healthcare services closer to the people that need them and providing comprehensive and accessible healthcare that meets the healthcare needs of individuals. This is achieved when all the members making up the community are responsible for their mandate. For instance, when healthcare facility provides the necessary healthcare service and prioritize patient healthcare needs, insurance company provides the required medical coverage, home to provide the necessary emotional and financial support. This will ensure effective healthcare provision (Catholic church healthcare personnel, 2022).

According to the respondent, community of healthcare stakeholders such as healthcare facility, home, insurance company among others have a shared responsibility of healthcare for all in the society.

From the results of the responsibility of healthcare provision stakeholders, it is evidenced that every stakeholder has a role to play and the goal of every stakeholder is to improve healthcare outcomes and to respond to people's expectations, while reducing inequities in both healthcare and responsiveness. The results agree with Lubbeke et al., (2019) who argue that community as stakeholders in healthcare provision play a major role in the direction of the healthcare provision industry. Their responsibility is vital as they provide funding, psycho-social support and strategic direction to the overall industry of healthcare provision.

This study then argues that a non-negotiable truth in healthcare provision is that the main goal for healthcare providers as well as for every other stakeholder in healthcare provision, must be to improve value for patients, where value entails healthcare outcomes achieved with minimum challenge especially in the normative order.

It can also be deduced from the results that healthcare provision is both individualistic and communal responsibility. Individual in the sense that healthcare provision decision involves individual decisions such as deciding to be involved in drug and substance abuse and deciding to seek medical attention or not. A Catholic Church leader asserted that,

> When discussing healthy lifestyles like regular exercise and abstaining from drug and alcohol misuse, a Christian discussion of healthcare provision cannot ignore the importance of individual responsibility. In reference to the bible, "For all the truth about us will be brought out in the law court of Christ, and each of us will get what he

> deserves for the things he did in the body, good or bad"
> (2 Cor. 5:10) (Catholic church Priest, 2022)

The informant here meant that every individual is held accountable for choices they make, including those regarding our personal health. This means, man is accountable for the healthcare choices they make. The opinion of the Catholic church leader is in agreement with Pope John Paul II who emphasized the role of the individual. He noted that;

> But man has been given responsibility to care for not only the earth but also himself. God gave man the ability to make his own decisions so that he could freely seek out his Creator and reach completeness. Such perfection can only be attained by an individual developing that perfection inside themselves. In fact, just as man uses his dominion over the universe to shape it in accordance with his own understanding and will, so too does man increase, develop, and deepen his likeness to God within himself by engaging in morally righteous deeds (Veritatis Splendor, no. 39).

The preceding assertions depicts that individual responsibility is key in healthcare provision. Communal responsibility on the other hand is where several inputs such as healthcare personnel, healthcare facility and community work together to facilitate the provision of healthcare service.

The study therefore established in this regard that healthcare provision involves various stakeholders and for it to be effective, there is need for every stakeholder to be liable for their responsibilities. However, the patient is the core stakeholder since his or her healthcare need initiates the process of healthcare provision and delivery. Therefore, it is the expectation of every healthcare facility that the patient's healthcare needs be the ignition of the process of healthcare provision. When the patient needs are not honored, often human dignity is not respected and this may give rise to normative or human right value challenges in healthcare provision.

2.6 Normative challenges in healthcare provision in general

The study identified normative challenges in healthcare provision as challenges in the nature of values, arising as a result of not confronting to or reflecting an established norm in healthcare provision set up that considers the same as a human right. Deviating from a specific standard particularly a standard determined by moral ideals of how things should be. That is, deviating from the healthcare provision standards as influenced by socio-economic considerations in healthcare provision going against established human rights criteria as espoused by the Catholic Church. The following were some of the normative or human values related challenges in healthcare provision:

2.6.1 Developed and underdeveloped healthcare divide

According to Wallerstein (2004), the present world-system has its origins in the seventeenth century. At that time, this world-system was only found in a tiny fraction of the globe, primarily in parts of Europe and the Americas. It expanded throughout time to include the entire globe. Wallerstein (2004) claims that the capitalist world economy is a hierarchical and spatially unequal distribution system based on the concentration of particular production types in particular constrained zones, which subsequently and thereby become the loci of the greatest accumulation of capital. Life processes in this capitalist world are now divided into those who have and those who have not. This probably explains WHO (2017) report which noted that, the gap between the "haves" and "have-nots" is widening in today's rapidly changing global society, particularly when it comes to access to healthcare, and the world may soon see an impoverished population without access to healthcare in already overburdened healthcare delivery systems. At least half of the world's population currently lacks access to the healthcare services they require, and each year, many households are

plunged into absolute poverty as a result of out-of-pocket costs associated with accessing healthcare services.

Disparities between the “haves and have-nots” affect every society in today’s globalized world. Despite great efforts by the governments and international organizations, the healthcare needs of the world’s population remain unsatisfied. The problem is where healthcare fits in and how much healthcare an individual can enjoy. Global health report (2021) noted that the healthcare systems of industrialized nations are vastly superior to those of emerging nations. The development of technology in industrialized nations has left poor nations far behind in terms of healthcare systems and services. In contrast to wealthy nations, which have both a low death and birth rate, developing nations have high rates of natural growth due to their high birth and death rates.

Compared to developed countries, emerging countries have greater infant mortality rates. This is due to the lack of medical services, higher rate of motherhood, inadequate nutrition for both the mother and the kid, lack of understanding about health issues, and tainted water supplies in developing nations. Education, a reliable supply of drinking water, awareness of disease, effective national healthcare policies, finances, medical resources, a neat and clean environment, good and nutritious food, quick service delivery, among other things, are all essential for a functioning healthcare system. Developing nations are deficient in these components. Developing countries frequently struggle with funding issues and have inadequate educational systems, which causes their health conditions to lag behind. Due to a lack of resources, developing countries are unable to devote as much of their Gross Domestic Product (GDP) to healthcare as developed ones do. Developing nations' cultural outlook, geographic setting, and

traditional beliefs frequently act as roadblocks to the improvement of their healthcare systems. As a result, resources, such as money and basic health infrastructure, are what differentiate industrialized, developing, and underdeveloped countries in terms of their healthcare delivery systems.

A 2017 WHO report makes an effort to explain how poorly healthcare initiatives are integrated at the local, regional and national levels in low-income countries. Opportunities for complementary initiatives and joined-up thinking are lost in the absence of a cogent, comprehensive approach, frequently with terrible outcomes. This is demonstrated by the availability of vaccinations, one of medicine's most effective life-saving measures. It's concerning to hear about a study on vaccinations for measles, diphtheria, tetanus, and tuberculosis that included Bangladesh, Benin, Brazil, Cambodia, Eritrea, Haiti, Malawi, Nepal, and Nicaragua. Less than 1% of Cambodian youngsters received all recommended immunizations, and nearly one in five did not receive any at all. In Haiti's quintile with the lowest levels of affluence, 15% of children had no interventions at all, and 17% received just one. Even in Nicaragua, which had the most encouraging data of the nations studied, just 13.3% of kids had received every recommended immunization. According to research, low- and middle-income countries account for 87% of premature mortality brought on by non-communicable diseases (WHO, 2017). This graph supports the differences in healthcare status between high-income nations (HICs) and low- and middle-income countries (LMICs). Healthcare access varies widely from nation to nation and even state to state. The COVID-19 pandemic demonstrated that universal access to healthcare is not a guarantee. Many nations were unable to quickly confront the pandemic due to a lack of systems, resources, equipment, and finance, while others were still able to contain it more readily.

According to a UN report, the gap between rich and poor is growing while vaccination equity is lacking. A growing healthcare disparity between the rich and the poor is the result of a new investigation by the United Nations Development Programme (UNDP) that reveals that only a small part of COVID-19 vaccines were delivered in developing nations.

Healthcare workers in the United States received the first doses of the COVID-19 vaccine on December 14, igniting optimism about the coronavirus pandemic's end in the nation. The long-awaited conclusion was very much within reach for the United States, Canada, the United Kingdom, and other industrialized nations. For residents of the impoverished world, this was not the situation. The richest nations in the world purchased more than half of the reserved doses of vaccines even though they only account for 14% of the global population, according to a British Medical Journal report published in 2021. According to the report, a quarter of the world's population won't have access to the COVID vaccination until 2022, and it's highly likely that won't happen until 2023 or 2024. The issue of hoarding by higher-income countries made the lack of vaccines in lower-income countries worse. For instance, Canada had purchased enough vaccine to provide each of its citizens nine doses. Due to their reliance on contributions or "leftovers" to supplement their supply of dosages, low-income nations were left at the mercy of those who had stocked up. This begs the question how can ethical considerations be applied to the distribution of the COVID-19 vaccination and, by extension, healthcare provision in general in order to move toward a more equitable approach to healthcare provision?

A widely accepted objective of medicine is to alleviate as many people's suffering as possible and to bestow as much good as possible on as many people as possible.

According to the findings of this study, it would be morally justified to give priority to racial and ethnic groups that are more at danger of being affected negatively by the virus. The needs of the underprivileged should take precedence in society, particularly in light of the state of the world's health. It is morally right for nations with the necessary capital and infrastructure to aid those without comparable means in the event of a pandemic. Even economically, it makes more sense for wealthier countries to assume the burden of ensuring developing countries have access to vaccines. No nation is immune from the effects of a pandemic until all nations are safeguarded because of the interdependent economies and the globalized character of our planet (Boardman, 2021).

"Vaccine nationalism" has larger impacts on society's perception of human rights in the context of medicine in addition to having an immediate impact on the health and economic outcomes of certain nations. The COVID-19 vaccination should not be included in a capitalist hierarchy where the wealthy have priority access to the greatest care while the poor are left with whatever is left since everyone has a right to safe and effective medicine. How can a just society turn a blind eye when individuals in need are disregarded and vaccine doses are hoarded? Will the moral responsibilities ever end at the national borders? This study makes the case that this philosophy of "every country for themselves" is not only immoral, but also detrimental to the common objective of pandemic recovery. Justifying the primacy of affluent nations in this epidemic by accepting health inequity as an unavoidable barrier opens the door to embracing any moral wrong that is challenging as a means of sustaining behaviors that benefit the privileged few. It is for this that bioethicists Ezekiel et al., (2020) proposed that instead of distributing doses based on population size, they should be distributed according to the need. That is, starting with providing resources to the areas that are most badly impacted, where the greatest amount of suffering can be avoided, and concluding with

the reduction of transmission and the return of normalcy to society. Ethical frameworks offer a platform for comprehending societal values like equity and justice in these incredibly unsettling times. This study resonated with the idea that unequal distribution of vaccines is a moral outrage and violates the ethical argument that no country or citizen, affluent or poor, is more deserving than another.

There are some truths about the failing healthcare system in the continents that are hidden beneath the surface of global healthcare. Global Development report (2021) notes that it seems to be true that, especially in developed continents like North America, Europe, and the Far East, the efficiency, sophistication, and accessibility of the healthcare systems are unmatched. For instance, there is typically one doctor for every 3,324 people in Africa as opposed to every 293 people in Europe. In the Central African Republic, the average life expectancy is 53 years, with 45 of those years being spent in "good health," as opposed to 82 years and 72 years in the Netherlands, respectively. More than five times as many people live with HIV in Africa as in Europe. Compared to 93% of Europeans, just 33% of Africans and 45% of South East Asians have access to sanitation infrastructure. Compared to children in high income nations, sub-Saharan African children have a mortality rate before the age of five that is more than 15 times higher. According to Thompson (2021) underdeveloped regions have a maternal mortality ratio that is 14 times greater than developed ones. This may also be the reason why, according to a 2003 report by the United Nations Development Programme, the health of people around the world was remarkably unequal four years into the new millennium. For instance, a child born today in Japan, for instance, can expect to live to an average age of 82 years, whereas it is unlikely that a newborn infant in Zimbabwe will reach his or her third birthday.

Healthcare disparities do not just occur between continents; they also exist inside individual nations. For instance, the American healthcare system has a negative effect on persons of color and other underprivileged groups in the United States of America. African Americans experience poor health outcomes, unequal access to treatments, and coverage gaps for health insurance as a result of these injustices (WHO, 2017). Similar disparities exist with regard to healthcare opportunities in Kenya. The distribution of resources, health outcomes, and health determinants differs significantly amongst Kenyan counties. Since they prevent people from reaching their full potential in terms of actively participating in civic, social, economic, and political life, health disparities have major social and economic implications. Kenya consistently has high levels of health and access disparities, according to a study by Ilinca et al, (2019) on socio-economic disparities in the use of healthcare services. Poorer people not only have lower health than wealthy ones, but they also have more difficulty getting the necessary healthcare services.

Socioeconomic disparities for a variety of healthcare services, such as reproductive, maternal, and child care, preventive care and vaccination, urgent care, inpatient, and outpatient treatment, have been identified within this context. Low demand and availability for formal, high-quality healthcare services were found to be substantially correlated with poverty levels. Poorer communities have lower-quality service providers and people from poorer households have been shown to be less likely to seek care in medical facilities when they are ill or have health issues. The study further revealed that in Kenya, there were socioeconomic disparities across the healthcare industries. While those from affluent households tended to rely on public care providers or use lower standard, frequently unlicensed care, the private sector was more varied in

terms of the sorts of care providers and predominantly served wealthy persons (Ilinca et al., 2019).

Kenyan development initiative report of (2017) based on Kenya demographic and health survey analyzed county performance in three health indicators: one-year old children immunized against measles, skilled birth attendance, and use of modern contraceptives by married women. According to the data, less than 75% of one-year-old children in six counties had received their measles vaccination. West Pokot, Mandera, Wajir, Samburu, Turkana, Narok, Marsabit, and Tana River are among them. In comparison to Kirinyaga, which had attained the maximum level of coverage at 100%, West Pokot had the lowest at 58%. In five counties, Samburu, West Pokot, Marsabit, Wajir, and Turkana, less than 30% of births were attended by trained medical workers. In contrast, trained medical workers attend almost 85% of births in the top five counties: Kiambu, Kirinyaga, Nairobi, Nyeri, and Muranga. Again, a distinct geographic trend can be seen here as all five of the lowest-ranking counties are found in the northern section of the nation, whilst the top five counties are all found in the central area. On top of that, all of the counties in the bottom five, with the exception of West Pokot (at 66%), have a poverty rate of above 70%. Contrarily, the percentage of the population living in poverty is lower than 30% in the top counties, with the exception of Muranga at 33% (Owino, 2017).

This first analysis suggests that a county's proximity to the northern or eastern sections of Kenya puts it at risk of falling behind in terms of health. In comparison to other parts of the country, counties in these regions also have some of the largest percentages of poverty, the lowest educational attainment, ongoing food insecurity, and a dearth of healthcare facilities and services.

2.6.2 Gender healthcare divide

According to the World Health Organization (WHO, 1948), health is not just the absence of illness or impairment but also includes a person's total physical, mental, and social well-being. One of two essential human capital assets that might affect a person's capacity to fully contribute to society, according to the 2012 World Development Report, is their state of health. Despite the fact that gender equality has advanced the most in sectors like education and labor force participation, health disparities between men and women still have a detrimental impact on many countries. This explains UN (2020) report which noted that every country on earth still has to make progress toward gender equity. At all levels of decision-making, women and girls are underrepresented. They also commonly lack economic independence and have less access to healthcare and education.

Men and women have different health needs, but historically, women have experienced a disproportionate amount of health disparity. This is because women are more vulnerable to abuse and mistreatment in an organized patriarchal culture that has been created by a number of cultural ideologies and conventions. Additionally, women are frequently excluded from opportunities like paid employment and education that could improve their capacity to access better healthcare resources. Women are frequently underrepresented in or excluded from mixed-sex clinical research, which exposes them to bias in medical professionals' diagnosis and treatment. Women frequently have less access to healthcare services than males do (WHO, 2009).

Health systems are defined by the World Health Organization (WHO, 2001) as those activities with the primary goal of promoting, restoring, or sustaining health. However, the way that well-being systems affect particular population segments may depend on

issues unrelated to healthcare systems. This is because it has been demonstrated that social, cultural, and economic frameworks affect healthcare systems. As a result, in addition to being "producers of health and healthcare," health systems are also perceived as "purveyors of a wider set of societal norms and values," many of which are biased against women (Gilson, 2003). Health systems in several nations were identified as being unable to sufficiently deliver on gender equity in health in the Women and Gender Equity Knowledge Network's Final Report to the WHO Commission on Social Determinants of Health in 2007. The fact that many healthcare systems tended to ignore the notion that men and women's health requirements can differ greatly is one explanation for this problem. According to studies included in the paper, the healthcare system may contribute to gender disparities in health by failing to treat women equally as both consumers (users) and producers (caregivers) of healthcare services. For instance, healthcare institutions frequently view women as objects rather than individuals and frequently deliver treatments to them as a way of achieving other goals rather than focusing on their wellbeing. When it comes to reproductive healthcare, these treatments are frequently offered more as a method of fertility control than as support for women's wellbeing.

Women in high income nations typically live longer and are less likely to experience illness and early death than women in low-income countries in every age category. Maternal mortality is the healthcare result that differs most noticeably between wealthy and developing nations. The majority of maternal deaths currently occur in countries that are experiencing poverty or other humanitarian crises, accounting for 99% of the more than 500,000 maternal deaths worldwide each year. This results from the absence or underdevelopment of institutional mechanisms that could safeguard the health and welfare of women in these areas (WHO, 2009).

Similar circumstances exist inside nations, where social and economic factors have a significant impact on both girls' and women's health. People with lower socioeconomic level or those who are poorer likely to have poorer healthcare results. Girls and women in affluent households have lower mortality rates and use more healthcare services than those in poorer households in practically every country. Such health differences due to socioeconomic position exist in every country in the world, even in industrialized areas. Health disparities and gender disparities are related, according to data from the UNESCO Institute for Statistics. In contrast to their male counterparts, many women in underdeveloped nations have a tougher time accessing and affording professional healthcare. The experience of women in Chad, where the average lifespan is 54 years, can serve as an example because research shows that men predominately control access to medical professionals, treatments, and knowledge. This means that for rural women in particular, the effectiveness of their support networks—their husbands, male family members, and their capacity to mobilize them—is crucial to how quickly an illness progresses. The gender gap issue may help to explain why, compared to developing regions as a whole, only one-third of rural women obtain prenatal care (U.N., 2011).

Women and girls face significant obstacles to getting access to healthcare in many parts of Africa, including a lack of knowledge, poor infrastructure, and social stigma. According to WHO research from 2012, one of the primary causes of the declining trends in the health indicators for women is the inability of the health systems in the majority of African nations to deliver affordable, high-quality care. This problem is caused by inadequate investments in women's health as well as other issues including inadequate women's empowerment and inadequate health system design. The poor and women in particular suffer from out-of-pocket (OOP) healthcare costs. The most important source of funding for the region's health system, OOP payments for

healthcare, are clearly linked to a general drop in the use of healthcare services. The analysis demonstrates that even with minimal costs, they inhibit utilization. OOP payment poses a particular challenge for women in Africa since they frequently rely on men for financial support, making it difficult for them to get paid healthcare services. The study affirms the notion that women's health is viewed as a matter of human rights and need to be supported in that regard.

2.6.3 Healthcare technology divide

WHO defines healthcare technology as the use of structured knowledge and skills in the form of equipment, medications, vaccines, procedures, and systems produced to solve health problems and improve people's quality of life. This covers medications, devices, processes, and organizational methods utilized in the healthcare business, as well as computer-aided information systems (WHO, 2004).

Rapid revolutionary and technological developments in the world's economy are having an impact on healthcare and overall wellbeing of the population. Healthcare delivery has undergone a transformation (Makary, 2022). Healthcare technology can be defined as any technology used in a healthcare setting. This comprises anything from information technology operations and medical devices to software, machine learning, wearable technology, and even cloud-based solutions designed to cure a health problem and improve people's quality of life. Today, virtually no aspect of the healthcare system has not been impacted by technology. The processing, storing and exchanging of data has shifted to a digital environment, bringing both vital benefits to patient care and creating new challenges. Healthcare technology has made healthcare more accessible, facilitated early disease detection and better track of the patient’s data. The challenge however is that this healthcare technology is not accessible for everyone.

According to a WHO report of 2022, not all communities and regions in Europe have equal access to digital health technology, which raises concerns about the unequal application of these tools to health. In a study conducted in collaboration with Public Health Wales' Public Health Data, Knowledge and Research Directorate, it became evident that those in poor health have the greatest difficulty using these tools. The study found unequal access to, engagement with, and usage of digital health technologies. The study's conclusions showed that while digital tools can significantly increase people's access to healthcare and healthcare providers' capacity to provide treatment, not everyone has equal access to them, particularly those with underlying medical issues. Furthermore, it demonstrates a clear disparity between wealthy and developing nations, not just in terms of the types and amounts of e-health activity carried out, but also in terms of awareness of the advantages e-health can provide. The case for more strategic and widespread investment in e-health cannot be made without convincing proof, which is still lacking. People can enjoy healthier lives thanks to smart and linked devices made possible by digital technologies. Wearable technology, digital platforms, software, artificial intelligence, and technologies that collect and transfer data and relevant health information amongst systems are examples of these technologies. These technologies can aid healthcare professionals and enhance care quality, diagnosis, and treatment. The survey also revealed that different populations had different patterns of access to, interaction with, and usage of digital technologies. People from ethnic minorities and those with language problems tend to use digital health technology less frequently and in smaller quantities in rural locations. The study also discovered that individuals with greater economic status and levels of education utilize digital health products more frequently. Tools are also used more frequently by younger people than by older adults.

The digital divide in healthcare has existed for some time, according to Rowe (2022), but COVID-19 brought attention to it and may have made matters worse. Telehealth, smartphone apps, wearable technology, and patient portals are all examples of digital health. It is a method of extending in-person care utilizing technologically advanced tools, and it is reliant on both internet connectivity and digital literacy. Insufficient financial resources to buy phones or pay for internet and broadband services, a lack of technological skills to use digital modalities, low literacy levels incompatible with most applications, and the lack of a private space for multigenerational families living in cramped quarters prevent underserved populations from underdeveloped countries from participating in digital health, according to Rowe, underscoring the larger issue of healthcare inequity. This study supported the notion that everyone should have an equal chance to gain from medical advances.

2.6.4 Rural-Urban healthcare divide

Globally, the International Labour Organization (ILO) research of 2014 revealed significant disparities in healthcare availability across rural and urban areas. According to the report, basic healthcare services are unavailable to 56% of people living in rural areas around the world, which is more than double the percentage of individuals who do not have access to them in urban areas (22%). Global evidence on disparities in rural health protection: Significant discrepancies in health access between rural and urban areas are seen worldwide, especially in developing nations, according to new statistics on rural health coverage gaps for 174 countries. The percentage of rural residents who do not have access to basic medical care is highest in Africa, where it is 83%. The poorest nations are those that have been most impacted.

However, Asia has the greatest distinctions between rural and urban areas. For instance, in Indonesia, the proportion of uninsured people is twice as high in rural areas as it is in metropolitan areas. The development of national health systems was halted for years due to underfunding, which ultimately led to the neglect of rural areas' health. The human cost of this is enormous (ILO, 2014). All citizens of a nation should have access to health care since it is a fundamental human right.

According to the ILO report of 2014, even if access to healthcare is legally guaranteed, those who reside in rural regions are nonetheless denied it since local enforcement of such legislation does not exist. The situation is made worse by the scarcity of healthcare professionals in rural areas of the world. Only 23% of the global health workforce is employed in rural areas, despite the fact that they are home to 50% of the world's population. According to the ILO, these regions require 7 million of the 10.3 million more healthcare workers that are needed globally. There are two places on earth where this issue is particularly severe: Africa and Latin America. For instance, in Nigeria, compared to 37% in urban areas, more than 82% of the rural population is denied access to healthcare services due to a lack of healthcare staff. A lack of services is intimately related to underfunding.

According to the ILO report, rural areas have roughly twice as many financial resource gaps as metropolitan ones. In Africa, the gaps are the widest. However, Asia and Latin America also have severe disparities. As is the case with rural communities in Africa and Asia who are burdened by OOPs, the degree of impoverishing out-of-pocket payments (OOPs) is also considerable in rural areas. OOPs are two to three times more prevalent in rural than in urban areas in numerous Asian nations, including Afghanistan, Bangladesh, Cambodia, and Sri Lanka. Life-threatening disparities have been made due

to a lack of legislative protection, a shortage of healthcare staff, poor funding, and excessive OOPs in many nations. According to an ILO report, one's health outcomes are unfairly influenced by where they live. This study contends that, because access to healthcare is a fundamental human right and everyone has a right to it regardless of where they live, the location of a household inside a nation should not affect that right for those who are in need.

In order to achieve fairness in service delivery and to create a global healthcare system, access to healthcare services in urban and rural areas continues to be one of the most crucial concerns in the health system. For the rural population of India, physical accessibility to healthcare facilities is a significant hurdle (Balarajan et al., 2011). Despite the limited availability of healthcare services, vulnerable groups tend to congregate in rural areas where there are more healthcare facilities than in urban areas. This is made worse by the urban private sector's explosive growth and the resulting uneven regional distribution of services. Even if medical care is geographically accessible, this does not guarantee equity for both urban and rural residents. This is due to the possibility that the cost for the rural population to get healthcare services may be higher than for the urban population.

Similar to the United States, 80 percent of China's poor people reside in remote areas, such as mountainous regions, which act as physical obstacles preventing them from getting access to basic healthcare (Liu, Hsiao, & Eggleston, 1999). The majority of tertiary hospitals are found in urban areas, while only roughly 55% of villages have functional healthcare facilities. The cost of healthcare varies between rural and urban areas in China, with rural costs being significantly higher than urban rates. The main cause of this is the disparity in insurance coverage between urban and rural residents.

Most people in rural areas lack health insurance. Because household income did not expand as quickly in rural areas as it did in urban ones, the impact of the rising medical costs is larger there. Therefore, the disparity in healthcare costs between China's urban and rural populations has influenced the distribution of access to healthcare services.

The unequal distribution of resources between the urban and rural populations is a significant concern. Healthcare funding and resources are frequently distributed geographically and distributed according to the needs of the people in several nations (Mary, 2008). To ensure that all populations have equitable access to resources, it is crucial to allocate resources effectively to urban and rural areas. In India, the distribution of resources among the states is unbalanced. Urban-based services receive a higher percentage of funding, which is exacerbated by the private sector's preference for higher-level therapeutic treatments and concentration in affluent urban regions (Balarajan et al., 2011). As a result of the unequal distribution of resources, patients with identical needs in urban and rural areas may not have equal access to the health service. Similar findings were made about China, where it was discovered that public resources were being allocated disproportionately to the urban and tertiary care sectors, while public subsidies for rural health care were sharply declining (Liu et al., 1999). Therefore, unequal distribution of resources will result in unequal access to healthcare for the rural and urban populations. Healthcare resources in Malaysia also contribute to an urban bias, which is exacerbated by the growth of private healthcare providers, who are concentrated mostly in highly developed commercial districts (Hanafiah, 1996).

There is a disparity in the level of healthcare that all nations' inhabitants receive. Numerous studies have demonstrated that there is a direct correlation between socioeconomic circumstances and an individual's health. According to this study,

having access to healthcare is a fundamental human right to which everyone, regardless of location, is entitled. Because they represent injustices, the study contends that healthcare discrepancies are morally unacceptable. Healthcare disparities may also be a sign that societal ideals like respect and defense of human dignity are eroding over time. In this regard, the Universal Declaration of Human Rights (1948) states that the foundation of justice, freedom, and peace in the world is the acknowledgment of the inherent dignity and of the equal, unalienable rights of every member of the human family. It also states in Article 2 that everyone has the right to all the freedoms and rights outlined in the declaration, regardless of their colour, gender, sexual orientation, religion, political affiliation, or place of birth or other status. Similar to how Martin Luther King stated that healthcare injustice is the most inhumane type of inequality since it denies human dignity and frequently results in physical death (Hamilton & Woods, 2013).

The study asks, "Who, then, should help to democratize healthcare access worldwide?" given the wide range of factors influencing access to healthcare globally. Throughout the history of humanity, religion has played a significant role in influencing practically every element of daily life, including attitudes and behavior. Religion has been a major motivator for both good and bad activities throughout practically all of history. Using the deprivation theory as a guide, religious institutions protect persons who are impoverished and deprived from the disruptive influences of everyday life (Elgin et al., 2013). This study maintains in this regard that, the Church is positioned to defend humanity.

In accordance with the Vatican II document *Gaudium et spes* (The Church in the Modern World), published in 1965, differences also arise between races and different

social orders; between powerful nations and weaker or less influential ones; and between international organizations that were born out of the widespread desire for peace, the desire to advance one's own ideology, as well as the collective greed present in nations or other groups. Underneath all of these people and societies is a man's longing for a rich and free existence. The church has a responsibility to speak up for all men in the light of Christ in order to explore the mystery of man and work with others to find solutions to the pressing issues of present time.

This study upholds the thesis that a specific theological duty, namely emancipation, is required due to the special nature of human experience of injustice and social deprivation in healthcare supply. The struggle between the wealthy and the poor, the possessors and the possesses, the employed and the unemployed, the powerful and the powerless, which was long-standing in Latin America and gave rise to her own brand of liberation theology, is now a common occurrence in our society. Nearly everyone in today's society is aware of the extremely wealthy, affluent elite. This class of elite, working with global capitalist forces, directs the country's health toward themselves at the expense of the general populace. The church is now charged with the critical job of liberation. It would imply that for the church, humanization—that is, making people's lives more human and society more equitable—is truly inseparable from Christianization.

In order to achieve this, Nyerere (1997) asserted that if the church does not actively participate in the rebellion against those social structures and economic organizations that condemn men to poverty, humiliation, and degradation, the church will cease to be relevant to man, and the Christian religion will become a collection of superstitions embraced by the fearful. If the church does not actively participate and take a leading

role in positive protest against the conditions of contemporary man, it will perish and, in a human sense, deserves to perish because it will then have no purpose that modern men can comprehend. "What is of utmost importance to the African church is the African person and problems he encounters in his life situation," Okolo (1985) states concisely. This study found that because the Catholic Church emphasizes the defense of human dignity in its teachings and because it asserts that access to healthcare is a fundamental human right, it is in a position to lessen the normative issues linked to healthcare provision.

2.7 Isomorphism: Catholic Church healthcare provision under pressure

The idea of isomorphism holds that organizations that are subject to the same set of environmental conditions will imitate one another. Isomorphism in this case explains how healthcare organizations incorporate change and how it causes these organizations within an institutional field to implement similar policies. Coercive, mimetic, and normative isomorphism are the three mechanisms identified by DiMaggio & Powell (1983) via which institutional isomorphic transformation occurs to enhance legitimacy.

According to Ashworth et al., (2009), coercive isomorphism emerges from formal pressures that are exercised on organizations, for example, regulations imposed by the government. Coercive pressures are often related to legal requirements, regulations and obligations as they apply to healthcare provision in this case.

Standard responses to uncertainty are termed to originate from mimetic isomorphism. Organizations mimic processes or structures of successful and acknowledged organizations to avoid uncertainty. Their processes and solutions are considered to be efficient and good. Even when organizations have no evidence of performance

improvement, copying is successful in the eyes of some healthcare providing organizations (Ashworth, et al., 2009).

Normative isomorphism occurs through professionalization, including two processes: First, medical professionals receive the same training at universities and professional training institutions and therefore develop the same ideas. Those drivers encourage shared values. Healthcare providing organizations tend to hire professionals with the same educational background and who share their values and have common ideas (DiMaggio & Powell, 1983). Second, the existence of professional and branch organizations ensure that individuals of a certain profession interact (Mizruchi & Fein, 1999). As such, certain ideas and helpful hints are spread stimulating change. Therefore, it is expected that Catholic church hospitals may be influenced by their network, causing them to adopt similar policies some which may not conform to Catholicism.

Interview responses from the Catholic Church leaders indicated that Catholic Church recognizes that people live in a world which is under the pressures from technological advancements, dynamism and interaction with other communities. This may have contributed to the rejection of moral norms that guide and promote Christian approaches in Catholic church healthcare provision. The Catholic church healthcare facilities therefore may not have remained immune from their influence. This position may resonate with Kirwen's (1979) argument that the Catholic Church must free itself and its followers all over the world from both the ethnocentric pastoral perspective and limited western preoccupations. If not, these pressures might keep distorting the various institutions that the vast majority of people have. Therefore, the Catholic Church has a liberating role to play in society, particularly in the setting of healthcare delivery.

This study argued that Catholic church healthcare facilities can be viewed from the perspective of an organization. In this way, Catholic church healthcare facilities are depicted as organizations responding and adapting to environmental forces, such as pressures from the surrounding institutions. Changes in terms of provision of their services, ownership and even their norms.

The interview responses from Catholic Church leaders in this study revealed that isomorphism stands out to be a great contemporary competing force to Catholic church healthcare provision due to competition for market position as well as social and economic fitness. The responses revealed that Catholic church healthcare facilities are undergoing coercive, mimetic and normative isomorphism. Isomorphism entails constraining process that forces Catholic church healthcare facilities to resemble other healthcare facilities in the same set of environmental conditions (DiMaggio & Powell, 1983).

Coercive isomorphism emerges from the government such as emphasis on digitization. Diocesan medical coordinator and the Catholic Church priests affirmed that in as much as they are governed by ethical and religious directives, they are also under the government-Ministry of Health. This is because healthcare services they provide is a mandate for Ministry of Health. Catholic church healthcare facilities therefore work in conjunction with Ministry of Health to ensure standard policies are upheld and undertake supervision to ensure right prescription for treatment of diseases are given. This is evidenced by the patients' register provided by the Ministry of Health used in Catholic church healthcare facilities. Catholic church healthcare facility also face pressure from Catholic Church environment of maintaining Catholic church healthcare

identity that access to healthcare is a right and this is made legal through the same ethical and religious directives.

Mimetic isomorphism is attributed to the fact that we live in a changing world which is experiencing rapid economic, environmental, technological and demographic changes all of which affect health and well-being. The key informants asserted in this respect that even catholic healthcare institutions are faced with fear of uncertainty. They therefore for example, negotiate the payment of healthcare services before offering treatment to avoid cases where patient claims not to have money to pay for the services they already received. The Catholic healthcare personnel also noted difficulty in payment follow up.

Normative isomorphism is attributed to Catholic church healthcare facilities collaborating with other healthcare providers meant for profit making such as private healthcare institutions as well as the government. Diocesan Medical Coordinator affirmed that healthcare personnel employed in catholic church healthcare facilities for example, are not necessarily trainees of catholic sponsored medical training colleges. This has an influence on how they undertake their duties because they may not be subscribers to the ethical and religious directives that govern the catholic church healthcare facilities as well as the Catholic church social teachings on healthcare provision. Additionally, Catholic church healthcare institutions work closely with Ministry of Health for instance in sourcing vaccination and in other instances government employed personnel may be deployed to work in catholic healthcare institutions. This then influence the way catholic church healthcare institutions operate and are compelled to operate like other non-Catholic church healthcare facilities. The deployed healthcare personnel for instance may be used to handling patients as they wish like being judgmental on their healthcare conditions and they transfer the same

attitude to catholic healthcare institutions. This may have the effect of contradicting the catholic healthcare provision stand which advocates for healthcare personnel treating the patient in a manner that the patient feels he or she had an encounter with God in that suffering experience.

In general, the responses constituting the findings in this study revealed that normative or human value challenges related to healthcare provision in general are caused by capitalistic world economy as well as environmental causes such as isomorphism. This is in resonance with Jacobson (2012) who posited that through processes of dismissal, disdain, and objectification brought on by advanced technology and socioeconomic inequities, human dignity is violated in the delivery of healthcare. Jacobson adds that the stakeholder positions, the asymmetrical relationships between the actors, the healthcare provision setting, which is marked by multiple tensions, including those between healthcare provision needs and resources like money, equipment, and specialists, crisis and routine, experience and expertise, and the embedding of healthcare provision in a larger social order of things, are all factors that contribute to these processes.

2.8 Conclusion

This chapter examined healthcare provision as a contemporary phenomenon in general. The findings of the study make it clear that healthcare provision is more than medical treatment and disease diagnosis. It also involves healthcare education, counselling, rehabilitation and re-integration to society. The access of healthcare service is a basic human right and it is today a common knowledge in the world domain. Regardless of one's circumstances, respect for human dignity is one of the fundamental principles of interpersonal relationships. The Universal Declaration of Human Rights, which affirms that all people are created equal and are therefore entitled to equal protection of the law,

and the World Health Organization's declaration on the promotion of patients' rights, which states that "patients have the right to be treated with dignity," are both based on the principle that human dignity must be respected. Dignity has been shown to have an important influence on the patient's healthcare provision journey. Additionally, various stakeholders are involved in healthcare provision such as patients, healthcare personnel and community. Amongst these stakeholders, patient was reported as the core stakeholder in healthcare provision process that is patient centered. This is evidenced by the several advances made by scholars such as Ferlie and Shortel. Failure to prioritize the patients' compelling needs give rise to the normative or human rights value challenges in healthcare provision.

The chapter also explored the normative challenges related to healthcare provision in general. The study unravelled that human value challenges related to healthcare provision exist and are dominant in our today's societies and have polarized the healthcare provision into haves and have-nots, gender health divide, healthcare technology divide, rural-urban health divide among others. The study further acknowledged that such divides in healthcare provision are morally wrong since they violate human dignity. Identified healthcare inequities are moral and conscience disorder. Therefore, the church holds a position to save humanity in such distress. Despite the environmental pressure so discussed under isomorphism, the study still identified Catholic Church as capable for liberating humanity because of its straightforward claim that access to healthcare is a basic human right and that human dignity is an inviolable right.

The next chapter will examine the position of the Catholic church on healthcare provision in general

CHAPTER THREE

THE CATHOLIC CHURCH'S POSITION ON HEALTHCARE PROVISION IN GENERAL

3.0 Introduction

This chapter deals with the Catholic Church's teachings and position on healthcare provision in general and in the Catholic Diocese of Kericho. To achieve this, the chapter explicates on the principles of Catholic church's social teaching on healthcare provision: dignity of human person, common good, subsidiarity and solidarity. Additionally, it examines the Catholic Church's teachings on preferential option to the poor and social justice. By inferring to liberation theology, the Catholic Church's teachings and position on healthcare provision was examined from the basis of theological reflection and biblical interpretation. This involved relating the experiences of normative challenges in healthcare provision explored in the previous chapter to the will of God by asking questions such as: What does the word of God teach concerning healthcare provision? How did Jesus in his time relate to the poor? If Jesus was here today, how would He respond to the phenomena of social injustice in healthcare provision? The discrepancy or similarity provided a platform for the study to judge the Catholic Church's effectiveness in alleviating normative challenges in healthcare provision and liberating the society from social injustices. This was crucial for the study as it formed the basis for making inference of the experiences of catholic church healthcare provision as conforming or as rightful and permissible by the Catholic church or not.

Finally, the chapter delves in the ethical and religious directives concerned primarily with institutionally based Catholic church healthcare facilities.

3.1 The Catholic church's social teaching on healthcare provision

This section assesses the catholic church's social teaching on healthcare provision in general. Catholic Church has a valuable contribution to healthcare in terms of provision and teaching. Catholic church's social teaching supplies four key concepts in the consideration of healthcare provision and healthcare resource allocation. These are: dignity of human person, common good, solidarity and subsidiarity.

3.1.1 Dignity of the human person

Dignity is that special value that ties a human person to their humanity. A person has a right to dignity when they are treated with respect and valued in an ethical manner. Catholic church healthcare ministry is rooted in a commitment to promote and defend human dignity. The fundamental human right, the right to life, includes the right to the means necessary for that life to develop properly, such as access to quality healthcare (USCCB,2009).

The basic tenet of the dignity of human life informs the United States Conference of Catholic Bishops' perspective on healthcare:

> The foundation of the healthcare ministry of the Catholic Church is a dedication to uphold and advance human dignity. This serves as the cornerstone of its concern for the sacredness of every human life from conception to natural death. The fundamental human right, the right to life, includes the right to the means necessary for the healthy development of life, such as adequate medical treatment. This right derives from the value of human life and the dignity that all people possess as being created in God's image (USCCB, 2009).

The United States Conference of Catholic Bishops meant that dignity of human person is traced to the story of creation that man was created in the image and likeness of God. Therefore, life of every human person is sacred and is highly valued.

From the viewpoint of the Catholic church, one of every person's basic right is access to healthcare, founded on the idea of the human person's dignity. Pope John XXIII listed healthcare as one of the fundamental rights that derive from the dignity of the human person in his encyclical *Pacem in Terris* (peace on earth) (Pope John XXIII, 1963). Pope John Paul II listed "the right to food, clothing, housing, and sufficient healthcare" as one of the human rights that the Catholic Church supports in his address to the 34th General Assembly of the United Nations (Pope John Paul II, 1979). The American bishops have also spoken out on this issue, describing access to quality healthcare as a fundamental right essential to the growth and maintenance of life as well as the capacity of individuals to fulfill the full measure of their dignity.

In light of this, Catholic church's social teaching views access to healthcare as a human right rather than merely a necessity. In this context, it is impossible to discuss meeting the needs of the poor without addressing their access to a basic requirement for realizing their full potential as human beings. That implies that, from the perspective of the Catholic Church, healthcare cannot be discussed as a fringe benefit that may or may not be offered to a person depending on the whim of an employer or market considerations. Terminology used by the Catholic Church and American bishops when discussing healthcare is not at all distinct from that found in the Universal Declaration of Human Rights, which affirms a person's right to health as a fundamental human right built on the right to life. Everyone has a right to a standard of living that is sufficient for his or her own health and well-being and that of his or her family, including access to appropriate social services and medical treatment, according to the Universal Declaration of Human Rights (UN, 1948).

According to the pastoral constitution of Vatican II, the foundation of human dignity is in the truth that the human being was made in God's image through love, is kept by God's love, and is called to a noble destiny alongside God. The foundation of human dignity is this. Thus, the declaration affirms that "dignity is rooted and perfected in God" and further declares that when the church upholds the dignity of the human vocation, it is in harmony with the deepest aspirations of the human heart.

The Kericho diocesan bishop of the Catholic church affirmed that dignity of human person is the core principle in Catholic church healthcare in the Catholic Diocese of Kericho. In an interview, he emphasized that:

> The concept of human dignity is based on the conviction that because a person is made in the likeness and image of God, has been reconciled to God through the work of Jesus Christ, and is ultimately meant to be united with God, they are deserving respect as members of both the human family and the family of God. (Catholic church Bishop, 2022).

The bible also reiterates on the same principle of human dignity that:

> Given that humans were created in God's image and likeness, human dignity comes from God and is a gift from God (Gen 1:26-27).

The foregoing assertions indicate that, as the human individual is the most essential and distinct expression of ourselves, human life is sacrosanct. According to the social teaching of the Catholic Church, everyone has the right to appropriate healthcare, which is a requirement for all catholic church healthcare facilities. It also suggests that respect for the patient's life is an unbreakable moral standard for all healthcare workers and providers. This commitment forbids any medical operation that directly or indirectly claims a person's life, including socioeconomic disparities in healthcare access, healthcare technology disparities, healthcare gender disparities, and haves and have-nots divides.

This teaching of dignity of human person is in agreement with WHO (2017) which acknowledged that each and every person has dignity, which is at the heart of the right to healthcare. This draws a common value that priority of every healthcare facility is human dignity and saving life and not money.

Furthermore, the Bishop added that:

> Man was endowed with free will at the moment of creation, allowing him to decide between good and evil. He continued by saying that every decision a person takes is answerable for it (Catholic church Bishop, 2023).

This is in line with Gen 1:26:

> Let's create humans in our likeness so they can govern over all other living things on the planet, including all livestock, all wild animals, and all creatures that move along the ground. They can also rule over fish in the water and birds in the sky.

According to the informant, the fact that God commands man to carry out his will reveals that man is not forced to carry out God's will. Man can choose to obey God or not. The idea is that humans have free choice and are accountable for their deeds. This then means healthcare access through the principle of dignity of human person does not neglect the individual's responsibility of his or her own health. One is accountable concerning individual actions which may harm his or her health. This makes it clear that healthcare is also individualistic as well. Free will given to man also impacts his or her healthcare depending on the individual choices made. For example, illness due to drug abuse is an individual choice and one is accountable for such choices. Therefore, reform in healthcare ought to begin with appropriate individual choices with regard to healthcare.

The responses implied that Catholic church healthcare institutions in the Catholic Diocese of Kericho are established for the defense of human dignity through

prioritizing patient's healthcare need. Furthermore, healthcare provision involves individual responsibility on one's health based on the choices one make.

3.1.2 Common Good

The common good is acting in everyone's best interests. Healthcare provision should function in a manner that benefits everyone in need of healthcare service and the society at large. According to Condit (2016), man does not pursue perfection in solitude. It is impossible to comprehend an individual's pursuit of happiness apart from the happiness of the society, or the common good, because people are social creatures by nature. Humans are also social creatures, and as a result, they form societies.

Catholic Church is a community and a society as well. Therefore, should work in pursuit of the common good for the community in terms of healthcare provision. The Kericho diocesan bishop of the Catholic Church noted in this respect that:

> All people are members of the same human society and have the right to take advantage of all the benefits that the world and nature have to offer in order to improve their quality of life. This is the foundation of the common good. The earth and all its inhabitants were made by God. Therefore, each person's capacity to contribute to the common good in the world that God created and gave to us is a direct link between their own well-being and that of all other human beings (Catholic church Bishop, 2022).

The assertion of the informant here implied that catholic church healthcare institutions are established for the good of all people in the community. In other words, catholic church healthcare provision is for the benefit of the entire population and community not specific individuals.

The Second Vatican Council's definition of the common good is adopted by the Catechism as:

> The sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily (CCC, no. 1906).

According to the definition, the common good should not be viewed as an impersonal objective that might be pitted against the interests of particular individuals. The pursuit of good by families and people is instead made possible by the establishment of the institutions, situations, and conditions that make this possible. As a result, it is everyone's duty to foster the conditions that will allow both oneself and one's neighbor to thrive.

In *Quadragesimo-Ano* (After Forty Years), Pope Pius XI highlighted that regardless of how extensive and far-reaching the State's influence on the economy may be, it must never be used to the point where it deprives the individual citizen of his rights, such as the ability to receive healthcare. It must ensure that everyone's fundamental human rights are protected. A well-ordered and wealthy society cannot exist without cooperation in the economy between private persons and the State, as history itself increasingly demonstrates. Both parties must work together well, and each must contribute in a way that is proportionate to the requirements of the larger good in light of the circumstances and conditions of human life as they exist today.

It could be argued that Catholic Church therefore is responsible for creating institutions such as healthcare facilities that facilitate pursuit of common good through alleviating the existing inequities with the aim of liberating the society to attain its fulfilment. Therefore, it is the responsibility of all civil society members to distribute the common good fairly. Each individual must have the chance to contribute to the common good while also working with others to produce products and ensure their fair distribution in order for human growth to take place. To ensure that goods are accessible to everyone

and to advance social justice, participation in the common good necessitates both contribution and distribution. Diocesan Bishop asserted in respect that:

> Catholic Church has interest in the development of the society. He asserted that common good in the Catholic Church is achieved when people work together to improve the wellbeing of the community and the wider world (Diocesan Bishop, 2022).

Bishop's assertion is in resonance with Matthew 22:40: Whatever you do for the least, you do for me. Here, Jesus was speaking to his disciples that when He comes back in glory, all the nations will be gathered and will identify with those who did good for him. For people to look like brothers and sisters, they should care for one another. Catholic church healthcare is entitled to care for every member of the community.

From the responses, the study can argue that Catholic church healthcare facilities are meant to meet the healthcare needs for the entire community not specific people. These catholic healthcare services should be engineers for social change which leads to healthcare development of the community. Considering how Catholic Social Thought views healthcare, it is simple to conclude that everyone should have access to inexpensive healthcare and that this is a fundamental right that should not be denied.

3.1.3 Solidarity

Solidarity is the capacity to identify with other people, groups, and institutions that cooperate for society's welfare. Working together for the benefit of society's overall well-being is a key component of solidarity.

A specific application of Christ's teaching to "love your neighbor as yourself" (Matthew 22:37–39) is the idea of solidarity. Love is defined as solidarity in its social component, which is the duty to look out for others' interests (Condit, 2016). A Catholic church priest affirmed that:

> Christians are united not only by their affection for those who are closest to them, such as friends and family, but also by their solidarity with the Church as a whole and, by extension, with all of mankind (Catholic church priest, 2022).

This opinion is in line with the Bible that,

> In addition to feeding the hungry, covering the naked, and tending to the ill, we should also love our neighbors (Matt. 25:40).

The poor and defenseless have a right to special consideration, according to the social teachings of the Catholic church. Pope John Paul II described the preferential option for the poor as a call to special solidarity with the weak and humbling, with those who are suffering and weeping, who are humiliated and left on the margins of life and society in order to help them more fully understand their own dignity as human beings and children of God. In spite of the fact that the commandment to love one's neighbor as oneself does not permit exclusion, he made it clear that the poor are given a special privilege. On numerous occasions, he reaffirmed the Catholic Church's solidarity with the underprivileged worldwide (Pope John Paul II, 1980).

The assertions above therefore mean Christians have a responsibility to care for the sick as they belong to the same family. This is in agreement with the teaching of Catechism of the Catholic Church which says,

> The right distribution of things, the fair payment for labor, and the enthusiasm for a more just social structure are the first ways that solidarity, which is born out of human and Christian brotherhood, is shown. It is much more crucial to cultivate the virtue of solidarity while sharing spiritual riches of faith than when sharing tangible commodities. (CCC, 1992 no. 1948).

Catholic Church priests reaffirmed that solidarity practice is an essential part of Catholic faith. They continued by explaining that in the Catholic Church, you cannot profess to believe in God the Father without seeing a brother or sister in everyone, and

you cannot follow Jesus Christ without laying down your life for those who Jesus Christ gave his life for on the cross. The informants in this instance suggested that solidarity includes seeing others as brothers and sisters and actively striving for their welfare. The principle of human solidarity is also applicable on the society. The Bible says in this regard in Lev. 19:18, thus "love your neighbor as you love yourself",

Christ further commands people to love one another. This is in tandem with the Golden rule found in Matthew 7:12*, "In everything, do to others what you would have them do to you."* This summarizes the rule of conduct of Christians on their duty to their neighbors and the state at large. In other words, it emphasizes doing good for others. In sum, solidarity compel Christians to love and care for all humanity not only the closest, such as friends and family.

The study argues from the discourse that solidarity in catholic church healthcare facilities demands that the healthcare needs of the vulnerable and weakest members of the society are met. Catholic church healthcare in the Catholic Diocese of Kericho is against any legislation and acts that excludes the poor and the weakest from receiving healthcare service.

3.1.4 Subsidiarity

Giving a small group inside a large organization the ability to decide on matters that directly impact them as opposed to delegating that responsibility to the entire group is known as subsidiarity. The Catholic Church guides Christians toward the goal of caring for the needy by offering the principle of subsidiarity:

> A community of a higher order shouldn't interfere with the internal affairs of a community of a lower order because doing so would strip the latter of its functions. Instead, it should offer assistance when necessary and

> work to coordinate its activities with those of the rest of society, always with an eye toward the greater good (Centesimus Annus, no. 48).

According to subsidiarity, those who are most in need of care must supply it (CCC, nos. 1803, 1894, 2209). For instance, families should rear their children, counties should keep their roads in good repair, and the federal government should properly fund for national security. The Church therefore is obliged to uphold norms and ethics in the society and defend human dignity.

It was stated by Pope Pius XI in *Quadragesimo Anno* as a "fundamental" and "fixed and unchangeable principle of social philosophy" that:

> When one can accomplish something through their own business and industry, they shouldn't turn away from others and dedicate themselves to the community. Transferring to the greater and higher collectivity functions that can be carried out and provided for by weaker and subordinate groups is also an injustice, as well as a serious evil and a disturbance of right order. Since all social interactions should by their very nature benefit those involved, they should never harm or engulf them (Pope Pius XI, 1931).

This point was emphasized by Pope John XXIII in his encyclical *Mater et Magistra* (mother and teacher), in which he cautioned that government action should never interfere with the full development of human personality, but instead should aim to augment individual freedom and development by enticing people to actively participate in determining how their lives should be lived (Pope John XXIII, 1961). This empowerment of people is crucial for both their own well-being and the wellbeing of society as a whole.

The Diocesan Bishop affirmed relatedly that subsidiarity is upheld in the Catholic Diocese of Kericho by ensuring the society is organized in such a way that those that are nearest to a given problem are most familiar with and are able to respond in the best way to solve that problem. Subsidiarity advocates that those that are closest to an issue

are given priority in solving that issue. Applying subsidiarity in healthcare provision therefore means those closest to the need are the patients. Catholic church healthcare facilities in the Catholic Diocese of Kericho are patient-centered.

According to the informant, subsidiarity reminds Christians and society at large that human dignity is more likely to be safeguarded when personal relationships, rather than bureaucratic or professional obligations, constitute the basis for action. Subsidiarity therefore calls for a good patient-healthcare provider relationship for positive healthcare outcome. Healthcare access involves good relationship between healthcare delivery elements. Good relation between patient and healthcare provider is developed when there are no biases and discrimination. In a nutshell, subsidiarity calls for a more humane relationship that prioritizes human dignity among the healthcare agents: patient, care team, organization and the environment.

In healthcare, this is the doctor-patient relationship. Catholic church healthcare is to keep each individual patient at the center of healthcare decisions to the extent possible. Healthcare needs should be ordered toward the good of the individual patient. Subsidiarity is not only applicable to medicine only but also insurance companies and governmental bodies. Their rationing of healthcare needs should be subordinated by the decisions of the patient and the healthcare professional working with him or her.

While the availability of healthcare is being threatened by rising demand, uncontrollable cost growth, and social inequality that jeopardizes the common good, Catholic church's social teaching offers a compelling solution based on respect for truth and human dignity. These four tenets lay the groundwork for a morally superior and financially prudent change in healthcare delivery.

3.1.5 Fundamental option for the poor

Providing the impoverished the preferred option requires providing their demands special consideration and importance. Catholic social teaching on healthcare for the poor tries to influence how people perceive this right. At all levels of Catholic church healthcare, Christians must declare their commitment to the biblical command to care for the poor via practical action. People are motivated to work to make sure that the nation's healthcare delivery system offers enough healthcare for the poor as a result of this mandate. The needs of the poor, uninsured, and underinsured should get special consideration in Catholic church healthcare facilities (USCCB, 2009).

The Catholic Church leaders asserted that the Catholic Church's healthcare system is judged more on how well it treats the needy than on how well it treats the wealthy. The teaching of preferred option for the poor in the Catholic Church exhorts Catholics to replicate Christ's love for the underprivileged by trying to build a society that puts the needs of the underprivileged first. This is done by modeling their behavior after that of Christ. The Catholic Church holds that individuals who are subjected to poverty are deserving of preference within the Church. Jesus portrays the final judgment in the Gospel of Matthew 25:31–46, saying, "That we will be judged based on how we treat the poorest and most vulnerable members of society." Thus, giving the poor preferential treatment is not an option; it is a need. This might be used to argue that, under Catholic healthcare, no one should ever be turned away from a medical institution due to financial hardship. In a hospital run by a Catholic church, the needs of the poor, the underinsured, and the uninsured must come first.

The foregoing discourse resonates well with Pope Francis, *The Joy of the Gospel*([Evangelii Gaudium], no. 179) when he argued:

> The Church has a long history of loving the underprivileged. The Beatitudes, Jesus' poverty, and his care for the underprivileged serve as the inspiration for this love. The Church, which has continued to fight for their relief, defense, and liberation since her founding and in spite of the shortcomings of many of her members, has a preference for those who are afflicted by poverty. In the pursuit of justice and freedom, love for others, and especially love for the poor, whom the Church sees as Christ himself, is rendered tangible.

Pope Francis here meant that giving the less fortunate the means to take an active part in society is the major objective of this special commitment to them. Its goal is to enable everyone to take part in activities that promote the common good. As a result, the phrase "option for the poor" does not act as a catchphrase to divide people into different social classes or groups. Instead, it contends that the community as a whole suffers because of the poverty and powerlessness of the poor. Their degree of suffering acts as a yardstick for how far society still needs to advance before being regarded as a true community of people. These wounds can only be healed by greater solidarity with the poor and within the poor. Priorities should be given to the needs of the poor over the wants of the wealthy, the rights of patients over the pursuit of financial gain, the preservation of human dignity over current conditions, and the creation of medical supplies above that for commercial gain.

3.1.6 Social justice

According to the social justice doctrine, everyone deserves equal economic, political, and social rights and opportunities. According to Catholic social justice theology, all people have equal and inalienable worth because they were made in God's image. Because of this inherent dignity, each individual has the right to everything essential to enable them to live up to their full potential as God intended. Catholic church healthcare is first and foremost a church ministry and a component of institutional discipleship in the church. By carrying out God's life-giving and healing work and the Church's

ministry of healing and compassion, it communicates God's presence as a sacramental reality. It represents the ultimate result of Jesus' work and God's love for humanity—the new creation—which will someday be brought about by the last healing. Therefore, when Catholic church healthcare addresses justice in the current system of healthcare access, it does so from the perspective of the church as a ministry that continues the healing mission of Christ rather than only as an economic endeavor and business (Sullins, 2014).

Catholic Church leaders in this study confirmed that the Catholic Church values social justice. People are more likely to work together for the benefit of society and the greater good as a result. In order to recognize the needs of the society and apply the proper tools to address those needs on a local, regional, national, and even international level, social justice requires people to work together as a group. These sources went on to say that the Catholic church provides fair healthcare. A just healthcare system attempts to improve everyone's health within the community while also fostering equity of care and guaranteeing that each person's right to healthcare is upheld.

In a discussion of the connection between the Gospel and justice, the Synod of Bishops declared that participation in social change initiatives and the promotion of justice "fully appear" as essential elements of the preaching of the Gospel (Synod of Bishops, 1971). The church fulfills its duty to communicate the gospel by emphasizing the need for justice (CCC, 1994). The Catholic church has always placed a high value on the dignity of the human person, who was made in God's image. But an individualistic perspective falls short of understanding this dignity properly. As the Trinity of God is accepted, so too is the necessity of the communitarian and relational nature of the human representation of God. Therefore, social justice entails recognizing human

dignity and ensuring that it is upheld in society. Respect for the common good, which is seen as people and social groupings having access to their own fulfillment, feeds human dignity. The Catholic Church is a group of people. As a result, the Catholic Church must create environments that allow people to thrive in their communities, such as improving access to healthcare equity.

Although there are differences among people, Pope Pius XI wrote in *Quadragesimo-Ano* (After Forty Years) that the church must strive to create more fair and humane conditions. Extreme economic and social inequality among people who share the same racial group is shocking and threatens social fairness, equity, and human dignity as well as regional and international peace.

In conclusion, it is not revolutionary to state that the social justice teaching of the Catholic Church is opposed to a healthcare system that offers one level of service and care to some segments of the population while simultaneously offering a different, inferior level to others (Scott, 2006). It is reasonable to suppose that the church does not merely smile upon social systems that permit people to be treated unequally in a community, regardless of one's familiarity with Catholic social justice teaching. Whenever one group in a society is treated unfairly, individuals in the ministry should halt, motivated by a sense of justice and compassion, and dare to assert that something is wrong. The process of putting things right then occupied their attention. Without relying on the theological features of some facts about how people and communities are viewed, systems can be restructured to better uphold social justice principles.

The aforementioned stance suggests to this study that having justice also means having compassion for others. Therefore, it is the duty of the Catholic Church to expose all forms of injustice in healthcare system in order to promote justice.

3.2 Ethical and Religious Directives for Catholic church healthcare services

Catholic healthcare services that are provided in institutions are primarily the focus of the ethical and religious directives. They speak to the people who fund these institutions and services, as well as the trustees, chaplains, doctors, nurses, and other medical professionals. These directives, which embody the moral teaching of the Church, are equally beneficial to Catholic church personnel providing healthcare in other settings. The moral precepts advocated here derive primarily from natural law, which is interpreted in the context of the revelation Christ gave to his Church. The Catholic Church derives its understanding of the nature of the human person, of human deeds, and of the purposes that drive human behavior from this source (USCCB, 2009).

According to the United States Conference of Catholic Bishops (USCCB, 2001), the two objectives of these moral and religious guidelines are to reaffirm the moral standards of conduct in healthcare that follow from the Catholic Church's teaching on the dignity of the human person and to offer authoritative direction on some moral issues that Catholic church healthcare is currently grappling with.

The Savior's concern for the ill was something the Catholic Church has always tried to emulate. Every aspect of Catholic healthcare is illuminated by the mystery of Christ, including how to view Christian love as the driving force behind healthcare, how to see compassion and healing as extensions of Christ's mission, and how to view suffering as a sharing in the redemptive power of Christ's crucifixion, death, and resurrection. The Catholic Church has always had to provide aid to the sick, suffering, and the dying in a variety of ways as a true imitation of Jesus Christ.

3.2.1 The social responsibility of Catholic church healthcare services

Catholic Church acknowledges that healthcare access system is confronted with a range of economic challenges such as rising cost of healthcare service, technological challenges such as embracing technology in healthcare provision, social and moral challenges such as concerned with poverty, and moral challenges such as abortion. Normative principles that underpin the Church's healing ministry direct the response of Catholic church healthcare institutions and services to these issues. Promoting human dignity, helping the underprivileged, advancing the common good, being a good steward of the available resources, and acting in harmony with the church are all responsibilities of Catholic church healthcare (USCCB, 2009).

The Catholic Church leaders in this study resonated with the United State Conference of Catholic Bishops (2009) that the social responsibility of Catholic church healthcare facilities in the Catholic Diocese of Kericho is to exercise responsible stewardship. Therefore, any medical procedure contrary to the Catholic church social teaching on healthcare provision and Catholic church moral teaching of the sacredness and human dignity is prohibited. It is the duty of the Catholic church to uphold its definitions. Specifically, a dedication to the sanctity and dignity of human life from conception until natural death.

3.2.2 The pastoral and spiritual responsibility of Catholic church healthcare

Human life is worthy of respect since human beings were made in God's image (Genesis 1:26) and because all share his eternal life that is free from all taint. Healthcare provided by the Catholic church must respect each person's inherent worth as a person and their eternal destiny. Catholic healthcare has been inspired by Christ's words, "I was sick and you cared for me" (Mat 25:36). When dignity and worth are veiled by the constraints

of disease or the fear of impending death, attention should be given to help those in need rediscover these qualities.

Catholic Church leadership in this study affirmed that the healing ministry of Jesus Christ is carried on by the Catholic church. As a result, the care provided in the healthcare facilities run by the Catholic Church in the Catholic Diocese of Kericho includes both physical and spiritual healing. Pastoral care for spiritual healing is provided by Catholic churches. In this way, chaplains are a part of the medical staff for the Catholic church. This is so because the Catholic church believes that healing can occur more quickly when there is acceptance and hope.

3.2.3 The professional-patient relationship

A connection requiring mutual respect, trust, honesty, and proper secrecy is established between a person in need of treatment and the qualified healthcare provider who accepts that person as a patient. The ensuing free flow of information must refrain from coercion, intimidation, or snobbery. Such a relationship allows the patient to open up and provide personal information necessary for good care, and it also helps the healthcare practitioner to use his or her expertise to maintain or improve the patient's health in the most efficient manner possible. Neither the patient nor the healthcare provider operates independently of the other; both take part in the healing process (USCCB, 2009).

When a healthcare provider and a patient use institutional Catholic church healthcare, they accept the church's commitment to the public witness and awareness of the dignity of the human person. A really intimate professional-patient relationship is fostered by the moral teaching of the Catholic Church on healthcare. The identity of the Catholic church healthcare institution is inextricably linked to this doctor-patient connection.

Catholic healthcare is guided by a religious conviction that upholds the dignity of the individual and the relationship between the patient and the healthcare provider in all medical decisions. This is in keeping with the principle that every human being has intrinsic dignity, regardless of the nature of their medical condition or their socioeconomic standing, and that dignity must be cherished and preserved. All patients at the Catholic church healthcare center are treated with respect for human dignity (USCCB, 2009).

According to the Catholic Church, a patient frequently obtains healthcare from a group of providers. The interaction between the person seeking healthcare and the healthcare professionals delivering that healthcare is a crucial component of the framework on which diagnosis and healthcare are offered. The Patient-provider decisions in the Catholic church healthcare facilities in the Catholic Diocese of Kericho are built on the patients' healthcare needs. Therefore, patients' healthcare needs should be the basis of the patient-provider relationship in catholic church healthcare facilities.

3.2.4 Issues in care for the seriously ill and dying

Christ's atonement and atoning grace encompass the entire individual, especially in their disease, suffering, and death. A Catholic healthcare facility is foremost a community of respect, compassion, and support to patients or residents and their families as they cope with the reality of death as a witness to its religion. Care for the dying through the alleviation of pain and the suffering that is brought on by it is one of medicine's main goals. The adequate care of the dying requires effective management of pain in all of its manifestations. The reality that life is a priceless gift from God has significant ramifications for the debate over how to manage the stewardship of human life. People do not have complete control over life because they are not the owners of

their own lives. They have a responsibility to protect life and utilize it for God's glory, but that responsibility isn't unqualified since they can refuse life-preserving measures if they don't provide enough benefits or are too burdensome (USCCB, 2009).

Catholic Church leaders affirmed that the Catholic Diocese of Kericho's healthcare facilities provide treatment for people who are in danger of passing away through illness, an accident, or old age. People who are in imminent risk of dying are given the knowledge they require to comprehend their condition and are given the chance to speak with their family members and medical professionals about it. They are given the pertinent medical knowledge they need to make decisions based on morally sound moral standards. Healthcare facilities run by the Catholic church are barred from extending the capabilities of technology or failing to provide patients with enough information about their condition. In essence, Catholic healthcare respects the belief that life is a gift from God and that only God has the authority to end it.

3.2.5 Forming new partnerships with healthcare organizations and providers

Healthcare organizations and providers affiliated with the Catholic Church have been associated with other healthcare entities. One way to look at such collaborations is as an opportunity for Catholic healthcare organizations and services to influence the healing profession by bearing witness to their moral and religious values. For instance, new alliances can assist in putting the social teaching of the Catholic Church into practice. In order to provide a continuum of healthcare to the community, new partnerships may present opportunities to realign the local healthcare delivery system, demonstrate responsible stewardship of scarce healthcare resources, and increase access to basic care for the underprivileged and vulnerable (USCCB, 2009).

On the other hand, when new partnerships are formed with people who do not adhere to Catholic church moral principles, they can seriously compromise the identity of Catholic church healthcare institutions and services as well as their capacity to consistently carry out these directives. Because of the inherent risks, new alliances must undergo a methodical, unbiased moral investigation that takes into consideration the many pressures that frequently push organizations and services to form alliances that may limit the autonomy and ministry of the Catholic church partner.

In this study, Catholic Church priests asserted that Catholic church healthcare facilities in the Catholic Diocese of Kericho partner with other healthcare providers such as the government in terms of deployment of healthcare personnel as well as the vaccinations and patient registers. This is because the Catholic Church compliments the government in healthcare provision. The informants remarked further that in their partnership, Catholic church healthcare facilities however are demanded to maintain their uniqueness of defending human dignity, common good, subsidiarity and solidarity.

From the above analysis, the study remarks that one key feature defining identity of Catholic church healthcare and known by all facets of Catholicism is the strong emphasis on the sacredness of human life and the dignity of human person. The ethical and religious directives make human dignity as the foundation of Catholic church healthcare provision.

3.3 Conclusion

This chapter examined the Catholic church's teachings and position on healthcare provision in the Catholic Diocese of Kericho. To this end, the study established that the Catholic Church has written teachings on healthcare provision and this express their stand on defense of human dignity. The study established that the written social

teachings of the Catholic Church on healthcare provision is also taught in the Catholic Diocese of Kericho. From the written social teachings on healthcare provision, the study established that the position of the Catholic Church on healthcare provision in the Catholic Diocese of Kericho is the defense of human dignity, common good, subsidiarity, solidarity, social justice and preferential option for the poor. The value of human life in healthcare provision is priority over all other considerations.

The dignity of the human person serves as the cornerstone of the Catholic Church's moral vision for society, which both affirm the sanctity of human life. All the tenets of the Catholic Church's social teaching on healthcare are based on this tenet. Therefore, the Catholic Church's healthcare ministry is defined by respect for human dignity. The subsidiarity principle supports the establishment of compassionate relationships in the healthcare system. Therefore, even though there are legitimate differences between men, the equal dignity of persons requires that a more humane and just condition of life be brought about since excessive economic and social differences between members of one human family or population groups work against social justice, equity, and the dignity of the human person. The teachings of the Catholic Church's ethical code of conduct, which are based on the human person's dignity, are reiterated in the Ethical and Religious Directives.

The next chapter will look at the implementation of the discussed Catholic Church beliefs and values in alleviating normative human right value challenges related to healthcare provision in the Catholic Diocese of Kericho.

CHAPTER FOUR

THE CATHOLIC CHURCH AND NORMATIVE CHALLENGES IN HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

4.0 Introduction

This chapter analyzes the primary data and discusses it in the context of the secondary data covered in the earlier chapters. Among the data analyzed are: History of Catholic church hospitals, Catholic church healthcare provision and human values challenges related to it, comparison of catholic church healthcare facilities and non-Catholic, evaluation of catholic church healthcare facilities visa vis the Catholic church social teaching on healthcare provision. This formed the foundation for examining the effectiveness of the Catholic Church in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho which was the main concern of this study. This is done from the lens of liberation theology which advocates for the synthesis of Christian teachings and socioeconomic analysis that emphasizes social concern for the poor and freedom for the oppressed people.

Liberation theology considers the church to play a significant role in attainment of liberation. Liberation entails more than only escaping from social, political, and economic shackles. In a more profound sense, it suggests viewing the evolution of humanity as a historical process of human emancipation. It is to witness mankind searching for a fundamentally different society where it will be free from all forms of slavery and where it will be the architect of its own future. To begin with the chapter looked at the demographic characteristics, education level and occupation of the respondents.

4.1 Demographic Characteristics

To build a background of information with regard to respondents who took part in the study with regard to age, level of education and occupation, this section provides a description of the analysis of the participants' demographic characteristics. The study was carried out among the following categories of respondents: Catholic church faithful and non- catholic church faithful community members, Recovered Patients, Catholic Healthcare Personnel and Catholic Church Leaders.

4.1.1 Response Rate

The study group consisted of 390 respondents, twelve responses from the respondents were excluded because of incompleteness, yielding the final study population of 378 (96.9%). This agrees with Cook et.al, (2000) who affirmed that in most cases, a response rate of 50% or higher is regarded as excellent.

4.1.2 Respondents' Gender

Of the 378 subjects involved in the study, 182 (51.8%) were women while 196 (48.2%) were men. The study's sampling methodology and the prevalence of the two genders in the study area, as shown in figure 4.1 below, both contributed to the equitable distribution of the informants with regard to gender.

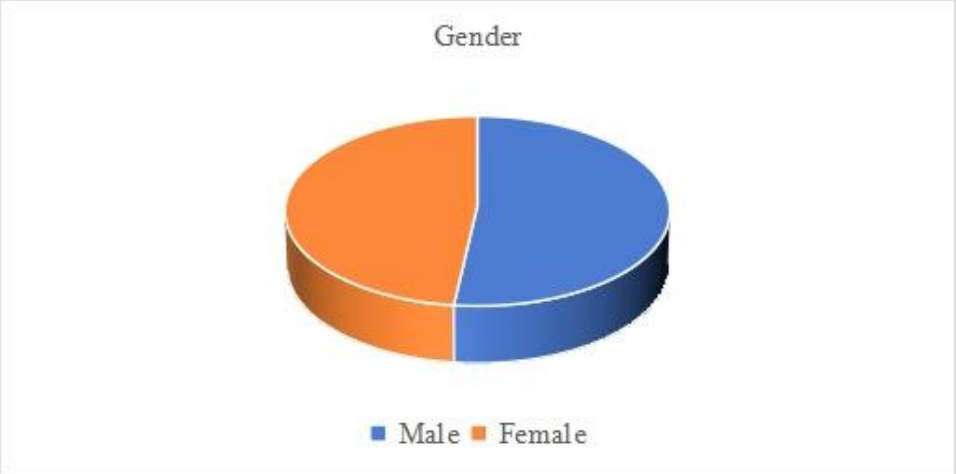

Figure 4. 1: Gender of Respondents

Source: Field Data (2022)

4.1.3 Informants Age

The study focused on respondents who fell in the following age brackets 18- 30years; 31-40 years; 41-50 years, 51-60 years and above 61 years. The youth who were in the age bracket of 18- 30 years were 46 (12.2%), the adults who fell in the category of 31-40 years were 70 (18.5%), those in age bracket 41-50 years were 104 (27.5%), those between age bracket 51-60 were 110 (29.1%) while participants who were in the age bracket of 61 and above years were 48 (12.7%) as distributed in following table 4.1. This age distinction was based on the Kenyan constitution, which regards the 18th year as the majority border, marking the point at which one has gained more of the individual and societal duties. Age was deemed relevant in this study as people of all ages are affected by ill-health differently (Crimmins & Kim, 2020).

Table 4. 1: Age of Respondents

Age (years)	Frequency	Percentage (%)
18-30	46	12.2%
31-40	70	18.5%
41-50	104	27.5%
51-60	110	29.1%
61 and above	48	12.7%

Source: Field Data (2022)

4.1.4 Participants' Education Level

The study categorized the respondents' level of education in the categories of: degree, diploma, certificate, secondary school, primary school, and none as represented in table 4.2 below.

Table 4. 2: Participants' level of Education

Education	Frequency	Percent (%)
Degree	36	9.5%
Diploma	12	3.2%
Certificate	8	2.1%
Secondary school	196	51.9%
Primary school	120	31.7%
None	6	1.5%

Source: Field Data (2022)

The findings showed that 36 (9.5%) of the respondents had attained degree, 12 (3.2%) had diploma, and 8 (2.1%) had certificate, 196 (51.9%) had attained secondary education, 120 (31.7%) had primary education, while 6 (1.5%) had none. The respondents' education level was ideal as it results in better, more dependable

occupations that pay more money and enable families to build capital that can be used to enhance health (Zajacova & Lawrence, 2018).

4.1.5 Occupation of the Respondents

This was established through a research tool on respondents' occupation. Table 4.3 that follows present this information.

Table 4. 3: Occupation of the Respondents

Occupation	Frequency	Percent (%)
Farming	258	68.25%
Commercial trade	94	24.87%
Formal employment	26	6.88%

Source: Field Data (2022)

From the study it was clear that a majority of the respondents were farmers. 258 (68.25%) of respondents were involved in farming and relied on it for subsistence, 94 (24.87%) were involved in commercial trade, while 26 (6.88%) were involved in formal employment as illustrated in table 4.3 below. Participants' occupations were required because different occupations had different distributions of health and mortality. For instance, in the UK, persons in the top occupational classes have a death rate that is 70% lower than those in the lowest occupational class (Ravwsteijn et al., 2013).

4.2 History of Catholic church hospitals in general

Catholic church hospitals were designed to provide medical care for the sick who were too poor to be cared for in their own homes. They were mostly founded by Catholic church sisterhoods. Catholic church hospitals have grown in number, sophistication, and geographic reach over time. Sisters volunteered their nursing services during epidemics, natural catastrophes, or conflicts, and they continued to assist the community after more permanent hospitals were built (McGuinness,

2013). Brotherhoods occasionally worked in hospitals, as was the case with the Alexian Brothers, who had been actively contributing to medical facilities throughout Europe for hundreds of years (Wall, 2011).

A Catholic church hospital established by a sisterhood had to be funded by the sisterhood because so many new hospitals had arisen in the late 1800s. Sisters had access to money that would allow them to help others even if they were meant to live in poverty. However, because catholic church hospitals required significant financial resources to construct and maintain, sisters had to find additional sources of income, such as individual gifts or fairs and events that were arranged by laypeople. Sisters frequently had to borrow money or take out loans to cover the costs associated with constructing or expanding catholic church hospitals. Typically, the sisterhoods who opened hospitals owned the facilities, so it was up to them to figure out how to keep prices down and pay for the expenses they spent. Sisters worked in nursing and administrative positions at hospitals but were not paid for their work because the sisterhood took care of all their requirements on a daily basis (Levin, 2011).

In Catholic church hospitals, patient payment has been a contentious topic for some time. Many believed that charging patients went against the benevolent principles on which Catholic church institutions were founded. There were also worries that patients who couldn't pay would be turned away in favor of those who could if those who could pay were forced. In the past, those who were poor and lacked access to medical care at home tended to use hospitals more frequently. Although patient payment later became customary in Catholic church hospitals, the underprivileged who accessed these facilities continued to receive free care. Although a bishop had to approve the opening of a hospital, most Catholic church hospitals were owned by sisterhoods for more than

a century, therefore the bishop had little to no control over the corporate boards of the hospitals and little influence over how the hospitals were administered. However, in a society where men predominated, a priest would normally serve as the chairman of the executive board for a Catholic hospital. In addition to leading committees and hospital units and making decisions regarding hospital policy, sisters essentially did everything else for the hospital (Wall, 2011).

Catholic church hospitals were mostly staffed by sisters from the time of their founding until the middle of the 20th century. They played a variety of duties in hospitals, including nursing, which involved the sisters actually providing patient care in the hospital. In order to heal the full individual, both physical and spiritual care was given. The nuns gave the patients' physical treatment top priority since only after their basic needs were fulfilled could the patients think about their spirituality (Kauffman, 1999). Throughout the 1800s, the nuns provided physical care, which included distributing food and medications. There were severe laws regulating sisters' behavior with male patients, and they could not touch males even to take their pulse (McGuinness, 2013). Nevertheless, they could help patients in some straightforward ways. Likewise, brothers who worked in hospitals were prohibited from interacting with women. Due to this, the Alexian Brothers in Chicago did not allow the admission of women to their hospital until 1962 (Wall, 2011). Depending on the patient's religion, different spiritual care was provided in the 1800s. Despite being associated with the Catholic Church, Catholic church hospitals sought to accept a range of religions and were designed to provide care to anybody in need (Kauffman, 1999). In order to protect Catholic church patients from proselytizing that might take place in other facilities, Catholic church hospitals were created.

Care for those who are disadvantaged, unable to pay, or without insurance is one of the main objectives of Catholic church hospitals. It has becoming more and harder for Catholic church hospitals to provide impoverished care as hospital prices have increased (Swetz et al., 2013).

This study notes in this regard that Catholic church hospitals were largely created and staffed by catholic church sisters with the intent to provide healthcare service to the poor and the vulnerable populations. Furthermore, during the creation of these catholic church hospitals, healthcare services were offered without charges. Sisters were responsible for looking for funds to run the catholic church hospitals.

4.3 Availability of Catholic church healthcare facilities in the Catholic Diocese of Kericho

In a relevant research item, the catholic church faithful and non-Catholic church faithful were required to affirm the availability of Catholic church healthcare facilities in the Catholic Diocese of Kericho. The responses to the item are illustrated in the table below:

Table 4. 4Availability of Catholic Church healthcare facilities in the Catholic Diocese of Kericho

Response	Frequency	Percentage (%)
Yes	341	90.2%
No	37	9.8%

Source: Field Data (2022)

The diocesan medical coordinator supported this data by noting that Catholic Church is like a government of its own. It is made up of different ministries and commissions

such as pastoral, healthcare, water, communication, tourism, environment and refugee program running independently. Healthcare commission was established to help disseminate the word of God through healthcare services such as curative, preventive, orthopedic and general counselling.

The Catholic Diocese of Kericho has established ten working healthcare facilities to give special attention to the poor and the needy by attending to their spiritual, economic, physical and intellectual healthcare needs. Among them, there is one Level 4 healthcare facility: St. Clares Kaplong Mission Hospital, Four Level 3 healthcare facilities. These are: Kipchimchim mission hospital, our Lady of Guadalupe, St. Lukes Matobo and Kaplomboi Health centre. Five Level 2 healthcare facilities. These are: Mercy Dispensary, St. Francis Monastry clinic, St. Anne's Kapsorok, Mercy Secondary School clinic and Mercy Mobile clinics. Fascinating one is St. Lukes Matobo established by Mexican sisters. It is responsible for provision of several services other than medical care such as alcoholic recovery and rehabilitation, rehabilitation of street children, orphaned and vulnerable, HIV/AIDS counselling and feeding programmes of the vulnerable people in the society. Additionally, there is one medical school St Clare's Kaplong School of Nursing which train nurses. Hospitals classified as level four are those that can do surgery, offer specialty clinics, and have the duty of serving as training facilities. Level three hospitals are those facilities that provide comprehensive curative, preventive, promotive and rehabilitative healthcare services including maternity services. Level two hospitals include dispensaries and clinics such as mobile clinics operating through migration from one area to another. Level one covers community health unit such as health promotion and education, early detection of conditions through screening.

The informant added that the Health Advisory Board, which is led by the Diocesan Bishop, provides direction to the medical office. The Medical Coordinator is responsible for overseeing its daily activities. The Health Department's mission is to "facilitate the provision of sustainable curative, preventive, promotive, and rehabilitative healthcare services to all in accordance with the social teachings of the Catholic Church," under the guiding principles of the dignity of the human person, the common good, preference for the underprivileged and poor, stewardship of resources, and subsidiarity. The diocese's healing ministry is an element of the institutional framework that aims to bring life to its goal and vision. A ministry of the Catholic Church, healthcare carries on the mission, love, and healing of Jesus. Every person is a treasure, every life is a holy gift, and every human being is a oneness of mind, body, and soul. This idea is at the heart of Catholic healthcare. The diocese's network of healthcare facilities and community healthcare programs significantly contribute to the country's healthcare system.

The diocesan medical coordinator also noted that the Catholic Church in the Catholic Diocese of Kericho is mandated to coordinate the management of Catholic church healthcare facilities and works in collaboration with the Ministry of Health in ensuring access to healthcare to all. Additionally, it advocates on behalf of government organizations for fair resource mobilization and distribution while also providing leadership on cutting-edge healthcare concerns. This aims at strengthening and creating efficacy in healthcare provision. This assertion aligns with the history of Catholicism and involvement in healthcare provision

Catholic organizations, monks, and laypeople created medical facilities all throughout the world as Catholicism spread as a global religion. The Roman Catholic Church is the largest non-government provider of healthcare services globally (Agnew, 2010).

Medicine has always been a focus of the Catholic Church. Jesus Christ, the founder of the Catholic Church, instructed his followers to heal the sick. Because of their reputation for providing care for the sick and elderly, early Christians encouraged practical almsgiving, which helped to establish hospitals and organized nursing. According to the renowned Benedictine rule, "the care of the sick is to be placed above and before every other duty, as if indeed Christ were directly served by waiting on them."

Over the past 200 years, the Catholic Church has experienced significant growth throughout Africa. Catholic missionaries-built hospitals all over the continent, just like they did on every other continent (Agnew, 2010). His Holiness Pope Francis and the Vatican's Dicastery for Integral Human Development are urging Catholic healthcare providers to work together more actively in order to make sure that the scope of Catholic healthcare services has the potential to improve global health and have an impact on many people's livelihoods, especially the poor and vulnerable, for whom this system was primarily designed. The study therefore established in this regard that Catholic Church in the Catholic Diocese of Kericho is actively involved in healthcare provision as part of the mission of Jesus Christ who is the founder and who commissioned the Church to carry out this mandate.

Catholic church faithful and non-Catholic church faithful were asked whether they had been treated in Catholic church healthcare facility or not. The following chart illustrates their response

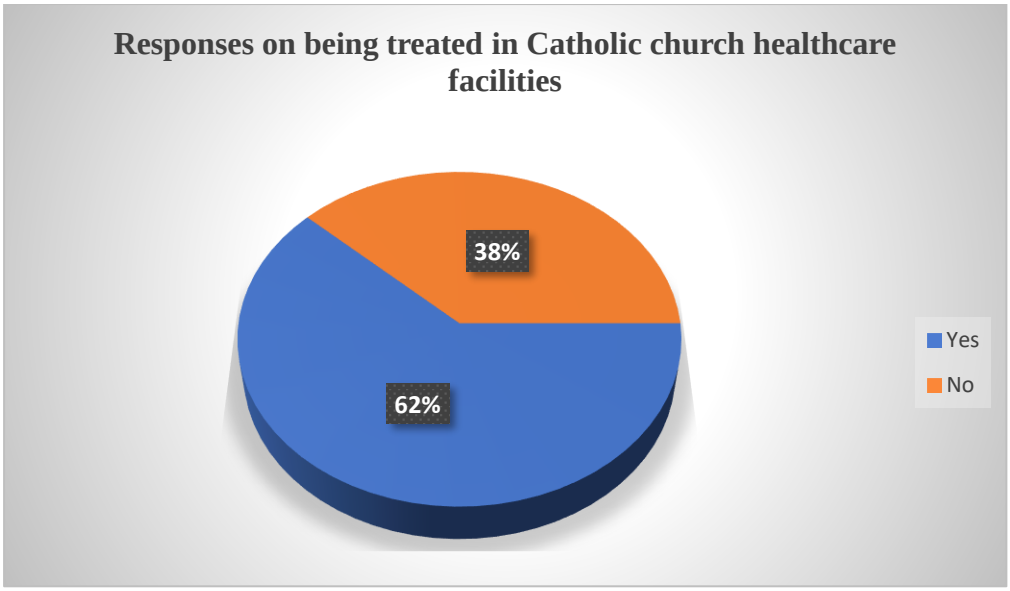

Figure 4. 2: **Treatment in the Catholic church healthcare facilities**

Source: Field Data (2022)

251 (62%) respondents affirmed that they have received treatment in Catholic church healthcare facilities while 127(28%) respondents affirmed that they have never received treatment in Catholic church healthcare facilities. From these results, the study established that catholic church healthcare facilities in the Catholic Diocese of Kericho are functional and responsible for offering healthcare services.

4.4 Patient-centered healthcare in the Catholic Diocese of Kericho

Patient-centered healthcare is where the patient healthcare needs initiates and directs the entire process of healthcare provision. Both the Catholic church faithful and non-Catholic church faithful were asked to agree or disagree if the patient healthcare need was responsible for initiating the process of healthcare provision. They were further asked to give reason for their answer

Table 4. 5: Patient-centered healthcare in the Catholic Diocese of Kericho

Response	Frequency	Percentage (%)
Disagree	264	70.1%
Agree	0	0
Other factors	114	29.9%

Source: Field Data (2022)

The tabulated results above indicate that majority of the respondents (70.1%) overwhelmingly disagreed that compelling healthcare needs did not necessarily initiate the healthcare provision process. The common reason given by majority was that the commercialization of healthcare services and facilities has taken pre-eminence. They explained that the ability to meet the cost of the healthcare service is responsible for initiating the process of healthcare provision.

Some of the respondents (29.9%) were for the dissenting views. Their views were that healthcare provision is determined by other factors other than the patient compelling healthcare needs. Some of the reasons they gave were, the availability of required equipment to meet the healthcare needs. Some healthcare needs demand the services of a specialist which is not necessarily found in all the healthcare facilities. From the opinions of the respondents, it was depicted that patient's healthcare needs in the catholic church healthcare facilities in the Catholic Diocese of Kericho do not necessary initiate the process of healthcare provision. There are other factors such as availability of equipment, medical specialist and the ability to meet the cost of the healthcare service.

The foregoing results contradicts WHO (2017) which emphasizes that right to health is a basic human right and promotes the idea of patient-centered healthcare that is the embodiment of human rights. According to the WHO, patient-centered healthcare is treating someone receiving medical attention with respect and dignity and engaging them in all decision-making processes. WHO goes on to say that people's human rights are protected, their outcomes are better, and healthcare delivery systems become more effective when they are given the chance to actively participate in their own healthcare.

4.5 Normative challenges related to Catholic Church healthcare provision in the Catholic Diocese of Kericho

A relevant item required the Catholic church faithful and non-Catholic church faithful to affirm the prevalence of normative challenges in healthcare provision in the Catholic Diocese of Kericho. The respondents asserted that normative challenges in healthcare provision in the Catholic Diocese of Kericho are widespread. The figure below illustrates their responses

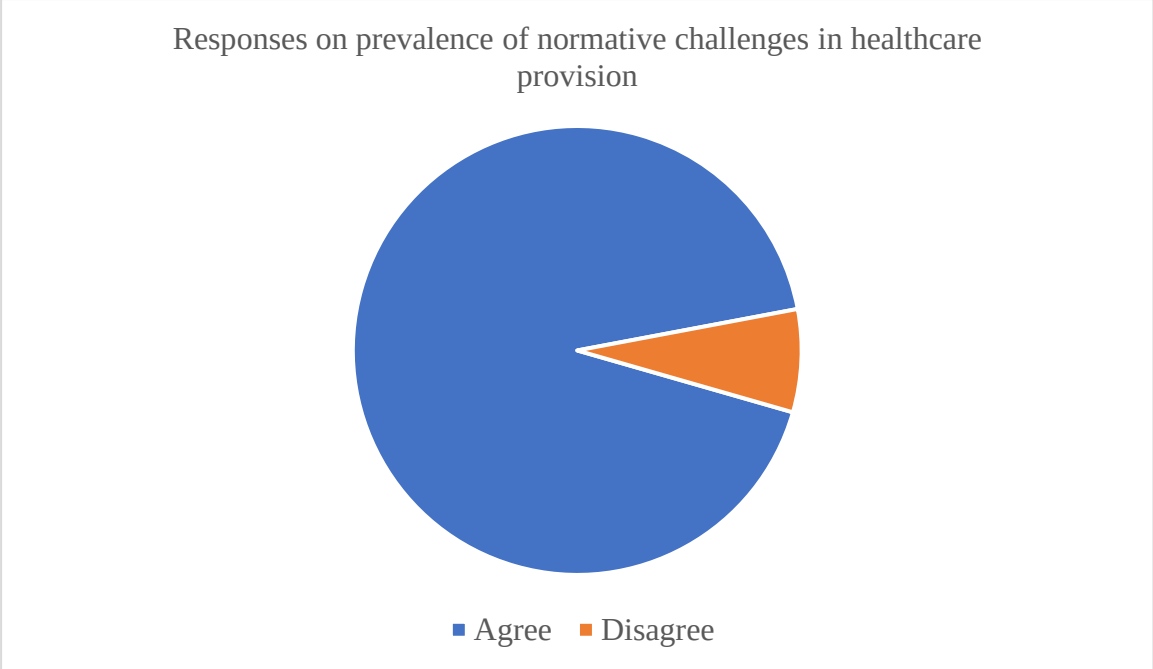

Figure 4. 3: Normative challenges in healthcare provision in the Catholic Diocese of Kericho

Source: Field Data (2022)

From the chart, majority of the respondents (93%) were in agreement that accessing healthcare in catholic church healthcare facilities is not guaranteed to everyone everywhere. The main reason behind the overwhelming responses seem to reflect the position of the public domain that access to healthcare is a basic human right therefore, the expectation of everyone who visits a healthcare facility is to receive healthcare service despite the prevailing conditions. To be deemed accessible, healthcare services must be available and timely.

Of the dissenting views were 7% of the respondents that disagreed that catholic healthcare facilities are accessible to everyone. The main reason behind their response seemed to reflect the position that a true Catholic healthcare facility cannot afford to deviate an established norm when they are tasked to upheld such norms and human values. From the responses, the study then concludes that normative challenges in healthcare provision in the Catholic Diocese of Kericho are widespread.

In another item, the recovered patients and catholic church healthcare personnel were asked to highlight challenges related to human values in catholic church healthcare provision. From the responses, the following challenges were highlighted:

4.5.1 Polarization of healthcare service

This is a state in which healthcare service is provided in a manner that favors a certain group in most cases the 'haves' and disadvantages others, the 'have-nots.' Medication deficiency was associated with situations where the catholic church healthcare facilities did not provide the prescribed medication. Recovered patients noted that the common experience in the Catholic church healthcare facilities is that you are given medical prescription by the doctor but the prescribed medication is not available in the dispensing unit. This forces the patients to go and purchase the drugs in other settings which are relatively costly.

Diocesan medical coordinator affirmed further that Catholic church healthcare provision is not efficient. The key informant attributed this to the deficiency of prescribed drugs and equipment. He explained that when the drugs and healthcare equipment are over or have expired in the dispensing unit, the diocese takes too long to procure and deliver other drugs. The healthcare facilities then stay too long without drugs. Patients are forced to go and look for medication in other settings.

Catholic church healthcare personnel also affirmed that they are faced with inadequacy of equipment as well as healthcare specialist. The informants explained that patients who have the ability to purchase the needed equipment for treatment which may not be available in the facility such as those for injection, can purchase and are treated. Those without the ability are given referral for a later treatment.

Interview responses from the catholic church healthcare personnel affirmed differences in the in-patient services provision which seem to portray a divide between the haves and have-nots. Of similar opinion, one opined that,

> We offer inpatient services based on the admission category. Our facility has a common room and private wing ward based on the affordability of the patient. Private wing is preferred by those who can afford because it has a lot of privacy, high quality care, reduced infection and fewer adverse events. Also, improved ability to rest increases recovery time and it provide excellent atmosphere to recuperate after undergoing extensive treatments. Due to the privileges in the private wing, the charges are higher compared to the common room (Catholic Church healthcare personnel, 2022)

According to the respondent, this probably meant that provision of in-patient services in the catholic church healthcare facilities are made based on the social classes one belongs. It could depict that people from high class are admitted based on the class they belong, that is, private wing since they can afford. Those who do not afford are admitted in the common room. These differences in the provision of in-patient services depicts the fact that those who have continues have greater opportunities to access better healthcare services compared to those who don't have.

Foregoing scenario conflicts with Vatican II; *Caritas in veritate* (Love in truth) that, if economic help is to be true to its intended use, it must not seek ancillary goals, such as being tied to certain pro-abortion healthcare policies.

4.5.2 Socio-economic divide

Recovered patients affirmed that socio-economic differences in catholic church healthcare facilities are prevalent. Majority of the respondents asserted that affordability dictates attention in the catholic healthcare facility. Of similar opinion, one respondent reported that,

> The affordability aspect dictates the urgency of attendance. If you don't have adequate finance to meet the required healthcare service, you are asked to source for the finance be it from relatives or any convenient source before getting the treatment (Recovered patient, 2023).

The respondent here meant that before receiving treatment, you must first meet the required finance to cater for the healthcare services to be delivered.

The aforementioned claim is in odds with Meyer's (2003) claim that everyone deserves access to high-quality healthcare, regardless of personal factors like affordability, identities, or qualities like ethnicity or gender.

A focus group discussion pointed that poverty is a social problem and a source of oppression in society. It restricts man's ability to obtain healthcare when necessary. Financial constraints prevent the poor from acquiring the necessities for optimal health, such as enough quantity of high-quality food and access to healthcare services. They continued by saying that one of the main causes of poverty is poor health. This is partially a result of the high costs associated with obtaining healthcare, which also include transportation expenses and other unofficial payments to healthcare professionals in addition to out-of-pocket expenses for services like consultations, tests, and medication. They were in agreement that both poverty and ill-health are sources of oppression in society as they hinder man from realizing their full potential. Poverty hinders efficient quality healthcare access while ill-health affects man's activities. Society therefore needs freedom from these oppressors. Additionally, families that are struggling financially due to disease may be forced to sell up possessions to pay for medical costs, take out loans with exorbitant interest rates, or accrue debt from the community. Lategan (2017), who maintains that poverty today is a serious societal issue, finds the worries of the respondents to be very relevant. He added that access to

healthcare is a fundamental human right, but it is also a costly one. No one will contest the value of healthcare access or support in general, he continued, but it is also undeniable that providing such services is expensive, particularly in societies where the government cannot cover all healthcare costs due to the prevalence of poverty and unemployment.

4.5.3 Health insurance cover dictating medical care

Interview responses from the recovered patients and catholic church healthcare personnel further revealed that payments for the healthcare service is first negotiated before offering the service. The two common forms of payment that emerged from the study were insurance company (NHIF) and direct payment from the recipient of the healthcare service. However, the two forms are faced with challenges. NHIF at times delays approval for medication whereas for patients who makes direct payments, a challenge emerge when they don't have money to meet the payments. The healthcare personnel affirmed that the patients are asked to source money from their relatives or friends first before being treated. One of the healthcare personnel opined that, "nothing is free. You must pay for it.'' The respondent here probably meant that every patient must be in a position to pay for the healthcare services he or she is to receive.

Recovered patients appeared to maintain that insurance companies are what dictates accessibility of healthcare service in Catholic church healthcare facilities in the Diocese of Kericho. They narrated that medical insurance companies have introduced measures to control costs. These regulations call for doctors to notify insurers of their actions and request authorization before providing treatments and undergoing procedures. You should first determine whether a procedure or test is covered by your health insurance plan before getting it done. Making sure a doctor has approved or requested the required

treatment or tests is the first step. The informants added that obtaining a doctor's opinion alone does not guarantee that the insurance will view the procedure as medically required. If the insurer does not consider it as medically necessary, then the insurer does not cover your healthcare bill. You will be forced to pay the bill from your pockets.

The social teaching of the Catholic Church emphasizes the importance of the common good and how healthcare is a component of a healthy community. People who are well and have their wounds healed are better equipped to pursue their own interests, to contribute to the common good, and to engage in community connections with their neighbors. A civil society in which people recognize one another as members is a requirement for the common welfare. Denying someone or a group of people access to healthcare is the same as treating them as less than full community members. Both the quality of community life and the reality of the common good are harmed. Millions of people who are uninsured or have inadequate insurance are unable to receive healthcare, which is a serious violation of the common good. The government and organizations that provide healthcare are obligated by the common good principle to ensure that everyone has access to healthcare services (Cochran, 1999).

4.5.4 Geographical location divide

Recovered patients noted that physical access to healthcare service is a challenge to them because of the distance from their residence to the healthcare facility. A similar position was held by the diocesan medical coordinator who affirmed that catholic healthcare facilities are not evenly distributed in the diocese. He isolated that high level healthcare facilities such as St Clares Kaplong, Kipchimchim mission hospitals, St. Lukes Matobo are located in urban centers whereas outskirts of the diocese are serviced by mobile clinics. He noted that this disadvantage the poor and vulnerable who in most

cases tend to be clustered in the rural areas. This also explains the high cost of healthcare service especially for rural residents. Therefore, patients in rural and urban areas do not have equal opportunity for the healthcare service access.

4.5.5 Healthcare technology divide

Interview responses from catholic church healthcare personnel revealed that catholic church healthcare adopts technology in their provision of healthcare. However, there is a discrepancy in the level of technology development across the catholic church healthcare facilities in the Catholic Diocese of Kericho. Of similar contention, one healthcare personnel noted that;

> Digital healthcare is highly demanded in a world that is becoming technologically oriented. Catholic healthcare facilities use technology in their delivery of healthcare service. Technology has facilitated early detection of diseases and has contributed greatly to quality healthcare outcomes. The challenge is unequal development of technology in various catholic church healthcare facilities in the catholic diocese of Kericho. Some healthcare facilities are underdeveloped in terms of healthcare facilities. Some level two healthcare facilities such as St Anne's kapsorok, Mercy Dispensary still use manual register for patients when developed facilities used desktop computers for patient registration and keeping patient's healthcare history (Catholic church healthcare personnel, 2023).

According to the respondent, Catholic church healthcare provision uses technology in their delivery of healthcare services. However, differences emerge in their level of utilization. High level facilities have highly developed technology compared to dispensaries and clinic which may have not even managed to adopt better way of keeping healthcare history of their patients. From the responses, this study can argue that there is a divide in healthcare technology among catholic church healthcare facilities in the Catholic Diocese of Kericho.

A focus group discussion contented that technology in healthcare has both advantages and disadvantages. It has facilitated efficiency in treatment of various diseases through surgery and operations. It has led to introduction of modern drugs compared to old times where traditional herbs were used for treatment of diseases. Technology through mass media aids in facilitation of mass dissemination of vital information pertaining healthcare for instance during pandemics such as the recent covid-19 on issues such as preventive and containment measures. It has also made it easy to trace the healthcare history of a patient.

On the contrary, technology has made patients to doubt their providers. This is because through technology, healthcare information such as the signs and symptoms of a disease as well as prescription on the diagnosis is easily accessible. The patients therefore seek healthcare access when they already have a background knowledge on the expectation. In case of discrepancies, the patient raises questions to providers and this makes them loose trust and doubt the providers. The challenge here is that patients fail to understand that some names of drugs are only trade names. Alternatively, there are substitutes of drugs and they may not bear the same name. Also, use of technology in provision of healthcare service is a contributor to the high costs of the healthcare services. This is attributed to the high costs of acquiring the digital healthcare equipment.

In sum, catholic church healthcare facility is also influenced by technological advancement which is a contributor to the high cost of healthcare in as much as it has improved the quality of the healthcare service. The concern of the respondents aligns with the study done by Sorenson et al., (2013) which established that, healthcare technologies are viewed as the main factor driving rising costs for healthcare access.

4.5.6 Gender healthcare divide

A catholic church healthcare personnel affirmed that the mission of Catholic church healthcare includes providing for people's healthcare needs throughout all stages of life. Catholic church healthcare institutions offer a wide range of expert services, such as acute and primary care, nursing homes, medical and social day care, home health, senior housing and assisted living, counselling, and case management.

The informant further noted that a person's total well-being is greatly influenced by their physical health. An initiative to educate women in rural areas about their health was therefore one of the programs that the Catholic church communities adopted. Its main objective is to empower women and give them the tools they need in order for them to properly care for both their own and their families' health and wellbeing. Every two weeks, the program brings together the mothers and grandmothers of the neighbourhood for a two-hour session on topics including good diet, personal hygiene, and common illnesses and their natural cures. these sessions are conducted by a volunteer midwife. Every lecture is followed by a home visit to see how they are able to apply the lessons at home.

The other communities, such as men, were still making preparations at the time of this study in terms of resources, such as teaching staff and logistics, in order to launch the program and sustain it over time.

4.6 Catholic church social teaching and healthcare provision in catholic church healthcare facilities in the Catholic Diocese of Kericho

Effectiveness of the Catholic Church in healthcare provision was determined by the compatibility of the teachings of the church on healthcare provision and the experiences in healthcare facilities. That is, whether the teachings of the Catholic Church on

healthcare provision are reflected in the provision of healthcare services in the Catholic Church healthcare facilities. Respondents therefore were required to agree or disagree on whether the listed teachings of the Catholic Church on healthcare provision were upheld in the healthcare facilities or not. Their responses appear in table 4.6 below

Table 4. 6: Catholic church teachings and healthcare provision in the catholic church healthcare facility

Teachings	**Percentage (%)**	
	Agree	**Disagree**
Human Dignity	5.3%	94.7%
Service to community	100%	0
Option for the poor	5.6%	94.4%
Call to Justice	5.3%	94.7%

Source: Field Data (2022)

4.6.1 Defense of human dignity

A total of 358 catholic church faithful and non-Catholic church faithful constituting 94.7% were in agreement that catholic church healthcare facilities do not necessarily prioritize the defense of human dignity. The respondents explained that you visit a healthcare facility and you are asked to first source the money from friends or relatives to meet the cost of the healthcare service if you do not have the money to meet the cost of the healthcare service. 5.3% held an opposing view that human dignity is highly regarded. Interview responses from catholic church healthcare personnel affirmed that catholic church healthcare facilities do not offer abortion services, artificial family planning on moral grounds that abortion involves taking away life since Catholic church supports the idea that life starts at conception and advocates for natural family

planning because Catholic church respect God’s design for married love and human beings are created in God’s image and likeness.

From the responses, the study deduced that, attendance in the Catholic church healthcare facility sometimes is based on patients’ ability to meet the cost of the healthcare service. This runs counter to the core tenets of the Catholic church's social class doctrine, which emphasize human dignity and preference for the underprivileged. All economic choices, government actions, and medical institutions must adhere to the core moral principle that everyone, especially the impoverished, must benefit. Furthermore, it is fundamental to the biblical depiction of justice that how a community treats the weak members of society determines its level of justice (National Conference of Catholic Bishops, 1986:93). Additionally, failing to value human dignity is at odds with Catholic church teaching, which holds that the dignity of the human person is the cornerstone of a moral vision for society. This is founded on the premise that people are more important than objects and that the quality of any healthcare facility should be assessed by whether it threatens or upholds the individual's life and dignity. Only when human rights and dignity are respected and obligations are met can a community be considered healthy.

It emerged from the study that it is common knowledge in the public domain that the expectation of every patient from healthcare facility is to satisfy their healthcare need. The study also unraveled the similar position of the Catholic church on healthcare provision that human dignity is the core principle of the catholic church healthcare provision. However, in catholic church healthcare facilities, the experiences indicate a mismatch. Recovered patients expressed a feeling of other factors determining accessibility of healthcare other than the patient healthcare need. Among the cited

incidences were the fact that if you are medically insured, insurance company has to make approval for the healthcare service to be administered if you do not have money to pay or you first solicit money from friends or relatives. In other words, the patients expressed the feeling that affordability is what dictates the urgency of accessibility of healthcare service in catholic church healthcare facilities. This contradicts the Catholic church teachings on healthcare provision that Catholic church healthcare ministry is rooted in the commitment to promote and defend human dignity. It also contradicts the principle of subsidiarity since decision is not made by the patient but rather the organization (USCCB, 2009).

4.6.2 Service to community

All the responses indicated that catholic church healthcare facilities in the Catholic Diocese of Kericho serves the healthcare needs for both catholic church faithful and non-Catholics. However, these Catholic church healthcare facilities work together with other governmental, secular and local healthcare facilities to build a weaker, unfair and unkind healthcare society that no longer values the dignity of human person.

Pope Benedict XVI makes a forceful plea for the "Cooperation of the Human Family" in *Caritas in veritate* (love in truth). The author claims that the development of peoples "depends, above all, on a recognition that the human race is a single family working together in true communion, not merely a group of subjects who happen to live side by side" (Caritas in veritate, 53). He proposes that the solidarity of the rich nations toward the impoverished countries be closely linked with the idea of subsidiarity in order to prevent paternalistic social assistance, which is humiliating to people in need.

Interview responses from Diocesan medical coordinator affirmed that Catholic church healthcare facilities usually offers free medical camps where healthcare education is

disseminated. He further noted that one of the ways of catholic church has ensured common good in society is building their own hospitals intended to cater for the healthcare needs for both the catholic faithful and Non-catholic church faithful.

4.6.3 Call to justice

It emanated from majority of the responses (94.7%) that catholic church healthcare facilities are injustices themselves. The explanation given was that the structure of catholic healthcare facility is made to attend to patients needs with respect to affordability of the healthcare service. Catholic church healthcare facilities are structures which exhibit institutional injustice as they do not offer equal opportunities in healthcare access. Institutional injustice refers to institutions creating disparities in representation, opportunities and resource allocation (Guala, 2006). The poor experience institutional injustice, inequities and discrimination through intersecting personal characteristics and social circumstances. 5.3% of the respondents however held a contrary opinion that Catholic church healthcare facilities are administering justice to its clients. The explanation the respondent gave was that they have always had their healthcare needs met whenever they visit the catholic church healthcare facilities.

It was clear from the study that catholic church healthcare institutions exhibit a significant level of injustice from their own perspective. This is evidenced by the responses from the recovered patients that access to healthcare service is determined by the medical insurance cover or the affordability of the patients. The poor and those without cover therefore get challenge in accessing the healthcare service.

The majority of respondents' views on the delivery of healthcare were at odds with the social teaching of the Catholic church on call to justice, which emphasizes that all

people are members of the human family regardless of their national, racial, ethnic, economic, or ideological differences. In a society where inequalities abound, love for all of our sisters and brothers necessitates that we work to uphold justice.

The foregoing position contradicts Mugambi's (1996) argument that, in the midst of injustice, cultural dislocations and other ills such as social injustices plaguing the world, the Church is the light and the leaven in human society. The goal of the Church's service to the human community should not only be to "save souls for heaven," but also to "humanize" society and instill in people a sense of personal accountability for advancing the social, political, economic, and spiritual order that is in accordance with God's divine will for the world. The goal of Catholic doctrine should be to establish moral and holy order. Moral because the Church strives for a total humanism, or the emancipation from all that stifles man and the growth of the entire man. It should indicate the path the society should follow so as to be reconciled and be in harmony.

A study by White et al. (2010) looked at hospital values and assessed how well the services offered were in line with these ideals. A significant finding was that institutions with a strong commitment to justice and compassion, such as Catholic church hospitals, paradoxically supplied fewer services in this area. This finding leads to the conclusion that the services provided frequently do not align with the hospital's ideals. This study supported the idea that while Catholic church hospitals hold particular principles, they might not always be able to incorporate those beliefs into the care they offer.

4.6.5 Option for the poor

A total of 358 respondents constituting 94.4% held that accessing healthcare service in the catholic church healthcare facilities is challenging. They noted that sourcing money from friends and relatives to meet the cost of healthcare service makes them delay in accessing treatment. They explained further after meeting the healthcare personnel, the prescribed drugs are not available in the pharmacy and you are given a referral to purchase them from other settings which is relatively expensive.

Other respondents (5.6%) held an opposing view saying that healthcare service provision at Catholic healthcare facility is effective. The position represented the respondents who did not have any challenge probably because they had ability to meet the cost of the healthcare service or they had a medical insurance cover that facilitated the access of the healthcare service.

The opinions of the majority respondents' conflict Catholic church social teaching on healthcare provision on preferential option for the poor upheld in the Catholic Church. The teaching places emphasis on the idea that a society's treatment of its weakest people serves as a fundamental moral yardstick. According to Catholic church tradition, society as a whole should prioritize the needs of the poor and vulnerable in a world marked by widening wealth and poverty disparities.

Results from the preceding chapters unraveled that one of the major goals of Catholic church healthcare facility is to provide care to those who are unable to pay, or without insurance. The findings indicated further that, as hospital costs have risen, it has become more and more difficult for Catholic church healthcare facility to provide healthcare for the medically needy or poverty-stricken patients. Diocesan medical coordinator

asserted that financing of the healthcare facilities is a big challenge due to decrease in donor funding. The healthcare facilities are majorly dependent on the Diocese for its running. The issue of inadequate funding has made it impossible for the Catholic church healthcare facilities in the Catholic Diocese of Kericho to the cater for the needs of the poor

Diocesan medical coordinator however remarked that as a way of serving those in need, St Lukes Matobo is responsible for offering healthcare services directed to people with HIV/AIDS such as offering food and procuring ARVs. They also offer counselling to people with HIV/AIDS and alcoholics recovery.

The findings of the study seem to depict prevalence of a disconnect between catholic church's social teaching on healthcare provision and the ideal practice of healthcare provision in the catholic church healthcare facilities in the Catholic Diocese of Kericho. Compatibility is witnessed in the service to community where the catholic church healthcare facilities are responsible for offering healthcare services to both the catholic church faithful and Non-catholic church faithful and building its own hospitals.

The primary data in this study reveals that the identity features of catholic church healthcare provisions of human dignity, subsidiarity, option for the poor and call to justice are not necessarily the identity feature of the catholic church healthcare provision in the Catholic Diocese of Kericho. The identity features that define Catholic church healthcare provision in the Catholic Diocese of Kericho is affordability and medical insurance cover. Ideally, this reverses what is theologically upheld in the Catholic Church in general. Teachings of the Catholic Church on Healthcare provision as unraveled in the foregoing sections advocate that defense for human dignity and preferential option for the poor be at the core for the service of humanity. The

expectation of Catholic church healthcare provision aligns with Borghesi (2021) who denotes that, the manner in which the Roman Catholic Church's core values: community duty, respect for human dignity, call to justice, and preference for the poor are blended, prioritized, and stressed in the healthcare ministry are recurring issues in discussions about catholic church identity.

4.7 Impact of the Roman Catholic Church environment on Catholic church healthcare facility identity

The settings of the Roman Catholic Church and the modern non-Catholic church healthcare institution, according to White (2012), are frequently at odds with one another. Figure 4.4 describes selected environmental forces that are impinging on Catholic church healthcare facility identity, as explained below.

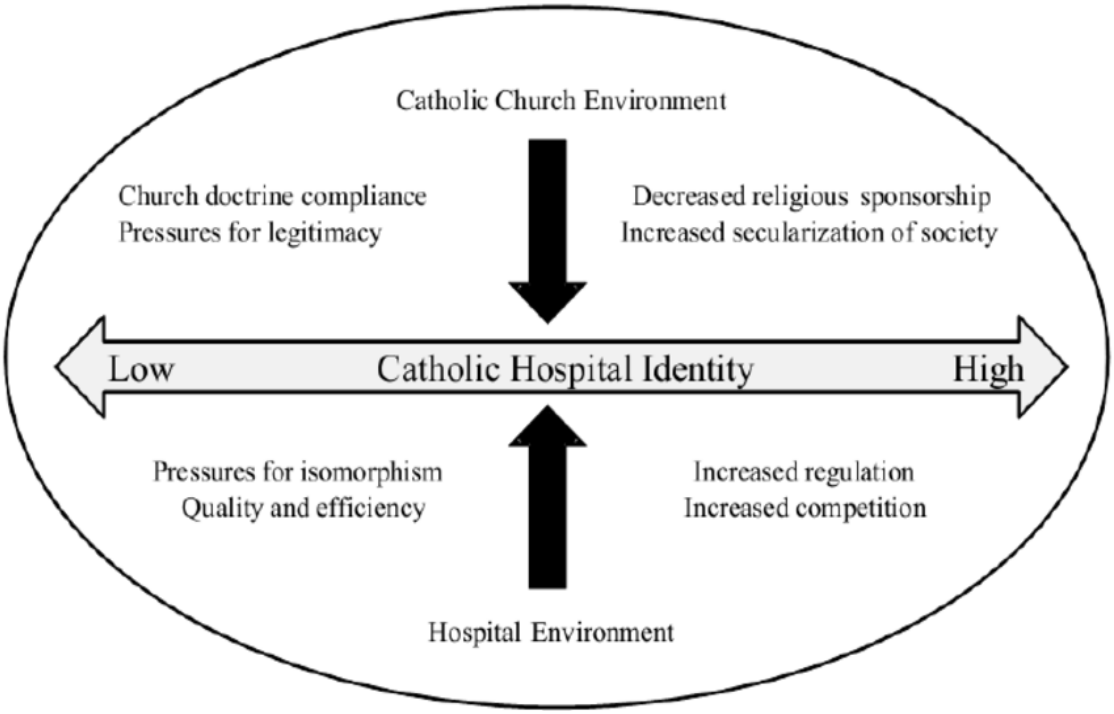

Figure 4. 4: Impact of the Catholic Church and contemporary healthcare facility environments on Catholic church healthcare facility identity

Source: White (2012)

The Vatican Cardinals, archbishops, or bishops are a highly centralized organization that issue extensive theological structures, processes, and directives for the Roman Catholic Church. Additionally, the sponsoring religious organizations orders impose each hospital with their special charism or sacred mission. The institutional setting at this level of the church hierarchy is strong. Although the Catholic church's identity has remained largely based on its adherence to Catholic theology and its view that access to healthcare is a fundamental human right, other environmental factors beyond its control have had an impact on the identity of Catholic church healthcare facilities. The increasing secularization of society, the growth of capitalism, the decline in the Church's reliance on donations to support its sponsored social works, and the decline in the number of religious nuns, priests, and other leaders and providers of Catholic church healthcare services are all factors that are changing the nature of Catholic church healthcare provision (White, 2012).

Diocesan medical coordinator affirmed that there is decrease in donor support and free healthcare services from religious healthcare providers. This is closely linked to secularization of society among others. The inadequate finance due to decrease in donor support in catholic church healthcare facilities has forced the catholic church healthcare facilities to operate like secular facilities for instance negotiating payment for healthcare service before administering the service so as to sustain themselves. Contemporary catholic church healthcare facility is slowly shifting to becoming a business structure in terms of healthcare service delivery, no longer dependent on Catholic Church’s social teachings on healthcare provision for catholic healthcare viability. The development of technology and new discoveries and innovations, including prostheses that help with illness detection and treatment, are examples of the environment that have influenced the modern catholic healthcare center. This viewpoint

is in line with that of White (2013), who said that the healthcare industry faced new environmental restrictions as a result of the competing pressures of growing regulation and market rivalry.

4.8 Catholic Church and hospital market environment conflict

The notion of Catholic church healthcare identity depicts the clash between the competing hospital market contexts and the Catholic Church. The numerous mission-driven components that are fundamental to the Catholic Church, in the framework of Catholic teaching, determine Catholic church healthcare facility identity, as depicted in Figure 4.4. The identity of Catholic church healthcare facilities is defined by a commitment to social justice, effective and efficient resource management, the provision of compassionate care, and the treatment of all individuals with dignity and respect.

Even though the institutional structure of the Church wants to retain legitimacy by being able to make a distinctive contribution to its healthcare mission, the Catholic Church identity is becoming more difficult to build and uphold. The Roman Catholic Church is rather loosely connected. The identity of Catholic church hospitals is under even more threat since the proportion of healthcare executives who are members of religious orders is declining (White, 2013) since a result, the sacramental dimension of the ministry is increasingly carried out by laypeople. In comparison to older hospitals, Catholic hospitals do not have as many prominent religious symbols and images.

Here is a summary of the external environmental challenges that the Catholic Church and contemporary hospitals are subject to. The Roman Catholic Church is under intense institutional pressure to maintain the integrity of its sponsorship of hospitals and adherence to Catholic Church doctrine, to advance its beliefs and values through a

sponsored social ministry that a more secular society may not understand, to infuse Catholic identity into hospitals that are increasingly being led by laity, and to continue its sponsorship of Catholic healthcare organizations as an example to the rest of the world.

Strong technical pressures that hospitals must deal with include competing in a market-based economy (isomorphic pressures), maintaining legitimacy through compliance with and approval from regulatory bodies, offering high quality, affordable health care services with acceptable results, enhancing the health status of the communities being served, and meeting the needs of all stakeholders.

Diocesan medical coordinator asserted that the greatest challenge central to Catholic church healthcare identity has been maintaining its uniqueness in terms of religious values and in providing healthcare to the vulnerable and underserved populations. The present condition is that there is decrease in donor support and rapid increase in population. This is making it difficult for the catholic church healthcare facilities to maintain its unique feature of defense of human dignity and option for the poor. Additionally, the informant noted that there are skirmishes from political influence which have hampered the kind of healthcare services offered in the Catholic church healthcare institutions. The skirmishes have led to loosing of catholic church lands where catholic church healthcare facilities would have been built. This position greatly agrees with the history of Catholic Church involvement in healthcare provision. The Roman Catholic Church has had a significant societal role in the delivery of healthcare for centuries, particularly in hospitals. Catholic-sponsored hospitals are a unique type of healthcare organization, with two distinct institutional contexts determining who they are. In addition to the institutional and technological contexts that all modern

hospitals must contend with (Somers, 1969), these hospitals also have the additional institutional environment of the Roman Catholic Church. Organizations that find it increasingly challenging to fulfill the competing sources of expectations on how the organization should function are the result of the interaction of these institutional pressures. The connection between churches and the social institutions they support, such hospitals, has deteriorated as society has become more secularized (Freeland, 1992).

As a result, Catholic church hospitals frequently face the temptation to transform from the "ecclesiastical" institutions of the early 20th century to the largest private provider of healthcare services to the underserved. The ecclesiastical presence has diminished over time as a more secular workforce has replaced a workforce that was primarily Catholic and comprised of members of religious institutions in Catholic healthcare. In parallel, Catholic healthcare organizations have altered their service offerings, organizational structures, and funding sources in response to commercial and regulatory challenges (White et al., 2010; Wall, 2011).

White (2013) proposed a potential solution to the predicament, stating that a number of requirements must be met if Catholic church hospitals are to continue providing care for the Catholic Church's strong institutional rulers. They must, first and foremost, continue to make more money than they spend on charitable giving and community outreach than their secular competitors. Second, the diocesan sponsors or religious organizations that were responsible for their initial establishment must figure out how to better instill in the new lay leadership than they have in the past a distinctive method to carry out the Catholic mission. In conclusion, the Catholic healthcare ministry must uphold and secure a genuine identity as part of its canonical role of stewardship, or the

management of a ministry's effectiveness in light of its purpose and mission. The goal of stewardship is to maintain the organization's mission in the foreground of discussions, planning choices, strategic considerations, and staff development, as well as to deliver services that are consistent with the organization's values.

4.9 Comparison of Catholic church and non-Catholic church healthcare facilities

An item required the Catholic church faithful and non- catholic church faithful to give their opinion on the comparison of services between catholic church healthcare facilities and non-Catholic church healthcare facilities. Their responses were as illustrated below:

Table 4. 7: Comparison of Catholic and Non-Catholic church healthcare facilities

Response	Frequency	Percentage
Unique	102	27%
Similar	276	73%
Others	0	0

Source: Field Data (2022)

276 (73%) of the respondents held that catholic church healthcare facilities are similar to their non-Catholic counter parts by virtue of offering healthcare service to both the catholic church faithful and non- catholic church faithful community members

102(27%) held a dissenting opinion that catholic church healthcare facilities are distinct in their service to the community evidenced by the fact that it is against some reproductive healthcare services such as invitro-fertilization and any procedure which takes away human life such as assisted suicide and abortion on moral grounds of its commitment to defend and protect human dignity.

A focus group discussion noted that all healthcare facilities work under the Ministry of Health and therefore have to meet required standards such as conducive and accessible environment in terms of safety, hygiene, healthcare workforce and access to essential medicine in order to continue to function. But there are a few distinct characteristics that stand out. A Catholic church healthcare facility's setting is meant to reflect the roots of the institution's religion. Catholic church healthcare facilities frequently display religious symbols, particularly crosses, which speaks to the spiritual atmosphere of the setting. The main distinction between Catholic and non-Catholic church healthcare facilities is the range of services provided and those that are not. As was previously said, Catholic church hospitals do not provide any services that go against their beliefs in the sanctity of human life and human dignity, including abortion, euthanasia, and artificial insemination. While these techniques are prohibited in Catholic healthcare, they might nevertheless be present in non-Catholic healthcare institutions since they do not have the same restrictions. Healthcare professionals working in Catholic church facilities are not permitted to refer patients to other healthcare providers or to refuse to provide specific healthcare services.

Recovered patients also noted that catholic church healthcare institutions are not in any way different from other non-Catholic church healthcare facilities. This is largely attributed to prioritizing the ability to meet the healthcare service cost. Common practice is the fact that if a patient doesn’t have money to meet the healthcare service, they are first given opportunity to source for money before receiving the service. This makes it hard for the poor to get access to timely healthcare service. Their concern resonates well with Pope Francis remarks on global healthcare inequities during the international conference of confederation of Catholic healthcare institutions.

In order to address global healthcare injustices and determine how to organize a response, a conference was convened between November 16 and 18, 2017 by the International Confederation of Catholic Health Care Institutions and the Vatican Dicastery for Promoting Integral Human Development. During the gathering, Pope Francis stated that improving fairness in access to healthcare will not be successful without addressing the structural causes of poverty. He asserted, " There will be no solution to the world's problems—or any problems, for that matter until the issues facing the poor are fundamentally addressed. To do this, there must be a rejection of the absolute autonomy of markets and financial speculation while also addressing the underlying reasons of unfairness." Pope Francis spoke directly to the Catholic healthcare professionals, reminding them that although efficiency and ethical business practices are significant, healthcare is not a business for the church. The people they care about must come first, and they should listen to them, go with them, and support them.

From the responses of the respondents, it can be argued that Catholic church healthcare facilities are almost similar to non-Catholic counterparts in their treatment of patients. This resonates well with Cochran and White (2002) who posited that empirical evidence of the uniqueness of Catholic church healthcare provision remains virtually non-existent. They affirmed that catholic church healthcare facilities have become leaders in end-of-life care; a common identity with public healthcare facilities.

4.10 Healthcare provision as a responsibility of the Church or a form of charity to the community

An item from the interview schedule required the Catholic Church leaders to respond to whether the involvement of the Catholic Church on healthcare provision is a responsibility of the Church or it is a form of charity the Church is offering to the

society. From the interview responses, the Diocesan Bishop noted that Catholic Church's involvement in healthcare provision is part of the mission of the church. According to him, Catholic church healthcare is a ministry of the church that carries on Jesus Christ's mission of love and healing. The entire Catholic Church is called to participate in the ministry of caring for the ill, just as Jesus performed healings while on earth. Jesus Christ addressed the needs of the body, mind, and spirit. In order to restore human dignity, he also provided food for the masses, treated the ill, and helped the blind, the handicapped, the lepers, and the lame. In short, Jesus catered for all kinds of healthcare needs to all people. Therefore, the healing ministry is necessary for the Catholic Church as a way of spreading the gospel of Jesus Christ. Jesus bestowed upon the Church his healing power. Therefore, Healthcare ministry is always a necessary and fundamental task, to be carried out by all, from individuals to parish communities, to the diocese and to all catholic healthcare institutions.

The Diocesan bishop reiterated that the Catholic church has adopted the healthcare ministry in their calendar where they celebrate the world day of the sick annually on 11th February. He noted that the day is basically meant to offer prayers for those suffering from all kinds of illnesses. He noted further that the main theme for that day is usually centered on saving and nurturing life so as to fulfil God's call to saving human life. They also celebrate the sacrament of anointing of the sick where the sick people are given hope that their suffering will end and their health will be restored.

Catholic Church priests also noted that Catholic Church involvement in healthcare provision is a responsibility of the church. They explained that it is one way of disseminating the gospel of Jesus Christ. The informants explained that you cannot preach to somebody who is unwell. You must cater for both the healthcare needs and

spiritual needs so as to be fully satisfied. Like the various parts of the body which work in unison for normal body function, so do the spirit, body and soul. Healthcare mission of the Catholic Diocese of Kericho forms part of its institutional structure which seeks to continue with Christ's work of healing.

The contentions of the key informants were in agreement that the Catholic church involvement is not a form of charity the church is offering to the community. Instead, it is the Catholic Church's duty to be active in the provision and delivery of healthcare services as it is a component of the church's mission. Their viewpoint is consistent with that of Lategan (2017), who contends that healthcare deals largely with people's vulnerabilities and that the church's role is to cope with those vulnerabilities. A fundamental human right, access to healthcare must be influenced by the church.

4.11 Liberation theology and the Catholic Church

A focus group discussion noted that in a world where everything seems to be measured in value of money and economic progress, poverty becomes an increasingly urgent problem of concern. Money seems to become the stimulant for economic activity, and financial gain appears to be the goal of continued efforts for development of the community. In such a situation, people wonder, where is the church? The poor and underprivileged cannot fulfill this process of "Liberation" by themselves. The inability of the poor and disadvantaged to improve their own social conditions assigns the church a duty to assist the poor in their struggle for "Liberation."

Jesus Christ: The Model of Liberation

Jesus portrayed the character of a Liberator. He liberated the poor, oppressed and outcasts through His words and deeds unmasking injustices and restoring what is

liberating and life-giving. Such Liberation has an impact within history, both in the present and in future, when the reign of God arrives in fullness.

Jesus was a liberator of the human being and of societally oppressed communities. He stated in Isaiah 61:1-2,

> "The Spirit of the Lord is on me, because he has anointed me to bring good news to the afflicted," at the start of his public ministry that his goal was to fulfil. He has sent me to announce a year of the Lord's favour, to bring freedom to the oppressed, sight to the blind, liberty to the prisoners, and freedom from oppression.

Jesus disputed the alienations of the time, including those experienced by Jews and others. It may be claimed that he was doing this by infusing a contestation of the problems in every institution into human life and religion. For the sake of morality, sincerity, and justice, he was challenging conventional ways of thinking and acting. Borrowing a leaf, there is therefore need to emancipate the people challenged by limiting contingencies such as poverty, illiteracy, poor health among others so that they too can live more freely.

Luke's Gospel emphasizes Jesus' social reintegration of the poor and oppressed. According to Luke 9:51-19:10, a number of Jesus followers and recipients of His miracles were the socially marginalized and the economically deprived. But Jesus wasn't just helping people out on a social level. In addition to curing their bodily ills, he was also interested in seeing them develop into emancipated individuals. This puts the Church and the clergy under pressure to work for the liberation of the enslaved. He cared about people and wanted to aid in their personal freedom. He wanted them to comprehend who they were as well as the genuine essence of the true religion. He assisted them in making the distinction between personal sin and social rejection that had elements of hypocrisy. He made an effort to provide people with the knowledge

and independence they needed to take charge of their life. In so doing, Jesus accomplished the key responsibility of Liberator who not only liberated the oppressed but conscientized them to be able to liberate themselves and others. He liberated both the oppressed and the oppressor.

Jesus in His ministry stressed personal worth of every human being irrespective of one's social condition. He aided people in seeing that they weren't as valuable as they thought they were because of things like power, fortune, social standing, physical prowess, intelligence, legal prowess, or even religion. When He brought back to life the only son of the Widow of Nain, He restored the dignity and worth of the widow both as a widow and a mother. The dead son was the Widow's only son. He represented her main claim to status in the community. The death of her son therefore meant that her "social security" was gone. When Jesus raises the son from the dead, He is in fact restoring two persons to life in the community: the son and his mother. He as well restored the social position and value of the widow who could have been a subject of social abuse and ostracism as was the case among the Jews at that time.

Although liberation theology has not been formally adopted by the Catholic Church for a long time, there are indications that it may be doing so under Pope Francis. Pope Francis, the first Latin American pope, has elevated the principles of this somewhat divisive movement within the Catholic church, particularly through his statements denouncing the evils of poverty and the perils of capitalism.

Though for a long time, the Catholic Church had not formally embraced liberation theology, there are signs of rehabilitation under the reign of Pope Francis. Pope Francis, the first Latin American pope, has elevated the ideas of this somewhat contentious movement inside the Catholic church, particularly through his statements against the

scourge of poverty and the dangers of capitalism. According to papal biographer (Ivereigh, 2015), Pope Francis has never identified as a liberation theologian and has even been critical of several aspects of the movement while still known in his native Argentina as Father Bergoglio. The Catholic church has embraced liberation theology in large part due to Pope Francis's goal for the church to be "for the poor" and his outspoken critiques of capitalism and consumerism. According to Ashley J. Mathew, Pope Francis' ideas, speeches, and actions share many similarities with Gutiérrez's theology. Both have emphasized that choosing the underprivileged requires getting to know them and making friends with them. Both have a great deal of regard for the poor people's spirituality, especially in daily life (Kirchgaessner & Watts, 2015).

According to Sung (2019), a well-known liberation theologian in Brazil, the Catholic church has abandoned liberation theology precisely because Pope Francis is aware that the goal of the church is not only to make God known to a world of non-believers but also to one where money is worshipped. Sung continues by saying that liberation theology has been elevated to the level of a Catholic church teaching in this way. He makes a connection between this change and the troubling rise in global inequality as well as the pope's personal experience working in some of Argentina's poorest villages (Kirchgaessner & Watts, 2015). Jimmy Burns (2015) agrees that Pope Francis's Latin American heritage, has made a fundamental difference, a position also endorsed by this study.

In conclusion, the hour of the African church's freeing battle has come, and African man is oppressed. In order to reform societal mechanisms that foster oppression, it must get actively involved in the political, economic, social, cultural, and health freedom of the people. The church must battle alongside Africans, sharing their joys,

disappointments, fears, and everyday burden in order to be relevant to them. The fight against all types of exploitation and poverty as being against God's will is necessary for the good news to become relevant in Africa. According to Nyerere (1997), unless the church actively participates in the rebellion against those social structures and economic organizations that condemn men to poverty, humiliation, and degradation, the church will lose its relevance to people, and the Christian religion will become a collection of superstitions that are tolerated by the fearful. If the church does not actively participate and take a leading role in positive protest against the conditions of contemporary man, it will perish and, in a human sense, deserves to perish because it will then have no purpose that modern men can comprehend. Therefore, liberation theology should be embraced by all African churches.

4.12 Overall effectiveness of Catholic church healthcare facilities in the Catholic Diocese of Kericho

Overall, the study concludes that Catholic church healthcare provision have a long history as a crucial part of Kenyan healthcare provision. They have spread to meet the needs of the people they serve. The Catholic Church compliments the government in healthcare provision. Even if the missions that guide them continue to reflect their religious heritage, the study's findings further demonstrated that catholic church healthcare facilities are, in most circumstances, identical to other types of non-Catholic church healthcare institutions. In a world that looks to be becoming more and more secular, it is also feasible that their differences, particularly in terms of moral and religious precepts and healthcare treatments they forbid on ethical grounds, may eventually drive them out of existence. Nonetheless, Catholic church healthcare facilities should serve their patients in accordance with their social teachings on

healthcare provision if they are to maintain a unique and catholic-based approach to healthcare provision.

The conclusion drawn from the findings is that how the healthcare services are offered in the catholic church healthcare facilities in the Catholic Diocese of Kericho often do not correspond with the healthcare provision values and teachings upheld by the Catholic Church in the Catholic Diocese of Kericho. Therefore, the point that is illustrated by this study is that although Catholic church in the Catholic Diocese of Kericho value certain things such as dignity of human person, caring for the poor, subsidiarity and call to justice, they have not been able to always include these values in their healthcare provision.

According to Maton and Pargament (1987), Churches and other religious organizations have a significant impact on society and can have an impact on a variety of areas, including civic, political, educational, and healthcare as well as the economy. As a result, they are considered legitimate in their communities and have access to the organizational roles, structures, and procedures that make the creation and implementation of healthcare service programs possible. Religious organizations have the ability to recognize social issues and have an impact on the development of solutions. Since the Catholic Church is a religious organization, it has the authority to recognize issues with healthcare delivery and to influence finding remedies.

The foregoing position is in agreement with Chase- Ziolek (2015) who argues that, the church has a rare chance to assert her position in promoting healthcare in a rapidly evolving healthcare environment as we stand at a pivotal moment in history. Growing national healthcare expenditures necessitate innovative cost-management strategies that either restrict reimbursement and control access to healthcare services or promote

wellness and illness avoidance to reduce the need for costly healthcare treatments. By identifying and reclaiming the biblical underpinnings of its ministries of health, healing, and wholeness, the church is in an ideal position to address the latter. As a result, the Catholic Church is accountable for effectively resolving the normative issues with the delivery of healthcare in the Catholic Diocese of Kericho.

To revert the main concern of this study, the main question of this study was, has the Catholic Church been effective in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho? To this end, the study submits that even though the social teachings of the Catholic Church on healthcare provision lay emphasis on human dignity, preferential option and social justice, the Catholic Diocese of Kericho continue to experience hardship in alleviating normative or human value challenges in healthcare provision.

4.13 Conclusion

This chapter examined the success of the Catholic Church in alleviating normative challenges related to healthcare provision in the Catholic Diocese of Kericho. To this end, the study concludes that the Catholic Church has made efforts in healthcare provision though there are still challenges in accessing catholic church healthcare provision. From this, it could be argued that catholic church has not been adequately effective in alleviating normative challenges related to healthcare provision in the Catholic Diocese of Kericho.

The study established that the identity of Catholic church healthcare identity is human dignity, responsibility to community, call to justice and preferential option to the poor. The results however indicated a mismatch between the teachings of the Catholic Church on healthcare provision and the ideal practice of provision of healthcare service at

Catholic church healthcare facilities in the Catholic Diocese of Kericho. The responses indicated that Catholic Church teachings and beliefs are abstract ideas whereas the practice itself is bound to affordability of healthcare service as the main "value" as well as other socio-economic factors such as education level, income level, wealth, employment and medical insurance cover.

Finally, the study found that upholding the Catholic church identity's distinctive religious ideals regarding providing healthcare to the weak and the poor has been a major challenge. This is attributed to the decrease in donor support and society becoming more secularized. Also, contemporary hospital environment is posing a challenge to the catholic church healthcare facility due to competition for economic fitness. Institutional forces and competing market pressure show that catholic church healthcare undergoes isomorphism: coercive, mimetic, and normative to the extent that they share similar features with non-Catholic church healthcare facilities. Catholic hospitals are under intense pressure from the Roman Catholic Church to maintain their uniqueness, yet environmental factors in the hospital industry are also exerting pressure for isomorphism. The study's summary, conclusion, contributions and recommendations are covered in the next chapter.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION, CONTRIBUTIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter mainly deals with the summary of study findings, conclusion, contributions and recommendations.

5.1 Summary of findings

The study held at its inception that healthcare provision today is in an incomprehensible paradox. This was attributed to the fact that the world globally was rapidly changing and the gap between the haves and have-nots was growing especially in terms of access to healthcare. As a consequence, the world potentially faced a future of impoverished population lacking access to care in already overburdened healthcare systems. This was evidenced by dominant healthcare provision challenges prevailing in the world today.

Yet the ideology of human dignity in healthcare provision seems to have been widely known to the extent that United Nations under World Health Organization acknowledged that human dignity was the core principle of the right to healthcare (WHO, 2018). Furthermore, the social teachings of the Catholic Church on healthcare provision equally emphasized human dignity. In principle therefore, the uniqueness of the Catholic healthcare was the defense of human dignity. Despite this wide knowledge on healthcare as a basic human right and defense of human dignity, healthcare provision still faced numerous normative or human right value related challenges that devoured human dignity. The question asked then is, what happened to the Catholic Church's position and values as antidotes to alleviating the said normative challenges in healthcare provision?

The study was based on liberation theology theory which proposes that one way to achieve liberation is by addressing the alleged source. To this end the study identified ill-health and poverty as source of oppression to society because they hinder man from realizing their full potential. Additionally, the study used a descriptive research design. Descriptive design was ideal for describing healthcare provision phenomenon and normative challenges associated with it. It was also ideal in establishing more valuable relationships between Catholic Church's position and the ideal practice of Catholic Church healthcare provision. Probabilistic and non-probabilistic sampling techniques were used. Stratified random sampling was used to select Catholic Church faithful. Purposive sampling was used to select Catholic church leaders (Priests and Bishop), catholic church healthcare personnel and diocesan medical coordinator. Convenient sampling was used to select non-Catholic church faithful. Snowballing was used to select the recovered patients. The main sources of data were primary and secondary data.

First objective was to evaluate healthcare provision as a contemporary phenomenon and explore the normative challenges related to it in general. The study revealed that accessing healthcare service was a basic human right and it was common knowledge in the world domain. A fundamental principle of human interaction is respect for human dignity regardless of their circumstances. The Universal Declaration of Human Rights, which declared that all people are entitled to the same rights and respect for human dignity, established this principle as the cornerstone upon which human rights are based. The World Health Organization's statement on the promotion of patients' rights, which said that "patients have the right to be treated with dignity," was also a retort. It has been demonstrated that dignity plays a significant role in the patient's experience receiving treatment. Additionally, patient is the core stakeholder in healthcare

provision process that is patient centered. This was evidenced by the several advances made by scholars such as Ferlie and Shortel. Failure to prioritize the patients' compelling needs gave rise to the normative challenges in healthcare provision.

Healthcare provision was faced with value related challenges. It was ironical that despite the various advances on patient priority and access to healthcare as a basic human right and a life of dignity, healthcare provision was still faced with human right value related or normative challenges arising basically as a result of failure of healthcare facilities to prioritize the patient needs over other prevailing conditions particularly socio-economic attributes. Normative challenges in healthcare provision as a result distorted the worth and value of human dignity. The term "normative challenge" refers to differences that are seen unfair, unjust, and inhumane as well as ones that were avoidable. It also has moral and ethical implications. The Catholic Church healthcare provision from this perspective could be seen to take over the task to liberate the society from ethical and moral unfairness and challenges in healthcare provision attributed to socio-economic differences by democratizing healthcare access.

The second objective was to examine the Catholic Church's position on healthcare provision in general. It was apparent that the Catholic Church upheld the sanctity of human life and the idea that an ideal of morality for society rests on the dignity of the individual. All of the tenets of Catholic church social teachings about healthcare provision were built upon this conviction. Human dignity therefore was the identity of catholic church healthcare provision. Principle of subsidiarity advocated for humane relationships in healthcare provision set up. Therefore, even though people have legitimate differences from one another, social justice, equity and human dignity demand that a more humane and just condition of life be established because excessive

economic and social differences among members of one human family or population groups undermine these values. Religious and ethical guidelines reiterated that the dignity of the human person served as the foundation for Catholic church healthcare's ethical standards of conduct.

To this end the study observed that the Catholic Church had written teachings on healthcare provision and this expressed its stand on defense of human dignity. The study established that the written social teachings of the Catholic Church on healthcare provision was also disseminated in the Catholic Diocese of Kericho. From the written social teachings on healthcare provision, the study established that defending human dignity, common good, subsidiarity, solidarity, and giving the poor preference were the Catholic Church's guiding principles in its healthcare policy. The value of human life in healthcare provision therefore was priority over all other prevailing conditions including economics.

Third objective was to examine the success of the Catholic Church in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho. The study in doing this recognized that the Catholic Church healthcare identity was human dignity, responsibility to community, call to justice and preferential option to the poor. The findings however indicated a mismatch between the teachings of the Catholic Church on healthcare provision as an ideal, and the practice of provision of healthcare service at Catholic church healthcare facilities in the Catholic Diocese of Kericho. It was clear that Catholic Church teachings and beliefs were cherished but not fully and adequately effected in the practice of healthcare provision. The reality was that, like elsewhere in the secular aspects of society, the practice was bound to affordability of healthcare service as well as other socio-economic factors such as, income level,

wealth, employment, geographical location and medical insurance cover. In this way, healthcare provision practice in Catholic church healthcare facilities in the Catholic Diocese of Kericho seemed not to fully reflect the teachings of the Catholic Church on healthcare provision hence leaving the normative healthcare provision challenges intact.

The study found that upholding the Catholic church identity's distinctive religious ideals regarding providing healthcare to the weak and the poor has been a major challenge. This is attributed to the limited donor support and society becoming more secularized. Also, contemporary hospital environment is posing a challenge to the catholic church healthcare facility due to competition for economic fitness. Institutional forces and competing market pressure show that catholic church healthcare undergoes isomorphism: coercive, mimetic, and normative to the extent that they share similar features with non-Catholic Church more secular healthcare facilities. Still, forces from within the Roman Catholic Church are pressuring Catholic Church healthcare facilities to retain their distinctiveness: a fact increasingly countered by isomorphism forces derived from environmental forces in the hospital industry.

5.2 Conclusion

The aim of this study was to examine the Catholic Church's efficacy in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho. To this regard, the study concludes that:

i. Healthcare provision is faced by normative challenges despite numerous advances on healthcare access as a basic human right

ii. Catholic Church has written teachings and religious directives that express their stand on healthcare provision which is human dignity, common good, solidarity, subsidiarity,

fundamental option for the poor and call to justice.

iii. Catholic church has put in efforts in healthcare provision. Despite the efforts, the findings in support revealed that challenges bound to norms and ethics were still witnessed in their facilities thus has not been adequately effective in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho.

The study therefore concludes that, catholic church's healthcare provision is an elaborate mandate. However, the findings in support indicated a disconnect between the Catholic Church's teachings and experiences in catholic church healthcare facilities in the Catholic Diocese of Kericho. It could be argued that the Catholic Church healthcare institutions were the way they are because of increasing secularization of society in the 21st century contributing to dynamism in the Catholic Church healthcare provision tradition over time. It has become challenging for Catholic Church healthcare facilities to maintain a distinct niche due to growing market and regulatory constraints. As the environment continues to evolve, Catholic Church healthcare will continue to redefine itself. According to White, Catholic Church healthcare facilities have had to redefine their identities throughout history in order to adapt to the shifting social landscape. In addition, freeing a person from limitations like poverty and illness is another aspect of liberation. It is to observe mankind seeking a fundamentally new society in which it will be free from all servitude and in which it will be the architect of its own future. The church is viewed as a sacrament in the history of freedom according to liberation theology. In spite of the Catholic Church's teachings' support for human values, the study's findings showed that hospitals run by the church face problems with those ideals. This study concludes in this regard that catholic church has not been adequately effective in liberating humanity in their healthcare service provision.

To revert the main concern of this study, the problem was, has the Catholic Church been effective in alleviating normative challenges in healthcare provision in the Catholic Diocese of Kericho? To this end, the study asserts that even while the social teachings of the Catholic Church on healthcare provision lay emphasis on human dignity, preferential option and social justice, the Catholic Diocese of Kericho continue to experience normative challenges in healthcare provision. The study submits in this regard that the Catholic Church has not been adequately effective in alleviating normative challenges related to healthcare provision in the Catholic Diocese of Kericho.

5.3 Contributions of the study

Religion through the changing times is an interesting area that continues to capture imaginations of many scholars. Relatedly, the difficult interaction between religion and secularism has been the subject of discussion for more than a century. Religion and religious institutions' dismissal of metaphysical issues as unimportant to human existence on Earth gave rise to secularism. Consequently, an argument has been sustained that as societies advance, the influence of religion in the same societies decline. Yet at the same there exists scholars who subscribe that in some cases religions are modifying themselves to cope with challenges of 'secular religion'. As secularism with its attendant values, reason, scientific evidence, and separation of church and state advances some religions have been known to modify their beliefs, practices, and traditions to remain relevant and address contemporary issues (Mostofa, 2023).

The collapse of religion with societal advancement was prophesied by scholars like Auguste Comte, Emile Durkheim, and Max Weber. The challenges created by the rise of secularism have forced religion to undergo adaptation. It's critical to remember that

past religions did not disappear when a new one emerged, the rise of secularism so far has not necessarily eradicated religions, but it there is little doubt that ‘secularism has continued to be a dominant religion of the 21st century. It is therefore common today to compartmentalize or distinguish between distinct spheres of life. Religion which prior to modernization permeated the entire life, becomes one mere sphere of life, and not the most important. This explains why religion in modern societies tend to become marginal, while essential functions to the operations of the society becomes rational. In such modern times as Eliade (1987) puts it, not only is the wider society less influenced by religion, but religious institutions and behaviors are increasingly influenced by values and standards that prevail in secular society, hence the tendency in religious performance has been for the distance between sacred and secular to diminish. The study’s reading is that religion might be diminishing the distance in a skewed way moving closer to the secular rather than the sacred.

More specifically, the relationship between churches and the non-profit social services they support, such as healthcare services, has become the focus of a protracted debate between those who favor minimal church involvement in social services and those who see such involvement as an essential component of religious belief and practice (Freeland, 1992; Cochran, 1999). Hospitals run by the Catholic Church were established to meet a societal healthcare need. In other words, Roman Catholics had a close relationship with organizations that were supported by the Church. Therefore, the "external forms" such churches use could have a significant impact on the power and importance of religion. This perspective backs up the claim that Catholic Church healthcare and educational institutions, which were formerly inextricably linked to the Catholic Church's social service orientation, have changed in order to survive. This aligns with Drucker (1995), who posited that a pluralist society of yesterday has been

replaced with individual organizations created for only one task. Single organizations are no longer obsessed with controlling everything in their areas.

As a result of the institutionalization (also known as compartmentalization) of beliefs and principles, the Catholic Church and, consequently, its sponsored healthcare ministry, have continued to reinvent themselves in response to external forces. The Catholic Church has played a significant role in social justice for many years. As a result, it has been inferred those Catholic hospitals must not only adapt to the intricate bureaucracy of their Church and religious sponsors, but also to the thoroughly institutionalized beliefs and values connected with the modern hospital (Somers 1969). As a result, the modern Catholic hospital can be thought of as having two nationalities. With all the expectations of mission effectiveness that this entails, one passport is granted for the Catholic Church as the religious sponsor. The other passport is given out for the area that the hospitals serve. Having two citizenships frequently leads to "dual competition." In other words, the Catholic church hospital is where the two institutions of religion and medicine come together to form a hybrid organization, with each group retaining such deeply ingrained values and ideas that either one may choose to reinvent itself in order to live. The groups that may exist now don't always represent the Catholic Church's and its sponsored healthcare ministry's original goals. However, it seems that the Catholic church's healthcare ministry is currently engaged in a new process of self-definition, involving new organizational alliances and structures. If existing organizational structures are incapable of advancing the Catholic Church's explicitly sacramental mission, it may be necessary to redirect their resources to new kinds of institutions that will forge a distinctly Catholic Church identity (Cochran, 2000).

To complicate the already complex scenario, healthcare facilities of the 21st century are developing at the intersection of changing governmental policies, highly specialized professions, cutting-edge technology, and fierce market competition. A unique instance of the contemporary hospital industry is that of hospitals supported by the Roman Catholic Church. They have a responsibility to the Church and their congregational sponsors as religious organizations to uphold the social function and Catholic identity of their healthcare ministry by acting in accordance with Roman Catholic social justice doctrine and belief. Hospitals continue to remain the focal point of Catholic church healthcare service, despite the fact that the ministry is expanded to communities in numerous ways. Catholic church healthcare has witnessed numerous transformations since its benevolent and modest beginnings (Farren 1996). As "ecclesiastical" organizations in the early part of the century, Catholic church hospitals have evolved into a significant portion of nongovernmental hospitals (Steven, 1991). This ecclesiastical setting has deteriorated over time as environmental changes have made the workforce's original, predominately Catholic, composition more secular. Concurrently, Catholic church healthcare institutions have adjusted their service offerings, organizational structures, and funding sources in response to environmental demands.

Nonetheless, the Catholic church's healthcare legacy has evolved into institutions that are more similar to other non-profit and/or for-profit healthcare providers. All Catholic church healthcare institutions are trying to keep up with economic, political, and legal constraints in order to be financially sound while maintaining a distinct Catholic church identity (Cochran, 2000).

Catholic healthcare has faced ongoing challenges in defining its identity within the larger framework of society, religion, and healthcare funding (Farren 1996). What started out about 200 years ago as largely a social welfare ministry in response to urban need and motivated by Christian altruism has become increasingly defined by its technical capacity. As the 20th century went on, society began to see hospitals less as places where the poor go to die and more as places where people from all socioeconomic backgrounds might improve their health (Kauffman 1995). According to certain Catholic Church leaders (McCormick, 1995), the government's 1990s market-place environment construction had unfavorable effects from a Catholic church social justice standpoint. The Catholic hospitals' goal to serve the underprivileged and medically needy has been threatened by the necessity of measuring healthcare delivery effectiveness only in terms of profitability.

The trend in modern societies mentioned above is today true of most developed countries of the west. It is also becoming increasingly true for the other world societies in their modernization endeavors. It is in this regard that White, K.R warned that throughout Catholic Church healthcare facilities, there have been redefinition of its identity to keep pace with the changing context of society. However, bearing in mind that secularism is an active overarching ingredient of present times, it is not difficult to see that in efforts for the distance between secular and religious to diminish as is the trend, at least in practice, it is the Catholic church through healthcare provision that seem to be shifting towards the ethos of secularism.

5.4 Recommendation

The study clearly acknowledged that the social teachings of the Catholic Church on healthcare provision emphasizes prioritization of human dignity over other prevailing

socio-economic conditions. Furthermore, liberation from any kind of oppression is desired by man. The Catholic Church hold a position to offer liberation for mankind. It is in view of this that recommendation are made thus;

Healthcare provision is a field that is characterized by a space of dialogue. The Catholic Church therefore should have a dialogic posture with the world from the perspective of the poor if it wants to define human dignity, defend human dignity and liberate people from oppression of normative challenges related to healthcare provision. It must target a much larger society with the aim of influencing the entire world than just a community of the sick.

5.5 Suggestion for further study

Since this study dwelt on The Catholic Church's Efficacy in alleviating Normative Challenges in Healthcare Provision in the Catholic Diocese of Kericho, it was restricted to respondents from the Catholic Church and residents within the Catholic Diocese of Kericho. In the course of this study, it was apparent that normative challenges associated with healthcare provision are multi-disciplinary. Normative challenges are not only ethics but also concerns bio-ethics that fell outside the immediate scope of this study. The study therefore recommends further study relating to normative challenges touching on bio-ethics.

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APPENDICES.

APPENDIX I: AN INTRODUCTORY LETTER.

Dear Respondent,

I'm a master's student enrolled at Masinde Muliro University of Science and Technology in the department of social science education. I am doing research on the topic, **"The Catholic Church's Efficacy in Alleviating Normative Challenges in Healthcare Provision in the Catholic Diocese of Kericho"** as part of the prerequisites for the award of the degree.

The questionnaire that is provided here is intended to get information from you for this study. Please answer the questions as best you can. Don't put your name anywhere in the questionnaire, please. The supplied information will be kept in strict confidence and used only for the study. You are asked to check the relevant alternative in the space marked [ ] or just fill out the blanks with your thoughts if clarification is needed.

Thank you.

Chepngeno Carolyne

REL/G/01-54120/2019

APPENDIX 11: QUESTIONNAIRE RESEARCH CONSENT FORM

Name of researcher: Chepng'eno Carolyne

Masinde Muliro University of Science and Technology,

P.O Box 190-50100,

Kakamega.

Mobile;……

Email:……..

Topic: "The Catholic Church's Efficacy in Alleviating Normative Challenges in Healthcare Provision in the Catholic Diocese of Kericho."

Please carefully read and fill out this form. Please check the necessary boxes to indicate your willingness to participate in the study before signing and dating the statement. Please ask for clarification if you have any questions or would like more information. I have had the research satisfactorily explained to me in verbal by the researcher.

- I am aware that this study is voluntary and that I can leave at any moment without having to give a reason. YES / NO
- I am aware that all details pertaining to me will be kept in complete secrecy and that my name won't appear in any published materials resulting from this study. YES / NO
- I am aware that any information I provide will only be used for research purposes and will be deleted after the research is finished. YES / NO

I voluntarily agree to take part in this research project, and I have been provided a copy of this permission form for my records.

Signature of the Respondent: …… Date……

APPENDIX III: QUESTIONNAIRE FOR CATHOLIC CHURCH FAITHFUL

SECTION A: BIO DATA

1. Please indicate your gender

   Male [ ]
   Female [ ]
2. How old are you?

18-30 years [ ]

30-35 years [ ]

35-40 years [ ]

40-45 years [ ]

45-50 years [ ]

Above 50 years [ ]

3. What level of education do you possess?

   Degree [ ] Diploma [ ] Certificate[ ] Secondary Education[ ]

   Primary Education [ ] None [ ]

4. What is your occupation?

   Farmer [ ]
   Business Person [ ]
   Formal Employment [ ]
   Any other (Specify)…….

SECTION B: HEALTHCARE PROVISION AS A PHENOMENON AND NORMATIVE CHALLENGES RELATED TO IT IN GENERAL

5. In your view, which of the following depicts or seem to depict your understanding on healthcare provision?

   Diagnosis of Disease [ ]

   Prevention of Disease [ ]

   Going to hospital to get medical care [ ]

   Promotion of health [ ]

Maintenance and restoration of health [ ]

Kindly explain your answer

6. a) From your understanding, which of the following components is involved in healthcare provision process?

   Patient [ ] Healthcare Personnel [ ] Community(Family, Healthcare facility Home, Church, Government, insurance company, pharmaceutical firms etc) [ ]

   Any other [ ]

   b) Kindly explain your answer

7. In your view, is access to healthcare service a basic human right or not? Yes [ ] No [ ]

   Give reason for your answer

8. In your view, do you agree that healthcare provision in Catholic church healthcare facilities the Catholic Diocese of Kericho is associated with abnormal and unexpected challenges related to human dignity such as medical negligence, socio-economic discrimination, delayed diagnosis?

   Yes [ ] No [ ]

SECTION C: CATHOLIC CHURCH'S TEACHING AND POSITION ON HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

9. In your view, is it true that human dignity is the identity of Catholic Healthcare facility?
   Yes [ ]
   No [ ]
   Give reason for your answer

10. In your own opinion, how do you identify Catholic healthcare facility? Give reason for your answer

Identity	Agree	Disagree	Reason
Priority to patient needs			
Serves the needs of all people			
First option to the poor			
Fair treatment to all			

SECTION D: THE EFFECTIVENESS OF THE CATHOLIC CHURCH IN ALLEVIATING NORMATIVE CHALLENGES IN HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

11. Are there Catholic church healthcare facilities in Catholic Diocese of Kericho?

    Yes [ ]

    No [ ]

12. Have you been treated in Catholic Healthcare facility?

    Yes [ ] No [ ]

13. Patient-centred healthcare is where the patient's healthcare needs initiates and directs the process of healthcare provision. In your own view, is it true or there are other factors responsible for initiating the process of healthcare provision? Yes [ ] No [ ] Other factors [ ] Give reason for your answer

14. In your opinion, how do you compare healthcare service provision in Catholic church healthcare facilities and non-Catholic church healthcare facilities?

Unique (Option for the poor, patient priority) [ ]

Similar with other facilities [ ]

Others (specify)

Kindly explain your answer

APPENDIX IV: QUESTIONNAIRE FOR NON-CATHOLIC CHURCH FAITHFUL

SECTION A: BIO DATA

1. Please indicate your gender

   Male [ ]
   Female [ ]

2. How old are you?

   18-30 years [ ]

   30-35 years [ ]

   35-40 years [ ]

   40-45 years [ ]

   45-50 years [ ]

   Above 50 years [ ]

3. What level of education do you possess?

   Degree [ ] Diploma [ ] Certificate[ ] Secondary Education[ ]

   Primary Education [ ] None [ ]

4. What is your occupation?

   Farmer [ ]
   Business Person [ ]
   Formal Employment [ ]
   Others (Specify)…….

SECTION B: HEALTHCARE PROVISION AS A PHENOMENON AND NORMATIVE CHALLENGES RELATED TO IT IN GENERAL

5. In your view, which of the following closely portrays your understanding of healthcare provision?

   Diagnosis of Disease [ ]

   Prevention of Disease [ ]

   Going to hospital to get medical care [ ]

Promotion of health [ ]

Maintenance and restoration of health [ ]

Kindly explain your answer

6. a) From your understanding, which of the following components is mostly involved in healthcare provision process?

   Patient [ ] Healthcare Personnel [ ] Community(Family, Healthcare facility Home, Church, Government, insurance company, pharmaceutical firms etc) [ ]

   Any other [ ]

   b) Kindly explain your answer above

7. In your view, do you agree that healthcare provision today is faced with a lot of human values/ value challenges related to human dignity such as socio-economic divide?

   Yes [ ] No [ ]

SECTION C: CATHOLIC CHURCH'S TEACHING AND POSITION ON HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

8. In your own view, how do you identify Catholic healthcare facility in the Catholic Diocese of Kericho?

Identity	**Agree**	**Disagree**
Priority to patient needs		
Serves the needs of all people		
First option to the poor		
Fair treatment to all		

SECTION D: EFFECTIVENESS OF THE CATHOLIC CHURCH IN ALLEVIATING NORMATIVE CHALLENGES IN HEALTHCARE PROVISION IN THE CATHOLIC DIOCESE OF KERICHO

9. In your opinion, are there Catholic church healthcare facilities in Catholic Diocese of Kericho?

   Yes [ ]

   No [ ]

10. Have you been treated in Catholic Sponsored Hospital?

    Yes [ ] No [ ]

11. a) Patient-centred healthcare is where the patient's healthcare needs initiates and directs the process of healthcare provision. In your own view, is it true or there are other factors responsible for initiating the process of healthcare provision? Yes [ ] No [ ] Other factors [ ]

    b) Give reason for your answer

12. In your opinion, how do you compare healthcare service provision in Catholic sponsored hospitals and non-Catholic hospitals?

Unique [ ]

Similar with other facilities [ ]

Others (specify)

Kindly explain your answer

13. In your opinion, do you agree that the teaching of Catholic Church on healthcare provision on human dignity, subsidiarity, option for the poor, goes hand in hand with the healthcare service provision in Catholic church healthcare facilities?

    Yes [ ] No [ ] Kindly explain your answer

APPENDIX V: INTERVIEW GUIDE RESEARCH CONSENT FORM

Name of researcher: Chepng'eno Carolyne

Masinde Muliro University of Science and Technology,P.O Box 190-50100,

Kakamega.

Mobile;…… **Email:……..**

Topic: "The Catholic Church's Efficacy in alleviating Normative Challenges in Healthcare Provision in the Catholic Diocese of Kericho."

Please carefully read and fill out this form. Please check the necessary boxes to indicate your willingness to participate in the study before signing and dating the statement. Please ask for clarification if you have any questions or would like more information. I have had the research satisfactorily explained to me in verbal by the researcher.

- I am aware that this study is voluntary and that I can leave at any moment without having to give a reason. YES / NO
- I am aware that all details pertaining to me will be kept in complete secrecy and that my name won't appear in any published materials resulting from this study. YES / NO
- I am aware that any information I provide will only be used for research purposes and will be deleted after the research is finished. YES / NO

I voluntarily agree to take part in this research project, and I have been provided a copy of this permission form for my records.

Signature of the Respondent: …… Date……

APPENDIX VI: INTERVIEW GUIDE FOR RECOVERED PATIENTS

1. In your view, do you agree that Catholic healthcare provision is faced with a lot of challenges which affects the value of human dignity?

2. In your view, which challenges did you experience which showed some kind of bias while accessing healthcare service in the Catholic healthcare facility? Kindly explain your answer
3. Apart from the above-mentioned challenges, in your view, what are the other catholic church healthcare programs which seem to advantage one group of people and disadvantage others with regard to their age, gender, etc. Kindly explain your answer

4. In your view, Catholic church healthcare provision is identified with priority to human dignity, option for the poor, service to community and call to justice. Has the Catholic church healthcare provision managed to maintain this identity? Kindly explain your answer

5. In your opinion, how do you compare healthcare service provision in Catholic church sponsored hospitals and non-Catholic hospitals in terms of how they treat their patients with regard to their income, place of residence etc?

APPENDIX VII: INTERVIEW GUIDE FOR HEALTHCARE PERSONNEL

1. From your understanding, what are the rights and responsibilities of healthcare provision stakeholders?
2. In your capacity, how do you handle a case where a patient seeks for healthcare service and doesn't have money to pay for the service?
3. Human dignity is the identity of Catholic hospitals. In your view, what do they do in ensuring they protect human life and if no, what do they do which is against human life?
4. Common good in the Catholic church implies doing good for the benefit of everyone. In your view, what does the Catholic hospitals do to ensure access to healthcare service for? Or what is it that it does which hinders access to healthcare for all?
5. From your understanding, comment on the adoption technology in healthcare provision; does it make the provision effective or no?
6. In your view, catholic church healthcare institutions face competition and pressures from neighboring healthcare institutions. How do Catholic healthcare institutions respond to these challenges?

APPENDIX VIII: INTERVIEW GUIDE FOR THE CATHOLIC CHURCH LEADERS

1. In your view, catholic church healthcare facilities are famously identified by their defense of human dignity, solidarity, subsidiarity, preferential option to the poor and call to justice. Do you agree? If yes, explain
2. From your understanding, how do Catholic Church handle issues of social injustices in society?
3. From your understanding, do Catholic Church involve itself in healthcare provision? If yes, is it a responsibility or it is just a favor the Church is doing to the society?
4. From your understanding, poverty is one of the greatest social problem barring individuals from enjoying good life and enhancing development. How do Catholic Church help in addressing this monster?
5. In your view, do you think the approach of healthcare providers and healthcare personnel to the sick and the suffering is increasingly the same as Jesus Christ's approach to the sick of his day? Comment on the approach
6. Have you ever heard about Liberation theology? If yes, what is the Catholic Church position about it?

APPENDIX IX: INTERVIEW GUIDE FOR THE DIOCESAN MEDICAL COORDINATOR

1. In your capacity, how is the catholic church involved in healthcare provision?
2. How are the catholic church hospitals spread in the Diocese?
3. In your capacity, what is the mandate of the diocese healthcare ministry department? Kindly explain
4. In your view, has the ministry managed to achieve its mandate? Kindly explain
5. In your capacity, what are the challenges in the healthcare ministry that seem to hinder achievement of its mission of ensuring healthcare access for all? Kindly explain your answer
6. Are the healthcare personnel in the catholic church healthcare facilities catholic church faithful or not? In your view, how does this impact the catholic church healthcare provision?

APPENDIX X: FOCUS GROUP DISCUSSION GUIDE

1. Compare and contrast catholic sponsored healthcare facilities and other healthcare facilities
2. How do Catholic church healthcare facilities respond to market pressures and institutional forces?
3. Discuss how poverty is a source of oppression in society today.
4. Comment on the use of technology in catholic church healthcare provision
5. Comment of liberation theology. Is it worth embracing?

Appendix XI: FOCUS GROUP DISCUSSION MEETING SCHEDULE

S/NO.	Facilitator	Venue	Date	Time
1	Researcher	Kipchimatt Hotel	15/8/2022	9:00-12:00 Noon
2	Researcher	Famous Gate Hotel	22/8/2022	9:00-12:00 Noon

APPENDIX XII: RESEARCH PERMIT (NACOSTI)

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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