INFLUENCE OF CULTURE ON HEALTH INSURANCE UPTAKE AMONG PATIENTS AT CHOGORIA MISSION HOSPITAL, THARAKA NITHI COUNTY

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KABARAK UNIVERSITY

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DECLARATION

The research project is my own work and to the best of my knowledge it has not been presented for the award of a degree in any university or college.

Signature: ______________________ Date:__________________

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DEDICATION

This work is dedicated to my family.

ABSTRACT

The government of Kenya plans to largely finance Universal Health Coverage through the National Health Insurance Fund (NHIF). However, most of the Kenyan population do not have health insurance cover. They rely mainly on out-of-pocket payment. The reality today is that uptake of health insurance is still low in general, particularly in rural areas, where the majority of Kenyans live. Studies have identified four main reasons why individuals are not registered for any form of health insurance: affordability, value, relevance and process. However, these reasons may be complicated by cultural and social beliefs, as revealed by studies done in other middle and low- income countries. The aim of this study was to describe cultural beliefs and practices that may have an influence on health insurance uptake. We used a qualitative phenomenology study design over a period of 3 months at Chogoria Mission Hospital. The target population of this study was patients seeking care at Chogoria Mission Hospital. The study used a purposive sampling to recruit participants from inpatient and outpatient departments. Through 20 in-depth interviews using a semi structured design and utilizing the constant comparative method of analysis, we identified the following themes: religious beliefs, patriarchal culture, traditional medicine use, economic priority, misconception of value and procrastination, peer influence of purchasing insurance and Harambe as factors that might have an influence on health insurance uptake. Unique to this study was the theme about health insurance being associated with family and community dissociation or cohesion. Compared to findings in other countries, the findings of this study suggest that culture also has an influence on health insurance. This study suggests that most reasons of non-enrollment are hinged on cultural motivation. The results of this study need to be explored more in details in other studies. The study recommends the following to the stakeholders: Identify and use community champions (religious leaders, local authorities, traditional healers, insured champions) as agents and advocates of health insurance in general but the National Health Insurance, specifically. Clinicians dealing with patient without health insurance should do a quick diagnosis of things that might be hindering patient to have insurance and do an appropriate counseling accordingly.

Keys words: *Health Insurance, Culture, Chogoria, Kenya*

TABLE OF CONTENTS

DECLARATION .... **ii**
RECOMMENDATION .... **iii**
COPYRIGHT .... **iv**
ACKNOWLEDGEMENT .... **v**
DEDICATION .... **vi**
ABSTRACT .... **vii**
TABLE OF CONTENTS .... **viii**
LIST OF TABLES .... **x**
LIST OF FIGURES .... **xi**
ABREVIATIONS AND ACRONYMS .... **xii**
OPERATIONAL DEFINITION OF TERMS .... **xiii**
CHAPTER ONE:INTRODUCTION **1**
1.1 Introduction 1
1.2 Background to the Study 1
1.3 Situation in Kenya 5
1.4 Statement of the Problem 8
1.5 Purpose of the Study 11
1.6 Objectives of the Study 12
1.6.1 Specific objectives 12
1.7 Research Question 12
1.8 Justification for the Study 12
1.9 Significance of the study 12
1.10 Scope of the Study 13
1.11 Limitations of the Study 13
1.12 Assumptions of the Study 14
CHAPTER TWO:LITERATURE REVIEW **15**
2.1 Introduction 15
2.2. Culture and health care 15
2.3 Culture and health insurance 18
2.4 Factors affecting insurance uptake 20

CHAPTER THREE:RESEARCH DESIGN AND METHODOLOGY 26
3.1 Introduction 26
3.2 Research Design 26
3.3 Location of the Study 26
3.4. Population of the Study 26
3.5 Sampling Procedure and Sample Size 27
3.6 Instrumentation 29
3.7 Data Collection Procedure 31
3.8 Rigor and Trustworthiness 32
3.9 Data Analysis 33
3.10 Ethical Considerations 34
CHAPTER FOUR:DATA ANALYSIS, PRESENTATION AND DISCUSSION ... 35
4.1 Introduction 35
4.2 General and demographic information 35
4.3. Data Analysis and Interpretation 37
CHAPTER FIVE:SUMMARY, CONCLUSION AND RECOMMENDATIONS .. 58
5.1 Introduction 58
5.2 Summary 58
5.3 Conclusions 59
5.4 Recommendations 60
REFERENCES 62
APPENDICES 69
Appendix I: Consent to Participate in a Research Study 69
Appendix II: 72
Appendix III : Consent to Participate in a Research Study in Kiswahili 74
Appendix IV: Interview guide in Kiswahili 77
Appendix V – NACOSTI Research Authorization 79
Appendix VI: IREC Approval 80
Appendix VII: Introduction Letter 81

LIST OF TABLES

Table1: Bio Data..36

Table 2: Emerging themes and sub themes 37

LIST OF FIGURES

Figure 1: Conceptual Framework 25

ABREVIATIONS AND ACRONYMS

CBHI : Community Based Health Insurance

GoK : Government of Kenya

KES : Kenya Shillings

LMICs : Low Middle-Income Countries

MD : Medical Doctor

MoH : Ministry of Health

MTP : Micro research- Thesis Project

MTP IF : Micro research- Thesis Project Insured Female

MTP IM : Micro research- Thesis Project Insured Male

MTP NIF : Micro research- Thesis Project Non-Insured Female

MTP NIM : Micro research- Thesis Project Non-Insured Male

NGO : Non-Government Organizations

NHI : National Health Insurance

NHIF : National Health Insurance Fund

NHIS : National Health Insurance Scheme

OOP : Out-Of-Pocket

SDG : Sustainable Development Goal

SHI : Social Health Insurance

UHC : Universal Health Coverage

UN : United Nations

UNESCO : United Nations Educational, Scientific and Cultural Organization

WHO : World Health Organization

OPERATIONAL DEFINITION OF TERMS

Culture: According to UNESCO (2001) culture is defined as "the set of distinctive spiritual, material, intellectual and emotional features of a society or a social group, that encompasses, not only art and literature, but lifestyles, ways of living together, value systems, traditions and beliefs". In the 35th conference of UNESCO, it was acknowledged that the most effective way to measure culture is through people's associated behaviours, attitudes and practices. For the purpose of this study, when we say culture, we mean cultural beliefs, behaviours and practices.

Harambee: A voluntary gathering of friends, family, neighbors, and other supporters to give money towards a fund for a specific purpose, such as hospital bills, school fees, or burial costs.

Health insurance scheme: A health insurance scheme has been defined as an arrangement in which contributions are made by or on behalf of individuals or groups (members) to a purchasing institution (a fund), which is responsible for purchasing covered services from providers on behalf of the members of the scheme (Gichuru, 2015).

Health insurance uptake: Uptake of health insurance refers to the enrollment of people into a health insurance scheme.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

The following sections will be discussed in this chapter: background to the study, statement of the problem, purpose of the study, objectives of the study, research questions and justification for the study, scope of the study, limitations of the study and assumptions of the study.

1.2 Background to the Study

1.2.1The concept of health insurance

Dixon, Tenkorang, &Luginaah (2011) define health insurance as a strategy for people who are not sure of their future health status to contribute to a pool, so that when they get sick, they can use the pooled fund for their treatment. Appropriate healthcare financing focuses on mobilizing and pooling financial resources and allocating them to health care providers in an equitable and efficient way.

Health financing can be based on insurance or out of pocket spending (OOP). OOP on expensive medical costs commonly leads to poverty through catastrophic expenditure. Health insurance is intended to cover expensive medical costs, preventing catastrophic expenditure and subsequent poverty. Health insurance can be public, commonly offered by the government as a social health scheme or private. The latter is offered by private companies or community based (ownedor run by local communities).

Sekhri & Savedoff (2005) define private health insurance as a voluntary, for profit commercial health insurance coverage. This study additionally noted that private insurance is a complementary system to achieve universal health coverage for the people

who can afford it. Criel and Waelkens (2003) argue that this sort of medical coverage is benefit arranged or roused by a benefit making thought processes.

Mathauer, Mathivet ,Kutzin & World Health Organization (2017) describe Community Based Health Insurance(CBHI) as having the following characteristics and features: The community is involved in driving its setup and in its management. CBHI works as a prepayment mechanism with pooling of health risks and of funds taking place at the level of the community or a group of people, who share common characteristics. Membership premiums are most often a flat rate (community-rating) and are independent of individual health risks; and entitlement to benefits is linked to contributing in most cases. The CBHIs operate on a non-profit basis and affiliation is voluntary. CBHI is intended to offer different wellbeing protection plans chosen by a group of individuals inside a given setting. Plans are organized, claimed and overseen by a group who share common characteristics such as those distinguished by geological area, ethnicity, religion, occupation or sex. Membership is obligatory and premiums are not settled based on calculated individual risks (Criel, 2003).

The WHO (2009) defines Social health insurance as an insurance program in which participation in the program is compulsory either by law or by the conditions of employment. In social health insurance the program is operated on behalf of a group and restricted to group members. Moreover, in the social health insurance, an employer contributes to the program on behalf of an employee. It appears that there is no exact consensus definition of social health insurance (SHI).Tangcharoensathien (2003) said that it can generally be perceived as "a financial protection mechanism, for health care, through health risk sharing and fund pooling for a larger group of population". He also mentioned people can think of social insurance as a part of broader "social security"

framework, covering all contingencies which need financial protection and risk sharing. For a health insurance to be characterized as "social", it must have certain features. In this report, the author states that countries' legislative body under the constitution needs to clarify what is expected from all parties for the SHI to be as effective as desired. Social health insurance is characterized by solidarity across the population and the responsibility for paying contributions with proper organizational arrangement to collect the regular income-related contributions from individuals according to economic means (non-risk- related payments); allocate these funds and choice of health care according to their needs and render social assistance to cover vulnerable populations.

According to the report by Tangcharoensathien (2003), "A country can be categorized as having Social Health Insurance, only if the majority of the population is legally covered with a designated (statutory) third-party payer through non-risk-related pre-payment (contributions) that are separate from general taxes or other legally mandated payments". In 1884, German chancellor Oto Von Bismarck initiated a model of SHI. This model was mandatory across the country for wellbeing protections. According to Criel & Waelkens, (2003) state endowments were used as reserves for funding this initiative to supply health care to the jobless, destitute and unsalaried individuals. However other non-European countries achieved UHC employing a tax-financed Beveridge model. The major difference between the two models is that one is funded by means of state back, and the other is funded basically with income from common charges. Both models have demonstrated to be effective in accomplishing UHC when government stewardship, stable political environment, and civic voice are present (Criel, & Waelkens, 2003). Social wellbeing coverage seeks risk-sharing across the nation as a publicright.

Premiums are commonly calculated corresponding to salary, autonomous of the individual hazard, and paid mainly by participants and their employers.

The World Bank and the International Monetary Fund successfully promoted SHI as a proficient model for scaling up protection inclusion as they have demonstrated in some developed nations. However, replication of this model in the low- and middle-income countries has not been successful. Some of the barriers included: developing countries have more informal sector workers, income inequalities, tax evasion, and corruption (Averill, & Marriott, 2013).According to Fenny, Yates & Thomson (2018), Social health insurance schemes in Africa leave out the poor. This conclusion was derived from literature review and comparison of social health insurance of five African countries: Rwanda, Kenya, Tanzania, Ethiopia and Ghana. Goudge et al (2018) in South Africa found that social health insurance was contributing to universal health coverage but with some irregularities such as inequities in its utilization among members.

1.2.2 Role of Health insurance in Universal health coverage

The World Health Organization has stated that every human being in the world needs access to health care regardless of his or her income status. Health insurance provides financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.One way to achieve UHC goal is through providing citizens with fully funded public health insurance coverage. High financial cost to access healthcare is one of the main reasons for the differences in utilization of health care among different social classes (WHO, 2005). Global statistics show that out-of-pocket payment for health care is high in Lower-Middle-Income Countries (LMICs). Out-of-pocket expenditure as percentage of private expenditure on health is 38.5 % in high income countries, 86.7 % for lower

middle-income countries and 77.6 % in low income countries (WHO, 2015). The concept of health insurance is growing in low- and middle-income countries and several studies have evaluated the impact of health insurance on the utilization of health care. These studies suggest that there has been a rise in the use of health facilities for both outpatient and inpatient care (Giedion et al., 2013). In the case of maternal health in Rwanda, Indonesia and Ghana, evidence shows that health insurance coverage contributed to an eight percentage-point increase in access to four or more antenatal care visits in Ghana, a three percentage-point increase in Indonesia and a five to eleven percentage-point increase in use of facility-based delivery of care (Wang et al., 2016).

1.3 Situation in Kenya

Since the early 1960s, Kenya has had health insurance for those employed in the formal sector that was financed through mandatory payroll contributions from formal sector employees.

Reducing costs of health care has been one of the main policy tools that successive Kenyan governments have used to increase the uptake of priority health services (Maina, 2016). Before 1988, limited health care in Kenyan government facilities was subsidized and provided at no cost to the patient. A fee was introduced in the 1990's which dramatically changed health facilities utilization, especially among the poor. However, the government of Kenya also implemented a series of measures that would facilitate access by providing free health care to all pregnant women and children less than five years during that same period. The government then reduced the user charges fee for primary care services to 20KES for health centers and 10KES for dispensary services (Chumaand Maina, 2012a). According to the Ministry of Health, these efforts increased health care utilization by 70% (MOH, 2012). Among other actions taken was

the expansion of the social national health insurance fund to the informal sector. Despite all these measures to address access and utilization of health service, uptake of health insurance is generally still low.

Today, only around 20% of the population is covered by health insurance, and of those covered 3% live below the poverty line (Zollmann, & Ravishankar, 2016). Despite the presence of public, private and community-based health insurance schemes offering inpatient and outpatient care in Kenya, there is still a low uptake of health insurance and high out-of-pocket payment in a country where 43% of the population live on less than a $1 per day (World Bank, 2016). According to Abebe (2013) social health protection systems are mechanisms that countries use to address the challenges related to providing access to healthcare services to citizens, especially the poorest segment of the population. In the absence of insurance, a high fraction of medical expenses is paid by households from out-of-pocket, and attendant financial constraints are significant barriers to access to healthcare in many low-income countries (Kimani, Ettarh, Warren & Bellows 2012). It has been shown that in countries where social health insurance schemes are well-implemented and well-funded, people can access health services based on the need and not ability to pay (WHO, 2010). Health insurance could be an option towards generating additional resources since the health system in Kenya is underfunded, (Carrin& Chris, 2005; WHO, 2010). Therefore, the government of Kenya in its national health sector strategic plan and national development agenda in Kenya vision 2030 decided to reach out to all citizens including the poor in order to maximize health facilities utilization and access to health care (MOH, 2012).

According to Kimani et al (2014), health insurance in Kenya can be accessed through public health insurance, private insurance and community–based health insurance. A

Health financing system is an essential component of UHC but progress toward UHC also requires coordinated actions across the pillars of the health system. Despite the presence of public, private and community-based health insurance covering inpatient and outpatient, the overall number of insured populations remains low.

Around 20% of the population is covered by a public, private or community-based health insurance scheme (Zollmann, & Ravishankar, 2016). The public scheme, NHIF, is the main insurer, accounting for about 98% of coverage. Although Kenya is a frontrunner in the East Africa region in terms of economic and technological developments, around that 80% of the Kenyan population do not have health insurance coverage and rely fully on out-of-pocket (OOP) payment. This can be financially burdensome given that 43 per cent of the population live below the poverty line (Zollmann, & Ravishankar, 2016). Health insurance is accessed either through a monthly mandatory payment for those in formal sector or by monthly contribution for those in informal sector. Kenyan residents including foreigners allowed to study or work in Kenya can participate when they have attained the minimum age of 18 years. There is no upper age limit for NHIF (2019). The amount of contribution increases according to income for people from the formal sector. The minimum level of contribution is Ksh 500 and the maximum is Ksh 1700 monthly, graduated according to income. Everyone willing to be a member under the voluntary category andthe self- employed pays Ksh 500 monthly (NHIF, 2019).

According to WHO, in order to reduce the reliance on OOP payments, it is essential that health systems introduce tax-funded national health insurance (NHI); contribution based social health insurance (SHI) and community-based insurances (WHO, 2015). In contrast Kenya is one of the few African countries that have had a national hospital insurance scheme in existence since the 1960s (IPAR, 2005). According to Zollmann, &

Ravishankar (2016) private health insurance contributed up to 9% of the total Kenyan population with Health insurance while the private non-commercial accounted for 6% in 2010. Moreover, the majority of those who registered did so because it was mandatory with employment (Zollmann, & Ravishankar, 2016).Some literature review in the Kenya Health Sector 2016 report identified four main reasons why individuals have not registered for any form of health insurance: affordability, value, relevance and process. In studies done in other countries, culture and social beliefs were shown to have a negative influence on health insurance uptake (De Allegri, Sanon, Sauerborn, 2006; Fenny, Kusi, Arhinful, & Asante, 2016; Asomani, 2014).

According to the electronic health record data of Chogoria Mission Hospital, 53 % of the people seen in 2017 inboth outpatient and inpatient settings were insured. The rest covered their bills using out-of- pocket payments and others have not yet finished paying their bills. Some of these out-pocket payment involved fund raising and disastrous payment which involved selling their belongings in order to pay for health care bills. Therefore, it is important to find out if culture influences the decision whether to enrol in health insurance.

1.4 Statement of the Problem

We did our electronic search on PubMed, MEDLINE, WHO Global Health Library, Hinari, Google Scholar and relevant websites such as WHO and World Bank. We also visited University library repositories.

Around 20% of the Kenyan population have health insurance while rest rely fully on out-of-pocket payment (Zollmann, & Ravishankar, 2016). This is a big financial burden for the 43 per cent of the population who live below the poverty line- living on less than

$1per day (World Bank, 2016). Even amongst those who have insurance, most only do because it is mandatory with their employment.

According to a review of studies done in Kenya (Zollmann, & Ravishankar, 2016) four main reasons have been identified as to why individuals are not registered for any form of health insurance: First, people said that they were not able to afford the monthly insurance payments. Secondly, people did not feel that they received adequate value from the insurance scheme. For instance, some were not happy because the national health insurance was not covering all their hospital needs even when admitted.Thirdly, people did not recognize the relevance of the scheme for themselves. For instance, some thought that health insurance was arranged for special people such as civil servants. Fourthly, people were not willing or able to negotiate the administrative processof enrolment. For instance, some did not like taking long trips in order to be registered, or they did not know how to provide birth certificates for their grown-up children.

These four main reasons are some of the personal factors highlighted by Walsh et al., (2012) that affect health insurance uptake. Personal factors are a reflection of people's way of life, practices and beliefs (De Allegri, Sanon, &Sauerborn, 2006; Fenny, Kusi, Arhinful, & Asante, 2016; Asomani, 2014). This is evidenced by a few studies in Africa: In some cultures, taking up insurance or setting aside money for care is perceived as a bad omen (De Allegri, 2006). Akubakar et al (2013) in their study found that most of those interviewed used both biomedicine and traditional healers. Health insurance is viewed as the only important coverage for clear biomedical conditions that hospitals can treat, while mental health, psycho-social and, spiritual issues are better covered by traditional healers. When people believe at some degree that their disease is a result of being bewitched, they will go to witchdoctors rather than hospital, hence they will not

see the need to buy health insurance. Asomani (2014) showed that people used multiple health seeking behaviors and utilized both traditional and modern medicine options.

Gitau et al (2016) in their study "An Assessment of Cultural Factors Affecting Insurance Uptake: A Survey of the Nairobi Central Business Districts" found some cultural and religious determinants that affect uptake of health insurance. Another tangential study titled "Socio-Cultural Determinants of Health-Seeking Behavior on the Kenyan Coast: A Qualitative Study," authored by Akubakar et al (2013), although conducted in rural Kenya, speaks only to cultural health behaviors but does not relate to health insurance. These studies showed that people used multiple health seeking behaviors by utilizing both traditional and modern medicine options. From these studies people in their responsepointed out the influence that religion has on insurance uptake (Gitau et al, 2016 and Akubakar et al 2013). People would not see the need of insurance if they can be prayed for and be healed. Akubakaret al (2013) said that his respondents depended on their spouse in order to apply for insurance. Maina (2016) in hercross-sectional study does discuss health insurance in the rural setting, but it is nonetheless restricted to maternal health. There appear to be no similar studies conducted in rural Kenya that investigated the influence of cultural belief on health insurance. The studies mentioned and which have some relationship with the current study were not done in the geographical area surrounding Chogoria Hospital to capture the Meru cultural, religious beliefs and practices.

Chogoria town in Tharaka Nithi county, grew because of the presence of Chogoria Mission Hospital which was founded in 1922. Many people came from different parts of the country to establish their base around the hospital. The original native people from the surrounding areas are the Ameru people. The people of the town and surroundings

predominantly profess the Christian faith. According to the hospital electronic record, most of the patients seen and treated at Chogoria Hospital come from Meru region except for some road traffic accident causalities and few patients coming from other parts of the country. This group of patients seen at Chogoria Mission Hospital constitutes a homogenous group in religion and culture, which is suitable for the study.

At Chogoria Mission Hospital, about 45% of patients seen during the year 2017 did not have any form of health insurance coverage despite the presence of ‘insurance kiosks’ at the hospital where insurance could be obtained. For the National Health Insurance Fund, to be registered, the following are required: A national identity (including passport if applicable), recent coloured passport size photo (including spouse and dependents if applicable). For people in the formal sector a copy of employer appointment or introduction letter are required (NHIF, 2019). The rest of the health insurances (teachers’ insurance, Britam insurance) have their representative at the hospital to guide people willing to enrol. The kiosks are open on working days from 9 am to 5pm.Uninsured patients pay out of pocket either themselves, with help from family members or with the help of community fundraising locally known as “Harambees”.

1.5 Purpose of the Study

Health insurance is favoured as the most appropriate means of health financing to achieve SDG (WHO, 2005). Health insurance uptake is however determined by various factors closely interlinked by culture. This study describes how culture influences health insurance uptake among patients at Chogoria mission hospital.

1.6 Objectives of the Study

The main objective of this study is to describe how cultural beliefs and practices influence health insurance uptake amongst patients at Chogoria Mission Hospital.

1.6.1 Specific objectives

i. Describe cultural determinants related to health insurance uptake among patients treated at Chogoria Mission Hospital

ii. Describe the influence of culture on health insurance uptake among patients treated at Chogoria Mission Hospital.

1.7 Research Question

i. How does culture influence health insurance uptake?

1.8 Justification for the Study

Research from middle- and low-income countries has shown that health insurance uptake was associated with an increase of health care access and that some cultural beliefs influence health care insurance uptake. In Kenya, some studies identified potential obstacles to health insurance uptake but have not studied the influence of culture. Furthermore, the few studies that investigated indirectly the influence of culture on health insurance were done in urban area Nairobi and one in coastal Kenya. This study will help describe cultural determinants that are associated with uptake of health insurance.

1.9 Significance of the study

This study will be of benefit to hospitals, insurance company policy makers, government officials but most importantly the patients. If the hindrances or obstacles are identified and addressed, there will be an increase in uptake of health insurance and thus utilization

of health care facilities which will translate into achieving the 3rd SDG and reduce poverty. It will describe the patients' cultural elements related to health insurance as well their role on health insurance uptake.

1.10 Scope of the Study

This study was done at Chogoria Mission Hospital located in Tharaka Nithi County-upper Eastern Kenya. Most of the participants in the study were from Meru region. These included natives of Meru region and others who have been living in Meru region because of either family or employment purposes.

1.11 Limitations of the Study

More themes could have potentially emerged if we included native Ameru speakers who neither communicated in Kiswahili nor English. However, while in the field we identified about seven dialects among the Ameru people which made analysis of all the dialects resource - intensive and beyond the budgetary allocation of my study. There was a sampling bias since the study used participants who were sick and in need of health care. A different point of view might have brought new idea by interviewing healthy people in the community. Interviews were done at a private Christian mission hospital which might not give a proper representation of the general population in that area. Private facilities may have a disproportionate number of insured patients because they are more expensive compared to public health institutions. This type of research does not test hypothesis and the findings may not be predictive or reproducible. The findings will focus on wholesomeness rather than individual part.

1.12 Assumptions of the Study

Based on literature review, our interactions with some patients and some additional informed people in the local community, we assumed that culture has an influence on health insurance uptake. We also assumed that when people's beliefs, religion and traditional practices view health insurance negatively, they would be unlikely to enrol in any health insurance.

CHAPTER TWO

LITERATURE REVIEW

2. 1 Introduction

This chapter will discuss a general overview of literature related to the main concepts, culture and health; culture and health insurance uptake; and the general overview of factors affecting insurance uptake.

2. 2. Culture and health care

Culture has various definitions in literature as captured by various authors. Despite being dynamic, culture has similarities contextualized by various authors as follows:James Spradley (1984)defines culture as acquired knowledge that people use to interpret experience and generate social behavior. This means that individuals learn from each other and from the environment what will shape their behavior, or how they interact within the society.

Anthropologist Redfield (1940) defines culture as “conventional understandings, manifest in act and artefact”. This suggests shared understanding of practices and beliefs by a group of people. However, this does not mean that all individuals of the group will share a given value, or that cultural ideas be translated identically even within the group. Spencer-Oatey (2012) said that “Culture is a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioural conventions that are shared by a group of people, and that influence (but do not determine) each member’s behaviour and his/her interpretations of the ‘meaning’ of other people’s behaviour.”

According to UNESCO (2001), culture is defined as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group that encompasses not only art and literature, but lifestyles, ways of living together, value

systems, traditions and beliefs". In the 35th conference of UNESCO, it was acknowledged that the most effective way to measure culture is through a society's associated behaviours, attitudes and practices. For the purpose of this study, when we say culture, we mean cultural beliefs, behaviours and practices as derived from the UNESCO definition (2011).

Anthropologists under the Lancet commissions (2014) opined that the impact of culture on health and health-care provision should not be underestimated. Culture has drastic effects on the availability, accessibility, acceptability, and quality of health care, and neglect of the cultural impact on health is arguably the largest single barrier in advancing the standard of health worldwide. A better acknowledgement and understanding of the cultural practices of individuals and groups served would allow healthcare systems to adjust practices to promote wellbeing and reduce waste. At present, the provision of health and social care is insufficiently sensitive to culture and is therefore unable to adapt to the values and expectations of health care recipients in order to better serve them. (de C Williams, Willott, Wilson, & Woolf ,2014, p.1630).

According to de C Williams, Willott, Wilson, and Woolf (2014) culture is to be viewed as the most important factor in the promotion of global health. These authors and anthropologist suggest that policy makers in low-and middle-income countries when implementing programs exported from high-income countries should consider the effects of local cultures. Capacity building should consider and assess indigenous capacities to respond to global health strategies and interventions.

The Lancet commissions concluded that the neglect of the role of culture in health-care provision may stem from an underlying perception in the biomedical community that cultural considerations hinder science. It is often assumed that evidence-based research is

scientific and therefore culturally neutral; however, this overlooks the reality of the pervasive impact of culture in all aspects of a society including the cultural backgrounds of scientists themselves. By acknowledging the pervasiveness of culture and its impact on health, the biomedical community can begin to incorporate cultural considerations into care pathways and medical decision making and begin to better allocate resources to improve health-care delivery worldwide. If the culture of biomedicine continues to focus on causes of disease, hierarchies of treatment, expectations of patient adherence, and following evidence-based practices without acknowledging cultural considerations, many barriers to care will continue to go unrecognized. A patient's opportunity and motivation to receive care and his or her likelihood to adhere to medical recommendations must be more thoughtfully considered so that poor outcomes will not continue to ensue, scarce resources will not continue to be wasted, and diseases will not continue to proliferate.

Individual socio-economic and behavioral considerations have a tremendous impact on health. Rather than focusing on these in isolation, a better consideration of culture in a community will allow for understanding of how behavior is affected by culture, of the commensurate willingness or unwillingness of individuals to participate in collective action, and of the health of a community at large." (de C Williams, Willott, Wilson, & Woolf,2014). Personal health behaviour, beliefs, and practices are deeply influenced by culture (Winkelman, 2009). These observations suggest that some interventions and programs that have succeeded in some countries may not necessarily work in other countries. Policy makers should consider that some policies might not be relevant or sustainable by local culture. Policy makers should understand that local cultures affect local ideas about health and related outcomes.

Realizing the above, the policy makers (government, health insurance companies) should change their cultural practices in order to accommodate and retain influence on their customers. Patients should be given necessary education and information to understand how their culture affects their attitudes towards health seeking behavior in order to improve health and wellbeing. Doing these will build trust of health care policy makers by consumers. An understanding of culture therefore is crucial to the sustainability of local healthcare systems, and the strengths and weaknesses of care practices. Cultural and social beliefs of a community shape healthcare practices and local ideas about illness. Any health intervention for community members must be made sensible in the context of local beliefs and practices. Patients' healthcare seeking habits are driven by their culture among many other factors. Culture dictates their beliefs and practices on healthcare financing choices as well. While policy makers advance their agenda on universal health coverage pegged on health insurance, this study demonstrates the importance of the interaction between healthcare insurance uptake and culture.

2. 3 Culture and health insurance

There is a growing awareness that access to of health care services and their effective utilization is about much more than just financial access. Culture and social beliefs have been found to play a role in life/health insurance enrolment or withdrawal (De Allegri, Sanon, & Sauerborn, 2006). Studies have highlighted a cultural inclination that setting money aside for healthcare may be perceived as attracting diseases (De Allegri, 2006) or inviting evil (Akach & Adobea, 2016). Some people have stated that when they save money for health insurance, they do not talk about diseases (De Allegri, Sanon, Sauerborn, 2006). Prepayment before illness was also associated with "inviting disease"

in a study done in Uganda (Basaza et al, 2008). In a study done in Nairobi business district the respondents agreed that the taking up of insurance cover is considered a bad omen in some cultures (Gitau et al, 2016).

In Benin, participants reported that it is only when someone becomes sick that they ask the community to contribute financially to help (Turcotte et al., 2012). Patriarchal cultures demand that women seek permission from their husbands to enrol (Sinha et al, 2006) while other cultures may demand that the husband provides the finances needed to access health care (Akubakar et al, 2013). Kenya has several options in healthcare financing and advocates for SHI which prevents catastrophic healthcare financing (MOH, 2012). Despite this, the uptake of health insurance in Chogoria is low, as described in chapter 1.

Patients without health insurance must pay out of pocket, either themselves with help from family members or through fundraisers conducted in the community (locally known as Harambees –"pull together"). This status is no different in Murang'a county where some patients saw no need for health insurance since the community cushioned them by paying for their bills through harambees whenever they fell sick' (Ndung'u, 2015). At Chogoria Hospital, we have personally encountered many cases of patients who underwent major surgical procedures and had to pay a substantial sum of money out of pocket, though they had time to apply for health insurance that would have otherwise covered the procedure. There are instances when persons known to have the means for insurance have not registered despite having directly experienced the impact of lacking health insurance.

Therefore, the purpose of our study is to describe and analyse the influence of culture on health insurance uptake, generate a theory and present the knowledge to the

policymakers in order to move towards the goal of universal health coverage, a critical goal of health systems in all countries irrespective of income status (WHO, 2015).

2. 4 Factors affecting insurance uptake

Literature describes factors affecting health insurance into three main categories. Personal factors that influence the decision to enroll, Economical factors and System related factors.

2. 4. 1 Socio-demographic factors

Demographic factors that influence the decision to enroll in health insurance schemes include age, education, income, family status, dependent family members and health conditions. Personal factors that influence uptake of insurance include individual's level of awareness about health insurance, attitude towards health insurance regarding need and benefits, the satisfaction derived from earlier experiences, interactions with friends and relatives or opinion about services based on word of mouth. Demographic factors have been widely referenced in literature as majoring affecting insurance uptake.

In Kenya several studies evaluated the influence of demographic factors on health insurance. A study done in Kiambu by Nguru (2018) found that insurance uptake was higher in people aged above 38 years. Ndung'u (2015) also noted that gender and marital status influenced the uptake. The finding was the same in the study done by Kiplagat, Muriithi & Kioko (2013) where she found that age was a significant factor. In Bungoma, Masengeli (2017) found a positive correlation between age, gender, marital status and ownership of health insurance. Being aged, male, and married were associated with high insurance uptake.

In Zimbabmwe, Mhere (2013) found that age was a very important factor of enrollment in health insurance uptake. He said that as people become older, they become more responsible and more open to the idea of health insurance. However, as they grow older people were unlikely to buy or renew their insurances. In Nigeria, being aged was found to be associated with large family and household dependents which paradoxically lead to low uptake of insurance. The author explains the phenomena by the fact that aged people had many responsibilities towards their wives and children with limited income (Oyekale, 2012). The common findings with all these studies are that the responsibility of buying health insurance was high with people at middle age.

In Pakistan, family members headed by males with more than one child and elderly dependents were associated with uptake of health insurance for health protection. This was because they were afraid of paying a lot of money when diseases arose in the family especially with younger and elderly people (Jahangee and huq, 2015). In Cambodia, the number of people living in one the household had a significant influence on the decision to enroll in a health insurance. The households with many dependents had a high enrollment rate. The same was observed with the level of education. People with a higher level of education were more likely to enroll. (Ozawa, Grewal & Bridges 2016).)

Fadlallah (2018) in his review found that socio demographic factors such as age and gender played an important role in deciding whether to buy insurance or to keep it. People who were married and older had higher rate of buying and keeping health insurance while single and younger people had lower rate of enrollment. In Ghana, Asomani (2014) discussed that demographic factors such as level of education, age and marital status influenced enrollment. He found that as people age, their health needs

increased, and found that women were more willing to enroll because of their protective instincts toward the family.

In terms of gender, literature has mixed findings. In some parts of the world, males are prone to enroll in insurance schemes, while in other parts of the world women take the lead. For example, in India, according to Sabine Serceau (2012), males were more commonly enrolled than female. This is like many other studies from different countries such as Fadlallah (2018). Masengeli's study (2018) in Kenya positively correlated male gender with insurance uptake. The low enrollment of the women was generally explained by the disadvantaged position they occupied in the society, as husbands tended to act as heads of families and hence decided on these issues. In contrast, in a Ghana study by Boateng &Awunyo (2013) females being were found to be more likely to renew their insurance when compared to men of the Delta Region. The authors concluded that the reason behind this observation was the will of the mothers to care more for their family members.

2. 4. 2 Socio-Economical factors affecting health insurance uptake

Affordability of insurance premiums is a main factor that affects insurance uptake worldwide. In Kenya, Kimani et al. (2012) found out that employment status was an important factor of participation in the NHIF program. Those who had employment were automatically enrolled. Those employed from the informal sector but who had a higher monthly income were also more likely to be enrolled compared to their counterparts from the informal sector who had no regular revenue. This was like the findings by Zollmann, & Ravishankar (2016 in their respective studies evaluating the determinants of health insurance choice in Kenya. They found that employed people were more likely to be covered with public health insurance as compared to private health insurance

because public insurance is a mandatory requirement with employment. Those studies noted that the poorer people in the informal sector were unable to participate in the National Health insurance fund because of lack of money to pay the required premiums. Zollmann, & Ravishankar (2016) found that among the main barriers of low uptake of health insurance, affordability was one of the main issues. In Pakistan, people with good economic status were more likely to be insured than their counterparts. This is explained by the fact they could afford the price of premiums for both public and private health insurance companies (Jahangee and Huq, 2015). In GhanaKotoh, Aryeetey, & Van der Geest (2018) found that the most common reason for not enrolling in the public national health insurance scheme was the inability to afford the premiums. In this study they found that poverty was an important factor among the poorest and some poor households with many members. Adobea and Akach (2016) found that low levels of income and lack of financial resources were major contributors of low enrollment in low- and middle-income countries.

2. 4. 3 System related factor and process

In Kenya, Zollmann, & Ravishankar (2016) found that the process set by health insurance scheme for registration and payment was a barrier to enrollment. Moreover, the difficulty in acquiring transportation and difficulty in producing required documents hindered enrolment. “The registration process is viewed as obscure, inconsistent across branches, difficult, logistically demanding, and time consuming”. Nyorera & Okibo (2015) in their study done in Kanyakine sub-county found that accessibility and process of registration negatively influenced the respondents from the informal sector to enroll in NHIF. Masengeli et al (2018) in Bungoma found that the process of registration and poor

experience and quality of care received from covered facilities influenced the membership in health insurance and its renewal.

In Nigeria, Ekwuluo, Eluwa, Okereke & Orji (2018) found that bureaucratic procedures and lack of specialized drugs were barriers to uptake for the poor. According to Fenny et al.,(2016) in his study of factors affecting uptake of health insurance in Ghana, poor social infrastructure, weak administrative processes to acquire the NHIS and poor quality of care hindered uptake. They found that poor quality of roads made transport difficult. Poor communication made information not accessible; consequently, people were not well informed as to procedures of insurance purchase. The respondents had a bad perception of the quality of care they received with their insurance cover, especially those with NHIS. In an article by Fenny et al (2018), people mentioned that the health system as it is currently built in Africa leaves out the poor. In Senegal, Mladovsky, P. (2014) found that quality of health services was identified as the most important determinant of drop-out from Community- Based health insurance schemes. Fadlallah (2018) found that "packages that covered outpatient and inpatient care and those tailored to community needs contributed to increased enrollment. Amount and timing of premium collection was reported to negatively influence enrollment".

2. 4. 4 Conceptual Framework

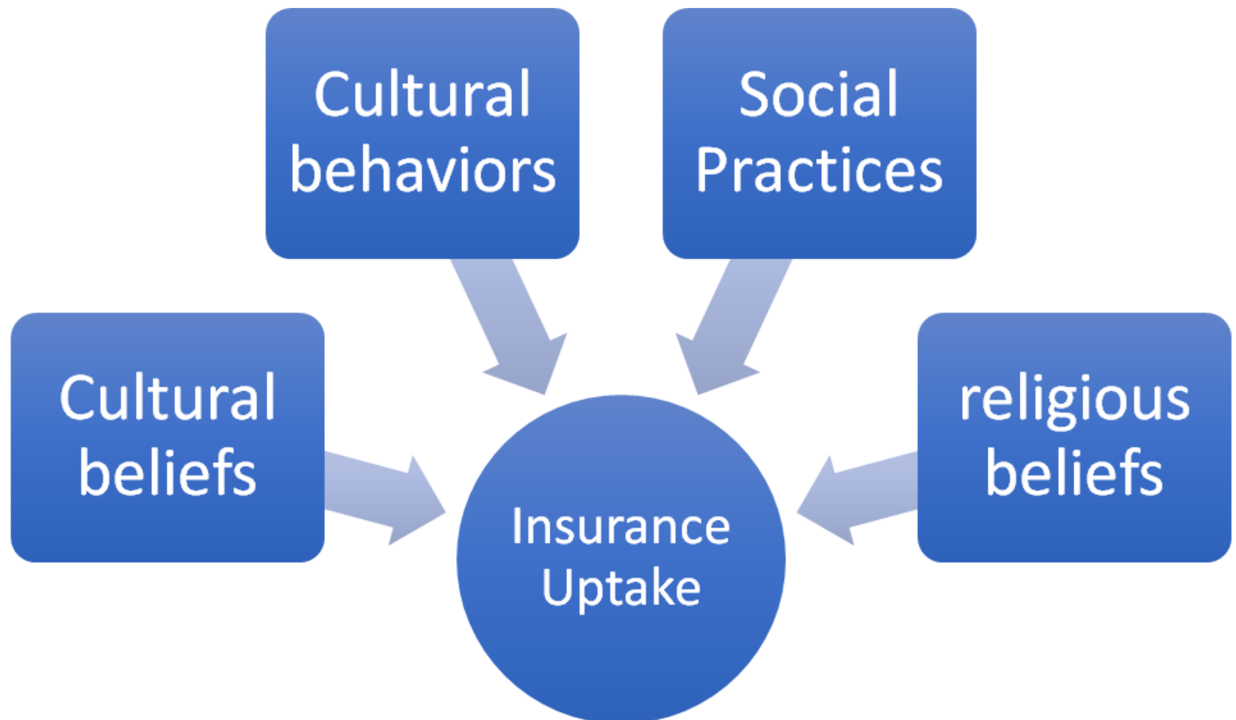

Figure 1: Conceptual Framework

This conceptual framework is derived from the analysis of the results of African studies that have shown a relationship between culture and health insurance and from the definition of culture. (Asomani, 2014; De Allegri, 2006). It shows how several components of cultural beliefs contribute to health insurance uptake behavior/ attitudes.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter details the research design, sampling procedure, ethical considerations, methods of data collection and analysis.

3.2 Research Design

The research design consisted of the use of a qualitative-phenomenology research method in addressing the research objective. The methodology consisted of exploring the beliefs and practises that affect health insurance uptake.

3.3 Location of the Study

The study was done at Chogoria Mission Hospital, a faith- based, private and non-profit hospital located in Tharaka Nithi County –upper Eastern Kenya. Chogoria Mission Hospital has an inpatient capacity of 295 patients and treats an average of approximately 450 outpatients daily. This Hospital serves as a teaching institution for healthcare and allied personnel. It also serves as a regional referral hospital. Therefore, the sampled patients are expected to represent several cultural subsets beyond those found in Chogoria alone.

3.4. Population of the Study

Our study population were patients aged from 18 years old or older among patients receiving treatment at Chogoria Mission Hospital in both outpatient and inpatient departments. This study aimed to explore cultureof individuals from Meru region getting health care at Chogoria Mission Hospital in general rather than the ethnic culture of people specifically. However, because all participants were from Ameru people, this study will act as a screening study to pave way for an anthropological approach which

can exhaustively explore the specific ethnic culture of Ameru people. We sought out participants with and without health insurance to provide a broader view of cultural beliefs and practices.

3.5 Sampling Procedure and Sample Size

3.5.1 Sampling Procedure

In order to directly address the research questions, we selected the participants using a purposive sampling method. We used this method because it helped us select people from both groups: those with insurance and those without insurance. We intended to represent the fullest range of participant's experiences, to include those with or without health insurance. For that reason, patients of different genders, age groups, educational backgrounds and religions were captured. For those who did not have insurance, they were more directly affected by the lack of insurance. We deliberately sought patients with and without insurance to more fully understand why patients chose to purchase insurance or why they didn't. In particular, because patients without insurance would have experienced the difficulties associated with out-of-pocket payment, we wanted to understand their motivations and intentions. It was assumed that both groups (insured and non-insured participants) possessed knowledge and experience with the phenomenon of interest either because they have lived the experience, or they have witnessed/knew people who lived the experience and thus would be able to provide detailed and useful information.

3.5.1.1 The recruitment process

Recruitment of participants was done by direct contact with patients meeting the inclusion criteria. We included patients from medical wards, surgical wards and obstetrics –gynecology wards and the outpatient clinic. In Medical ward, participants

were recruited on every Tuesday of the week. The second patient admitted before midnight of the previous day according to the electronic records and meeting the inclusion criteria was recruited. In surgical ward, every Wednesday of the week during data collection, the second patient admitted before midnight of the previous day and according to the electronic records, meeting the inclusion criteria, was recruited. In Obstetrics and Gynecology, every Thursday of the week during the data collection, the second patient admitted before midnight of the previous day according to the electronic records, and meeting the inclusion criteria was recruited.

The research team in collaboration with the clinician in charge of the department approached patients about the study and invited them to participate. When approached patients did not agree to participate, the next admitted patient meeting criteria was approached for recruitment. In the outpatient clinic, on each Monday of the week during data collection, we picked a different adult outpatient room for each week for the researcher to recruit eligible patients. The patient was recruited in the morning and the interview was done after the patient was done with his/her visit. The days of interview were chosen purposively: For inpatient participants, the day of recruitment and interview was selected based on the fact that there was no major round on that day in each ward concerned. We did this because we did not want patients to be missing during rounds or family members visit. For outpatient, we deliberately chose Monday because that is when there is a big number of people coming for follow up for many outpatient clinics and that would increase our chance of getting stable patients willing to participate.

We picked the first patient entering the outpatient room after 9 AM, meeting the inclusion criteria and who agreed to participate in the study. One patient was recruited per day. The recruitment was followed promptly by interviews to prevent loss of

opportunity in case of unexpected discharge from the hospital.All the patients who participated in the study were attended to and their disposition in seeking care was not affected by the study.

3.5.1.2 The inclusion criteria were as follows:

a. Aged 18 years and above

b. Medically stable as assessed by the primary caregiver or the triage nurse

c. Able to communicate in either English, Swahili

d. Consented to participate in the study.

3.5.1.3 Exclusion criteria were as follows:

a. High school students

b. Patients who did not reside in the Meru region and therefore did not represent the local culture

3.5.2 Sample Size

According to Guest, Bunce & Johnson (2006), a sample size of six interviews is enough to develop themes, and saturation is usually reached after twelve interviews. We planned for twelve interviews, allowing for up to twenty additional interviews if required. We conducted a concurrent data collection and analysis in order to recognize thematic saturation. A sample size of 20 participants was reached through thematic saturation. We reached thematic saturation when we had interviewed seven patients without insurance and eleven with health insurance. We allowed 2 more interviews from each group to see if we would get more themes, but we did not get new information.

3.6 Instrumentation

We used a semi structured study guide. The interview guide was developed based on

results from other studies that evaluated the influence of culture on health insurance uptake (Fenny et al, 2016; De Allegri et al., 2006; Asomani, 2014). We also used one audio recording device for data collection.

3.6.1 Pilot study

A pilot study was done in order to evaluate the interview questions and prompts since this study had a semi structured guide and the research assistants have conducted research interviews before. The pilot study was done 1 month prior the start of data collection at PCEA Chogoria Mission Hospital. This was done to avoid the recruitment of the same patient into the actual study. At first, two participants were involved. One participant for the pilot study was a member of the research team in order to evaluate the assistants' skills. One pilot participant was used to review the questionnaire and prompts. His answers to various questions revealed that he easily understood the questions. This participant was a patient from surgical ward who met the inclusion criteria. These interviews were done in English. Four other participants were used to evaluate the main researcher's and research assistants' ability to conduct an interview in Swahili and the also to evaluate the Swahili research guide.

It was found that the main researcher's knowledge of Swahili was not adequate to conduct the interviews. Hence research only assistants were used to conduct interviews. The main researcher however designed the entire proposal and the tools of the study. In total six interviews were done for the pilot study - two in English and four in Swahili. The original interview guide was developed in English and translated into Swahili and Kimeru by English-Swahili teacher, and verified by the research team for semantic meaning.

3.7 Data Collection Procedure

We used a voice recorder and semi structured guided questionnaire to collect data (Appendix A). Semi structured interviews allow participants to give important information while reflecting on the questions. Data collection was performed by trained research assistants. These were four nursing students in their final year of schooling who had experience in research as suggested by their principal and the hospital nursing director. The choice of nurse was motivated by the fact that they reside in the hospital compound and work in the hospital thus they knew how the hospital is organized and works. Moreover, they had already been involved in other similar researches. The researcher ensured that they were trained about the research objectives and procedures. The researcher and research supervisor conducted a two-hour training session, followed by mock interviews.

The research assistants were fluent in both English and Swahili. Interviews were done during daytime, Monday through Friday from 9:00am to 5:00pm except during visiting hours. The interviews for inpatients were held in the office of the head nurse for each ward to ensure privacy. The interviews did not interfere with the office work or visiting since they were done after visiting hours and for 20-35 minutes once per week in each department. The head nurse had prepared for that session to happen. Interviews for outpatients were held in the Family Medicine office to ensure privacy. The digitally recorded data, with the permission of the participants, were transcribed. Interviews conducted in Swahili were transcribed in the original language then translated in English by a professional English -Swahili teacher. The transcribed data from Swahili to English were cross checked by the researcher and research assistants for accuracy and semantic meaning. Participant were free to contribute.

3. 8 Rigor and Trustworthiness

To enhance rigor and trust worthiness of this research the following steps have been followed as described by Noble and Smith (2015). The research team conducted online debriefing and feedback to assist the researcher to uncover biases. This debriefing was consistently performed throughout the study to ensure reflexibility during the process. As an example, the initial interviews inadvertently included mainly the insured patients, so subsequent interviews purposively included noninsured.

Representativeness of the findings in relation to the phenomena was maintained by the sample of the 20 participants with and without health insurance. Both groups agreed to share their experience in depth. Moreover, a semi structured audio recorded interviews was done. This allowed a revisiting of the data recorded anytime for theme analysis and cross checking. The researcher pulled particularly rich extracts from transcripts to illustrate themes. These quoted extracts allow the reader to make their own opinions or judgments about whether the final themes are true to participants' accounts as discussed by Noble and Smith (2015).

To ensure consistency and neutrality, the process was reviewed by multiple teams from the initial formulation of the research topic until the final manuscript. A team from Micro research assisted in formulation of the research topic, and then review teams from Kabarak University supervised processes with proposal and data collection. All patients had same questions and had prompts. All themes were openly discussed, and cross checked by research supervisors. Where applicable, themes have been changed or adapted after consensus was reached by the research team. A third supervisor with more expertise in qualitative research was added to the team to ensure procedural excellence and integrity.

3. 9 Data Analysis

The transcripts were analysed using a constant comparative method as described by Creswell as a "process of taking information from data collection and comparing it to emerging categories" (Creswell, 2003).According to Clarke and Braun (2006) the first step of thematic data analysis as described is to get familiar with the data. The main researcher listened to the audio recordings as they were recorded.

The recorded data were transcribed and those done in Swahili were translated by an English -Swahili teacher. The transcribed and translated data were cross checked by the research team including the main researcher, research supervisors and the research assistants. In the second step of the analysis, data was organized in a meaningful way to generate codes. In this process an inductive data analysis was used to give the researcher the liberty to openly generate the codes. Some of the codes were anticipated according to the referenced literature, and others were identified during analysis.

Manual coding was done by the main researcher and the research supervisors independently then cross checked. The coding was done by highlighting the text and writing notes as different codes were identified. The third step was to search for the themes. This was a back and forth iterative process in which the researcher reads through the codes several times in order to generates themes and address themes as they become apparent. The fourth step involved the review of established themes and how they relate with the data. Using the conceptual framework and emerged themes, more themes were added, and others were combined. If themes were determined to be overlapping and with minimal difference in meaning, they were combined. During the fifth step of analysis, some themes were renamed as the researcher noted traces of patterns, connections, similarities, or contrastive points and some themes were renamed. Before writing up, the

researcher reviewed the codes and themes then proceeded to identify illustrative quotations as communicated by participants.

3. 10 Ethical Considerations

The researchers declared that there was no conflict of interest in the study. The institute of postgraduate approved the proposal of this study and the Kabarak University Institutional Research and Ethics Committee approved the study. After approval by the National Commission (NACOSTI), Chogoria Mission Hospital also approved the study to be done. Participants were provided an information sheet, and an informed consent form was signed by the participant before starting the interview (Appendix B). Each Participant was assigned a code in order to keep confidentiality. Identifying information was removed from the recordings. Interviews were held in the offices of nursing head of each ward and in the Family Medicine office in order to maintain participant confidentiality. Participants had the right to stop or withdraw from the study at any time. Both recorder and transcripts were kept locked in the Family Medicine Office.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This chapter covers and describes data analysis, presentation and interpretations of findings on the influence of cultural and social beliefs on health insurance uptake. The chapter will also compare our findings with other researchers through discussion of the results.The main objective of this study was to describe cultural beliefs, behaviour and practices that could have an influence on health insurance uptake at Chogoria Mission Hospital.

4.2 General and demographic information

4.2.1 General Information

The average duration of time with each patient, including patient sampling with the medical professional in charge of the department, obtaining informed consent, and conducting the interviews, was 1.5-2 hours. The actual interview duration for each patient ranged from 25-35 minutes. Five patients refused to participate in the study, stating that they were not ready. Two of the patients who refused were from inpatient postnatal and medical wards and three were from outpatient department.

4.2.2 Demographic Data

Twenty subjects from different departments of the hospital were interviewed; eight were female and twelve were male. Four participants were unmarried. Most participants had one or more children. Five of the subjects had a tertiary level of education the rest either had primary or secondary school education. The majority of the participants with insurance had had at least one form of health insurance (NHIF + either farmers'

insurance or teachers' insurance). All the noninsured participants were from in the informal sector. All the participants consented to be part of the study.

Table1: Bio Data

Characteristics		**N=20**
Gender	Male	12
	Female	8
Age group	18-34	9
	35-50	7
	51-69	4
Marital status	Married	16
	Divorced	2
	Single	2
	Divorced	
Religion	Christian	19
	Other	1
Employment	Informal	13
	Formal	7
Residence	Tharaka Nithi County	16
	Meru County	4
Education	Tertiary	5
	Other (Primary and secondary)	15
Health Insurance holder	Yes	12
	No	8

4.3. Data Analysis and Interpretation

4.3.1 Method of data analysis

Table 2: Emerging themes and sub themes

	Theme	Sub themes
1.	Religious beliefs	• Saving for health insurance is inviting evil • Insurance is a sign of lack of faith
2	Harambee	• Health insurance is better than Harambee • Harambee is a community health insurance for old • Harambee as a backup plan when health insurance does not fully cover costs
3	Patriarchal culture protector	• Husband is viewed as primary provider and • Women are now getting empowered
4	Following other people's examples of purchasing Insurance:	• peer influence
5	Health is not a priority:	• Misconception of value and procrastination Economic priority
6	Traditional healers	
7	Absence or presence of health insurance affects social dynamics	

4.3.2. Religious beliefs

4.3.2.1 Insurance is a sign of lack of faith

Chogoria is a mission hospital and 19 of the 20 participants reported Christianity as their religion. This is confirmed by discussions being generated around different church denominations and the unique characteristics of these denominations. However, both uninsured and insured did not have religious beliefs that affected their health insurance uptake. These participants were already in the hospital which poses a selections bias.

However, participants knew churches, church members and people who held beliefs that acquiring health insurance was associated with a lack of faith in their God and that they should pray to be healed rather than visiting hospital. This translates into knowledge of a generic community culture beyond the hospital. During the interview one participant

confirmed that indeed he believed in healing through prayers rather than visiting the hospital. He has however changed his mind upon reflecting on the potential benefit of NHIF against the bill he has since accrued. According to the participants' response, the presence of people with such beliefs in the community requires a public health intervention. Some participants stated that some religious leaders discouraged the purchase of health insurance, believing that this practice demonstrated an absence of faith and/or may invite evil into one's life.

> "…there are some people who don't believe in ensuring their lives because they have been saved for instance a religion like 'angel maria' they don't believe in hospitals they believe if they get sick, they should pray and God will heal them. Even some from where I come from, they don't believe in hospital some ladies give birth, but the infants end up dying..." MTP7 IM

> "…. They say not to get a health insurance because God has insured you with the blood of Jesus. You know we can say there are such churches or denominations with their own beliefs. For example, there those in their churches they don't believe in visiting the hospital, in some part in Chuka there are denominations known as 'kabonokia' where people don't believe in going to the hospital or being treated. You see for such a person you can't convince him to get a health insurance…" MTP8 IM.

"Yes, they tell you that if you get a health insurance you don't believe in God" MTP 15NIF.

In their article, Osei-Akoto and Adamba (2011) said that believing and depending strongly on prayers for healthcare can influence uptake for health insurance negatively.

This was also noted by Baidoo and Bus when they observed the belief that buying health insurance implies inviting sickness (Baidoo and Buss 2012). This was consistent with the findings by Asomani in Ghana where a sect called Gvikiikoko was teaching its followers not to enroll in health insurance because they believed it was associated with lack of faith in God. Because the number of followers of the sect was huge, this might have had a negative implication on health insurance uptake. Asomani noted however that leaders from some other churches were encouraging their members to enroll in health insurance (Asomani, 2014).

According to Nduna, Jewkes, Dunkle, Jama Shai & Colman(2013) religious beliefs played a major role in low penetration of insurance in general, health insurance included. Fenny et al., (2016) in Ghana found evidence of strong religious beliefs that mitigate against health insurance uptake . A trend analysis of longitudinal enrolment in NHIS in Ghana found that uptake and renewal are decreasing. Among contributing factors were religious beliefs (Nsiah-Boateng &Aikins, 2018). Though our findings might not be extrapolated to the general community, they are similar to Gitau's findings. He recorded that most of his participants believed that religion may influence the decision to take up insurance cover or not (Gitau, 2016). Further, respondents reported that Christian sects such as Kabonokia and Angel Maria churches have taught strenuously against health insurance. The respondents to this study also said that some church leaders were actively teaching and promoting health insurances during their church services. Gitau respondents agreed that Islamic religion is against insurance products that pay interest on premium savings. Some sects of the Christian faith had a negative opinion of health insurance since they were covered by their faith. They said that taking insurance was associated with confessing that bad things would happen. The respondents also agreed

that "some indigenous religions in Kenya do not believe in seeking medical attention and hence may not see the need for a medical cover" (Gitau, 2016).

Saving for health insurance is inviting evil

Most of the participants denied having the belief that saving for insurance is inviting evil. Several of the participants knew of other people who held such beliefs. The majority of the insured participants felt that people holding such beliefs were mistaken and needed insight about health insurance while few among non-insured had the beliefs. Most participants knew of other people who believed that saving for health insurance invited evil.

> "There's one of my auntie's who say that it is asking God to make you sick since you have a health insurance for your body"MTP15 NIF
>
> "It's just like my grandmother, she can't get insurance because she believes that's like calling sicknesses upon the family" MTP20 NIM.
>
> "Yes. Some believe so, since my age qualifies me to be a leader so I interact with many groups of people you'll hear people say that if you get the health insurance you will be opening doors for your family to often get sick and if you don't acquire one this will not be the case". MTP6 IM
>
> "…Yeah. by the way that belief is very common because someone thinks you when saving money, it's like praying to get sick that's the myth, the culture… People believe that. You get people saying that getting a health insurance is like praying for sicknesses to befall you so you can use the insurance savings… That's what I'm telling you. There are some who believe so. There's someone who you can't convince to pay for NHIF even if you give them money they will claim that you

want to bring evil spirits in their family there some in the society who are like that"..
MTP7 IF

One participant said that he used to be in that category of people who believed that health insurance was associated with getting sick. He reported to have not registered because he believed it was a call for bad things in his life.

> "Health insurance covers, there are some myths that come with it. That it is like signing your own death sentence You see it is like signing your sickness sentence. that's why I have never thought of going for one" MTP17 NIM

Overall, participants reported that some people used to think that acquiring health insurance was associated with bringing diseases home. The participants recommended that everyone should be enrolled in a health insurance scheme. In this study, participants revealed that there are beliefs in the community that taking a health insurance was synonymous with inviting evil in one's family. This did not affect the majority of our participants' decision in this study to enrol irrespective of their insurance status, but in some other studies in Africa, this belief was associated with mitigating the insurance uptake. If people see health insurance as inviting evil in one's family, they will not join any form of health insurance. The belief is shared by the findings of Tabor's respondents from rural Benin. They viewed saving money for health insurance or for a disease as to be "wishing oneself the disease" (Tabor, 2005). In Ghana several studies had related this belief with low uptake of health insurance (Nsiah-Boateng &Aikins, 2018). According to the University of Ghana Institute of Statistical, Social and Economic Research, participants believed that insurance uptake was inviting evil (Akach and Adobea, 2016). A study from Burkina Faso revealed a cultural inclination that setting money aside for healthcare was perceived as attracting diseases (De Allegri et al., 2006). In Uganda,

prepayment before illness was also associated with inviting disease (Basaza et al., 2008). In a study done in Nairobi business district the respondents agreed that the taking up of insurance cover is considered a bad omen in some cultures (Gitau, 2016).

4.3.3. Social solidarity: Harambee

From the respondents of this study, it appeared Harambe was an acceptable sort of community health insurance or a kind of social solidarity. All the participants stated that harambee is not a good strategy for the community to use as a health insurance. They stated that harambee is inferior to health insurance and no one should count on it. Several of the participants felt that everyone in the community has his or/her own problems and harambees only add to their problems. Some said that even when the community contributes, the cost of the hospital bills often exceeds the money raised, and the families remain strapped with high debt.

> “No, I prefer to have the health insurance. You know on August I was asked for Ksh 136, 000 when my child was admitted in the surgical ward, if I had no health insurance and I opt to call for a harambee people would raise just around Ksh 50,000 or 20,000 and they would also complain about the same. Now that’s not a good thing it is better to have the health insurance...” MTP11 IM

> “..These days when you invite people for a harambee they never turn up since everyone has the health insurance. And there are campaigns against harambees. And if you call for a harambee people won’t show up…. People claim they cannot attend a harambee to raise hospital bill since one should be having a health insurance and you have been left behind by time.” MTP2 IM

However, non-insured participants irrespective of their observations about harambee as discussed above still often chose to pay their hospital bills by calling for a Harambe in their local community or through media.

> "For now, since I don't have any insurance scheme, I still go for the harambee. Because at least that you have to organize your few friends they give you something small and add to what you have" MTP15 NIM.

> "..I will call for a harambee or I call the personnel from 'muugafm'(a local meru radio station)…because people will be informed about me then they will contribute funds". MTP16 NIF

A participant said that even the politicians have refused to be called for medical fund raising in order to promote health insurance.

> "no! For instance, in our area, all politicians say they should not be invited to a harambee for hospital bill since health insurance is there for that purpose…" MTP1 IM

4.3.3.1 Harambee as a backup plan

Insured participants suggested that harambee can be used as a back plan in cases where the hospital bills are beyond what the health insurance covers.

> "...call for the harambee if the funds aren't enough selling land but where will my children turn to after that? (laughter) That is very stressful…" MTP19 NI

> "...For NHIF there is a limit let us say Ksh 500,000 so if the amount is more than that you'll have to call for a harambee". MTP10 IM.

> "I would call for aid using a harambee if the bill is too high or if you have a cow you can sell it…" MTP3 IM

"If the bill is very high you'll have to part away with your property or organize a harambee…." MTP2 IM

4.3.3.2 Harambee as a community health insurance for old people

One participant said that harambee is used by older people to cover their health bills.

"...You see, for most of the elderly people trying to convince them to get a health insurance it's very hard for them to save money. If told to contribute every month they will find it very hard to do that. They hope for a harambee to come and help them..." MTP 3IM.

The cultural support network in moments of need in the community is not a Kenyan practice only, it a practice that is shared by some other countries. Asomani (2014) in Ghana, when he was assessing the influence of this social solidarity network, found that it was difficult for a sick person to get financial support from more distant relatives. even in the culture they believed that it is important to help the most vulnerable members of the nuclear family . This is similar to the findings of Aboderin (2004) in which he agreed that traditional support networks were growing weaker. Gitau indicated that when respondents in his study became ill, they believed that the society would pay for them through the social solidarity called Harambee (Gitau, 2013).

4. 3. 4 A patriarchal culture

4. 3. 4. 1 The husband as the primary provider and protector

In African culture, especially the patriarchal cultures, the husband is often viewed as the one to provide for all the needs of the family including matters related to health. Some insured participants were positively motivated by the fact they had the responsibility to provide for their families.

"...It covers the children the wife and you. Now it is very crucial if you are married and have a family to get a health insurance..." MTP2 IM

"...Yes. I thought to myself that an emergency may occur to my child or me and if it happens it requires a lot of money for the hospital bill and one doesn't have the money so the health insurance will cater for it…" MTP6 IM

"…To be honest, getting a health insurance depends with one's mindset and how seriously you take your health like some may think they will never get sick. Also, it depends with who will use the insurance apart from you. Like for me I have children so I thought it would be very stressful if someone fell ill and start crying foul how you have no hospital money and the person is already in hospital so I thought it is good for emergency cases and when you have no money it will be a good thing to rely on…" MTP7 IM

"…I thought about it and came to a conclusion that it is a very good idea since it can help my family; my wife and my children something of the sort…" MTP4 IM

This study noted that among factors that motivated people to enroll in health insurance was the sense of responsibility of a man towards his family. This was related to the cultural belief that a husband is the household provider and protector. Most of the participants who are insured were motivated by that cultural responsibility. Previous studies in some countries of Africa found similar beliefs. In GhanaDuku, Nketiah-Amponsah, Janssens & Pradhan., (2018) found that marital status of the respondents and the motivation to protect the family were identified as determinants of enrollment in health insurance from both rural and urban areas of two different regions of the country.

Socio-demographic factors such as being married were linked with a positive enrollment in a CBHI scheme by Fadlallah's review (Fadlallah et al., 2018).

Several studies in Kenya have shown the correlation between marital status and the number of household occupants with increased health insurance uptake. In Bungoma, "Married patients were found to be 10 times more likely to own a health insurance cover as compared to patients who were never married. Marriage increases desire for health insurance to protect children and avoid catastrophic health expenditure" (Masengeli et al., 2017). Gitau (2016) in his study in Nairobi reported that married couples had a high rate of health insurance uptake. This was also the case with Ndung'u's (2015) study in Murang'a County in which being married and having children was associated with high enrollment in health insurance.

4. 3. 4. 3 Women are now being empowered

Some patients experienced unpleasant consequences of depending on the husband for health-related expenses. After they had seen how they were subjected to obeying their husbands while putting their lives and the lives of their kids in danger, they had to find alternative ways to get health insurance They had to look for jobs that would allow them to apply for the health insurance without relying on their spouses.

> "..when we separated with my husband I stopped working so later I looked for temporary jobs and I opened accounts which I save the little earnings I get for my children and the bank does the contributions on my behalf for my NHIF that means even if I don't have money the bank does the remitting for my NHIF…" MTP1 IF

"…My child got admitted in Nkubu hospital for a week then they reported that they can't diagnose my child with any disease. But when I was told to pay for the hospital bill I was unable to and still my husband had declined to make the NHIF contributions….so the card remained in the house. I insisted for him to make the contributions to no success that's when I went to Huduma center in Meru town and acquired one and listed my child in it and I saw its benefits You know men are hard headed because I told my husband to renew the NHIF card, but he didn't see its need. They are very difficult to convince…" MTP11 IF

As found in this study, some women found it difficult to pay health care since they were depending on their husbands, as demanded by culture, but the latter were not paying the required premiums. Similar results were also recorded by Fenny et al. (2016) in Ghana that the dependency on the husband's support was an obstacle to health insurance enrollment since wives needed permission from their husband to purchase insurance. A study done in Coastal part of Kenya described the same phenomenon where wives await on husbands to decide on the fate on the family, health insurance included (Akubakar, 2013). However, from the result of this study, some women were empowered and challenged this culture. We believe that this empowerment results from several aspects of the political will of the Kenyan government that seeks to modify or adapt social and cultural patterns in order to achieve the elimination of prejudices and practices against women. Moreover, women empowerment is a central key point to the 3rd UNSDG (EQUALITY, 2010). The women should be able to make decision related to their lives in several aspects and be part of the household decision making process. Despite the presence of societal and structural beliefs and practices that undermine the women at many levels, these ladies did not stop since the lives of their loved ones were

endangered. Similar results to this study were found in Zambia where women, despite the presence of social challenges, were more willing to be engaged in household decision making which would result in more utilization of healthcare facility. The more educated they were, employed and wealthier, women had more decision-making power in their household (Boateng, Mumba, Asare-Bediako, & Boateng, 2014). This reflects that the societal and structural barriers can be overcome if women are given the same chances as men in life.

4. 3. 5. Following example of purchasing insurance: peer influence

Many participants were motivated to take up health insurance by seeing the example of others who were enrolled. Some saw that other patients were able to be discharged from hospital without calling for a harambee or selling property and recognized that this was a consequence of having health insurance.

> "...if they know of someone who has been assisted by the health insurance it's when they start getting the essence of the insurance when it's too late..." MTP6 IM

> "…Most do not have. Butafter they heard that NHIF cover will be paying for my health care costs some have acquired the health insurance…." MTP3 IM

> '…. There are two things; one being influence from other people who told me its importance. The second thing is that the wife to a colleague of mine happened to get sick, she went to hospital and the medical expenses were high Ksh 70,000 but the NHIF catered for the expenses then I thought to myself that the NHIF is very important if I also get it..." MTP11 IM

This study found that some members were motivated to enroll or not in health insurance because of peer influence. They enrolled because a friend or a family member was enrolled. For those who were not insured during their hospital stay, they were also considering enrolling in health insurance since they have been noticing their fellow patients being discharged without any problem because they had insurance. This was very important because those who were able to enroll due to peer influence probably avoided falling in in the categories of those who were to do catastrophic expenditure on health while poor. This should be set an example to those who have a health insurance to talk to their relatives and neighbors about the benefits of having insurance.

Cofie, in Burkina Faso, found similar results, that persuasion by friends or relatives was associated with health insurance uptake (Cofie, P., De Allegri, Kouyate, &Sauerborn, 2013). In Thailand the sustainability of health insurance was correlated with peer influence or family members' influence (Supakankunti, 2004). In Senegal, the enrolment was strongly linked with having (or being told by) a family member or a friend who had already enrolled in health insurance (Mladovsky, 2014). This was like a report published by the World Bank. Through quantitative data analysis, they found the motivation to enroll or not in community-based health insurance was associated with the number of friends or family relatives in the scheme (Alkenbrack, Jacob &Lindelow, 2013). Asomani in Ghana also confirmed the same (Asomani, 2014). Masengeli (2017) in Kenya found that having one or more relatives insured was associated with insurance uptake.

4.3. 6 Health is not a priority

4. 3. 6. 1Misconception of value

Both insured and noninsured participants noted that they knew people who were unaware of the existence of medical insurance and how to obtain it and of its benefits. The participants in this study mentioned that among other reasons hindering people from acquiring health insurance were lack of awareness and ignorance.

> "…It's due to lack of adequate education and knowledge, they lack enough information about the health insurance… My relatives who are elderly will say they won't get sick, so it is not of much importance." MTP4 IM.

Some of the noninsured people deliberately chose not to enroll despite the awareness and the high out pocket payment. They did not recognize value in having health insurance.

> "I don't get the time to go and enroll in it. I usually say I will get one but the year comes to an end before I do. I feel like I have lost the money but since there is no alternative I just have to pay, This is when a person who is contributing to the scheme and he never gets sick, they say that it is a waste of time and money so instead of contributing they opt to pocket the money to alternatively buy something else" MTP13 NIF

> "those that have children with good financial status know that there's no need to get medical cover since their medical costs will be paid for by their children" MTP 15NIF

> "You have a family you have to take care of all the issues in the house, yeah, so being the bread winner, you just have to plan for the Ksh 500. You know the family doesn't get sick each and every day. So, the Ksh 500 that I'm supposed to

pay maybe this month if I'm not sick and my family member is not sick then the Ksh 500 is put into another use. People tend to like to put their money where they think even if they don't get sick maybe they can get a refund".MTP18 NIM

4. 3. 6. 2 Economic priority

All participants in this study unanimously responded that economical prioritization was among factors that hinders people from acquiring health insurance irrespective of their socio economic and income status. This feeling was shared among both insured and noninsured participants. Allfelt that the monthly cost of the premiums was difficult to afford for workers in the informal sectors, but they also felt that the penalties associated with delays of paying the premiums were high. Most of the participants prioritized other family expenses higher than medical insurance. In the context of limited income, they felt that medical insurance expenses were not justified while their extended families needed their support, which is culturally seen as a responsibility they have to honor. Some of the participants understood and were willing to get the insurance but were unable because they have other extended family responsibilities.

> " I have been trying to get health insurance but after school, hustling, usually you don't get enough so you balance what you get….when you are hustling you have to decide whether you'll put food on the table or whether you'll buy insurance" MTP13 NIM

> "my monthly salary is so little for my expenses and I heard the monthly contributions are Ksh 500. For me that amount is so much" MTP 17 NIM

> "...You'll get for me I'm supposed to pay Ksh 500 every month; you find that some can't come up with such amount in a monthly basis since they need to buy

food for the family. For some families it will be difficult since other expenses are inclusive in the little income they get. I'm saying in some families it might not be possible because you have children in school who need school fees and food, so you end up without saving…" MTP3 IM

Most of the uninsured participants felt that the cost of monthly payment was too high to allow them to participate in health insurance schemes. The majority were doing traditional farming which generally does not generate much discretionary money. This situation was complicated by the penalties associated with defaulting or late payment. They felt that the insurance premiums were too much money to pay monthly while they had other family issues to deal with. Most of the participants choose to prioritize what to do depending on what is needed at that time they get a little amount of money. This feeling cut across both insured and non-insured. The hardship endured by uninsured people make them prioritize food, schooling and basic needs that are daily needed at their level and hope for not getting sick. It is sad because the poor put their fate in luck and the fate does not respond to their hope. They often get sick due their extreme bad living conditions and thus require medical attention on regular basis.

"The Ksh 500 is a lot of money. I usually use it to feed my family and my siblings. I also pay school fees for my siblings" MTP16 NIF

Asomani (2014) observes that uninsured participants expressed the inability of raising the required amount for the premium even if they were willing to enrol because they had other responsibilities that required immediate attention rather than health insurance. Some of his informants had to drop out from health insurance schemes since they could not keep up with the required premium contributions.

The findings in Asumani's study were not isolated, but rather shared similarities with other studies done in the same country, such as Fenny et al. (2018). In these studies, the inability to pay the required minimum premium represented the greatest challenge to enrolment. Fadlallah et al (2018) in his systematic review of barriers to implementations of CBHI in low-and middle- income countries found that the amount and timing of premium collection was reported to negatively influence enrolment. De Allegri (2006b) also found that lack of prioritization was associated with a low uptake of insurance from the majority of non-insured people.The above findings bear similarities with several studies done in Kenya. These studies included Kiplagat et al., 2013, Nguru, 2018; Kimani et al, 2012; Masengeli, 2017; Ndung'u, 2015 and Kipaseyia, 2016 whoevaluated the barriers to penetration and uptake of health insurance. Affordability was mentioned as one of the main factors. All these authors' informants mentioned struggling to raise the monthly fee required for premiums because it was expensive, and they had other cultural - economic responsibilities which were viewed as family priorities.

4. 3. 7. Traditional healers

The findings of this study about traditional herbal medicine use were mixed. Some participants, whether insured or not, completely disagreed with the use of traditional herbal medicine, while others were willing to consider it. For some of the noninsured participants, health insurance was viewed as only important if the diseases were clearly biomedical conditions that hospitals can treat, while mental health, psycho-social, spiritual issues were better covered by traditional healers. Since the participants were Christians, they thought that herbal medicines could be used if witchcraft was not engaged. In the community, traditional medicine is used by the elderly people who grew up in the era of its more common use. One participant said that people believed that

scientific medicine was a white man's way, so they would go into the forest to look for traditional medicine there. It was not clear from this study whether the use of traditional herbal medicine was associated with lack of means to get health insurance or cultural practice though there was a strong inclination towards cultural practices.

> "…Depends with the situation. Where one cannot get health services and the healer is available then it's okay because both have the same end result which is to heal." MTP2

> "some people talk of how they are sick and yet they cannot go to the hospitals but just to the witchdoctors because they say they are not natural illnesses but curse or being bewitched". M TP19 NIM

> "Even due to culture in the past there are people who used to believe in traditional and herbal medicine although they still exist people don't strictly adhere to them since they have been educated. People in the past eras did not believe in hospitals but in the god of kirinyaga who they believed that if they prayed to him, he will heal them, and the formal medicine was a white man's way so they would go into the forest to look for traditional medicine there. MTP15 NIM

In this study, the participants who agreed that formal health care was useful did refute the utility of traditional herbal medicine. However, Asomani noted that people who hold beliefs that diseases are caused by unknown spirits may not see the need for health insurance and are likely to seek health care outside formal health care, such as the traditional herbal practitioner (Asomani, 2014).

A study by the World Bank found that some households from low income countries, especially in rural areas, continued to use traditional healers irrespective of their socioeconomic status. The study compared insured people and noninsured on the use of traditional healers and found that both groups used traditional healers, but that non-insured spent more on such healers than insured (Alkenbrack, Jacobs &Lindelow2013). This reflects the cultural beliefs inclination in traditional healers rather than the lack of means to afford to pay the premiums of health insurance uptake.

In Fenny's study (2016), some of the noninsured participants said that they did not see the need to enroll in health care insurance scheme since they rare got sick. When they did become ill, they used herbal medicines and found them to be effective. In Mauritania among factors assessed to be associated with persistent low uptake and dropping of health insurance, traditional medicine took the third position (PSSD, 2002). People preferred to either treat themselves or visit traditional healers in the community. De Allegri et al (2006) in Burkina Faso said that people who associate disease causation with spirituality were less likely to take part in health insurance. When asked about cultural taboos or beliefs that hinder uptake of health insurance, the respondents in Nairobi said that people still practice herbal medicine (Gitau, 2013).

4. 3. 7 Chieftaincy

When asked about what could be done to increase the uptake of health insurance in the community, one participant suggested that community leaders could be used as advocates and agents of health insurance companies because the communities listen to their own leaders.

> "as I told you I am qualified to be a community leader and people listen to me. If I tell them to enroll, many will listen others will not" MTP6 IM

This study noticed that community or traditional leaders play a major role in the promotion and accessibility of health services in general to their local communities. This is true because community/traditional leaders are viewed as the gurus and have the final word on matters that affect their members. They serve as the link to the people and convey message from different organs of the government to the people. These traditional leaders are influential in their respective communities and they have the ability to bring change. In Meru region, the traditional council of Elders known as Njuri-Ncheke, is a very influential a group of traditional and community leaders that are influential across the entire Ameru community. They influence socioeconomics, judiciary and politics in the country (Mburugu& Macharia, 2016). These community leaders can be used to influence the communities to understand the use of health insurance. Fenny et al. (2016) noted that when the leadership system is strong at the community level, the traditional leaders will influence and recommend uptake of health insurance schemes to their community members and make sure that what is needed to enroll is available. If the leadership is found to be weak, it will create a loophole for the insurance companies to take advantage of the vulnerable poor people who in return make no effort to enroll or renew their membership in the scheme.

4. 3. 8. The presence or absence of health insurance changes the social dynamics

Some patients indirectly mentioned that absence of health insurance was a source of family and community dissociation in moments of need. One patient said that her family members did not come to visit her when she was hospitalized because they feared to pay for her hospital bill since they were unaware that she had health insurance. As mentioned above, local politicians and community members may dissociate themselves from people

without health insurances and may not attend events related to fund raising, events that are normally viewed as a source of social cohesion.

> "…For instance, in our area, all politicians say they should not be invited to a harambee for hospital bill since health insurance is there for that purpose…" MTP1 IM

> "…. If you have the health insurance, it helps so much. Like when I got admitted my relatives never visited me because they thought I have no health insurance and I decided not to tell them… they thought if they visited me, I would ask for money. I cleared my child's bill alone using the card and even today I will just clear the medical bills using my health insurance card and will not ask them for any money. That's why it is very useful…" MTP11 IM.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter covers the summary, conclusions and recommendations from this study.

5.2 Summary

This study aimed to explore cultural beliefs, behaviors and practices that could influence health insurance uptake or withdrawal. Several cultural beliefs with potential influence on health insurance were expressed by the participants. Religious beliefs, cultural beliefs that saving for health insurance is inviting evil or a bad omen, traditional medicine use, and social solidarity events such as harambee were among described findings. Though not described as a cause to low uptake but as an impact of non-enrollment, health insurance was described as a source of change to social dynamics.

With regard to religious beliefs, participants from this study reported mixed findings. There are beliefs that uptake of health insurance was associated with lack of faith in God or inviting evil. However, these beliefs did not affect their decision to enroll in health insurance since many people who held those beliefs had health insurance and most of those who were uninsured denied also being associated with such. Some church leaders played a role in influencing their members positively to enroll in health insurance while other church leaders negatively influenced uptake as described in the findings.

Regarding patriarchal culture, the study found that many of the participants were motivated to enroll in health insurance schemes due to cultural expectations for a husband to provide for and protect their family members. The husbands enrolled to accomplish their cultural responsibilities. This study also noted that this belief negatively

affected women who depended on irresponsible husbands. Many of the participants said that despite the good will to buy health insurance, they had competing responsibilities with limited low income hindering them to acquire health insurance.

As pertaining to peer influence, this study noted that having a friend or a family member who had health insurance was associated with an uptake of health insurance. Some participants were motivated by their peer's experience with health insurance.

Most participants denied the use of traditional healers or herbal medicines. However, they knew people in the community who are using traditional healers because they believed some diseases are caused by spirit. Such people usually don't see the need of health insurance. Some participants said that the use of herbal medicine without witchcraft is as potent as modern medicine.

All the participants categorically refuted the use of harambee as a recommended form of health insurance. They said that is was an old practice that is currently being campaigned against by government officials and disliked by the community. However, some older people in the community were described as people who still believe in harambee as a form of community health insurance. Some uninsured participants were described as having no other choice besides calling for a harambee.

5.3 Conclusions

Cultural beliefs and practices still have a limited but significant effect on health insurance uptake. These cultural beliefs and practices are multifactorial, some affecting health insurance uptake negatively, and others affecting uptake positively. The findings from this study are not to be generalized to other regions of Kenya but should create opportunities for future studies to assess the magnitude of cultural influence on health

insurance. As the Government of Kenya is committed to achieving universal health coverage through the provision of health insurance, any factor or determinant with potential to be an obstacle to this goal should be evaluated and addressed. Because some religious sects continue to teach their members not to use medical insurance, these sects should be researched as well.

5.4 Recommendations

5.4.1 Policy recommendations

i. Identify and use targeted influential people in the communities (religious leaders, local authorities) to be the agents and advocates of the National health insurance.

ii. Local authorities should encourage the religious leaders to educate their members about health seeking behavior in general and health insurance specifically. Religious leaders should regularly remind their members to enroll and renew their health insurances. The religious leaders should show examples by enrolling in health insurances.

iii. To work closely with traditional healers/herbal medicine in order to promote Health insurance uptake.

iv. Use of insured people from local communities as they will serve as example of having benefited from being insured. We encourage the public to learn from their peers who are insured of the benefits of having health insurance.

v. Those with capability to support their family members, to help them by paying their Health insurance since they will not get bankrupt by doing so but they can be bankrupt by paying hospital bills of their relatives and attending multiple community harambees.

vi. Clinicians when managing a patient without health insurance should do a quick diagnosis of where the patient belongs in terms of beliefs related to insurance and counsel the patient accordingly.

5.4.2 Recommendations for future research

i. This study found that religious beliefs and relying on prayers for preventive and curative health was associated with an inclination to avoid acquiring health insurance. Church members or sects holding those beliefs should be studied to evaluate their role in promoting negative attitudes towards health insurance uptake in the community.

ii. This study was done in a faith-based hospital which is a private institution where most people who visit the hospital would either have insurance or have money to pay for health care. Subsequent studies should engage different hospitals including private and public hospitals, as well as people who do not use medical facilities.

iii. Among the limitations of this study was language. Subsequent studies should be done at the community level using local dialect as the main study language. This will help to capture information that could have been missed in this study done in Swahili and English.

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APPENDICES

Appendix I: Consent to Participate in a Research Study

Title of Study: Influence of Culture on Health Insurance Uptake at Chogoria Mission Hospital.

Investigator:

Name: **Boaz Niyinyumva** **Phone:** O724352380

Research assistants:

Name: **Elisabeth Smith** **Phone:** 0796140009

Name: **Eliphas Mutegi** **Phone:** 0723782755

Introduction

- You are being asked to be in a research study of effect of culture and social beliefs on health insurance.
- You were chosen as a possible participant because you may be positively or negatively affected whether you have or do not have a health insurance
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to identify cultural and social belief that may have an impact on obtaining health insurance.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you will sign consent, then we will do an interview in which we will record what you say so that we can transcribe it later. We will do the interview in the office to keep the confidentiality. The interview will take 20-45 minutes. It will be done once only.

Risks/Discomforts of Being in this Study

- As it is now, there appear to be no risk or expected **Benefits of Being in the Study**
- We expect no direct benefits for your participation in this study however we believe that the result of this study may trigger a large study that can change policy in regard to health insurance.

Confidentiality

- This study is anonymous. No identifying information will be published.
- The records of this study will be kept strictly confidential.

Payments

- You will not be paid by participating in this study. However, you will be given a small token after the study (Tissue paper- 2 rolls pack).

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you.You may refuse to take part in the study *at any time* without affecting your relationship with the investigators of this study or the hospital. Your decision will not result in any loss or benefits to which you are otherwise entitled. Youhave the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process; additionally, you have the right to request that the interviewer not use any of your interview material.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. Should you have more questions about the study, contact me at Boaz NIYINYUMVA at boazsis@gmail.com or at 0724352380. You can also contact Kabarak University Institutional Review and Ethic Committee at 0724887431 and irecsecretariat@kabarak.ac.keIf you like, a summary of the results of the study will be sent to you using the above contacts.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Subject's Name (print): ____________________________ Date: ________________

CODE Assigned:

Subject's

Signature/Thumb Print:

Investigator's Signature: ______________________ Date: ______________

Witness' name for those who cannot read/code:

Witness's Signature/Thumb Print:

Appendix II:

Part One: General Information

Informant's details:

Patient's hospital number (to be kept confidential):

Assigned Code Number for Study:

Future Contact Information (to be kept confidential):

Age:

Gender:

Female: Male:

Home area:

Marital Status:

Married: Divorced: Single:

Level of education:

Primary school: Secondary school: College: others:

Employment: Informal: Formal: None:

Income: (Give brackets for selection)

Religion:

Tribe:

Part Two: Questions

Q1: Tell me about yourself.

Q2A: How often do you get sick in a year?

Q2B: If you have a family, how often do your family members get sick in a year?

How have you/family paid your health bills?

Q3A: What do you know about health insurance?

Q3B: Do you have any health insurance? (If no go to 3D, if yes go to 3C.)

Q3C: (If yes to 3B) What were your motivations to get it?What are some of the reasons hindering people from acquiring health insurance?

Q3D: (If no to 3B) What are some of the reasons people do not acquire health insurance

Q4: What are the reasons why you don't have health insurance?

Q5: What do you think about saving money to buy health insurance?

Q6: What do your family/elders think about the needs and benefits of health insurance in case of illness?

Q7A: Are there some cultural or social practices or beliefs that may prevent you from getting health insurance?

Q7B: Some people believe that saving for health insurance is like calling "bad" into someone's life. What do you think about it?

Q8: What are your spiritual beliefs about the relationships between God/gods, spirits and illness; and the need for health insurance?

Q9A: Is a "harambee" a better option/strategy than health insurance?

Q9B: Do you see a "harambee" as a form of community insurance?

Q10: What are your beliefs about sicknesses?

Q11: How do you feel about using traditional healers instead of having health insurance?

Q12: Why do some people **not** obtain health insurance?

Q13A: How would you pay for health care if you did not have health insurance?

Q13B: How have you paid for health care costs in the past?

Q13C: What are your plans to pay for future health care costs?

Q14: Are there any other ideas about health insurance that you would like to share

Appendix III : Consent to Participate in a Research Study in Kiswahili

Kichwa cha Utafiti: Ushawishi wa Utamaduni kwenye Ushauri wa Bima ya Afya katika Hospitali ya Chogoria Mission.

Utangulizi

• Unatakiwa uwe katika utafiti wa utafiti wa athari za utamaduni na imani za kijamii juu ya bima ya afya.

• Ulichaguliwa kama mshiriki iwezekanavyo kwa sababu unaweza kuathiriwa au kuathiriwa kama una au hauna bima ya afya.

• Tunakuomba usome fomu hii na uulize maswali yoyote ambayo unaweza kuwa nayo kabla ya kukubali kuwa katika utafiti.

Kusudi la Utafiti

• Kusudi la utafiti ni kutambua imani ya kitamaduni na kijamii ambayo inaweza kuwa na athari ya kupata bima ya afya.

• Hatimaye, utafiti huu unaweza kuchapishwa kama sehemu ya karatasi iliyotolewa na mahitaji ya kitaaluma.

Maelezo ya Utaratibu wa Utafiti

• Ikiwa unakubali kuwa katika utafiti huu, utaulizwa kufanya mambo yafuatayo: utasaini makubaliano, basi tutafanya mahojiano ambayo tutaandika kile unachosema ili tuweze kuandika baadaye. Tutafanya mahojiano katika ofisi kuweka siri. Mahojiano itachukua dakika 20-45. Itafanywa mara moja tu.

Hatari / kutokuwepo kwa Kuwa katika Masomo haya

• Hakuna hatari inayoonekana (au inatarajiwa). Kunaweza kuwa na hatari zisizojulikana.

Faida za Kuwa katika Masomo

- Tunatarajia faida yoyote ya moja kwa moja kwa ushiriki wako katika utafiti huu hata hivyo tunaamini kwamba matokeo ya utafiti huu inaweza kusababisha utafiti mkubwa ambao unaweza kubadilisha sera kuhusiana na bima ya afya.

Usiri

- Utafiti huu haujulikani. Hatuwezi kuchapisha au kuhifadhi maelezo yoyote kuhusu utambulisho wako.
- Kumbukumbu za utafiti huu zitahifadhiwa kwa siri. Rekodi za tafiti zitahifadhiwa kwenye faili iliyofungwa, na habari zote za elektroniki zitafichwa na kuhifadhiwa kwa kutumia faili iliyohifadhiwa nenosiri. Hatutajumuisha taarifa yoyote katika ripoti yoyote ambayo tunaweza kuchapisha ambayo itafanya iwezekanavyo kutambua wewe.

Malipo

- Hakuna malipo / malipo ya kushiriki katika utafiti huu. Hata hivyo, utapewa ishara ndogo baada ya kujifunza (pakiti ya karatasi ya tishu-8)

Haki ya Kukataa au Kuondoka

- Uamuzi wa kushiriki katika utafiti huu ni kabisa kwako. Unaweza kukataa kushiriki katika utafiti wakati wowote bila kuathiri uhusiano wako na wachunguzi wa utafiti huu au hospitali. Uamuzi wako hautakuwa na upotevu wowote au faida ambazo huna hakika. Una haki ya kujibu swali lolote, na pia kuondoa kabisa kutoka kwa mahojiano wakati wowote wakati wa mchakato; zaidi ya hayo, una haki ya kuomba kwamba mhojiwaji asitumie nyenzo yoyote ya mahojiano.

Haki ya Kuuliza Maswali na Ripoti Mahangaiko

- Una haki ya kuuliza maswali kuhusu utafiti huu wa utafiti na kuwa na maswali hayo yamejibiwa na mimi kabla, wakati au baada ya utafiti. Ikiwa una maswali zaidi kuhusu utafiti huo, wakati wowote usihisi huru kuwasiliana na mimi, Boaz NIYINYUMVA kwenye boazsis@gmail.com au kwa simu nambali 0724352380. Unaweza pia kuwasiliana na Kamati ya Chuo Kikuu cha Kabarak na Kamati ya Maadili kwa 0724887431 na irecsecretariat @ kabarak .ac.ke .Kama unapenda, muhtasari wa matokeo ya utafiti utatumwa kwako kwa kutumia anwani zilizo hapo juu.

Kibali

- Saini yako hapa chini inaonyesha kuwa umeamua kujitolea kama mshiriki wa utafiti wa utafiti huu, na kwamba umeisoma na kuelewa taarifa iliyotolewa hapo juu. Utapewa nakala iliyosainiwa na dated ya fomu hii ili uendelee, pamoja na vifaa vingine vya kuchapishwa vilivyohitajika na wachunguzi wa utafiti.

Jina la Somo (kuchapisha):

CODE Iliyochaguliwa:

Sahihi ya Sura / Thumb Print:

Ishara ya Mpelelezi: Tarehe:

Jina la Shahidi kwa wale ambao hawawezi kusoma / msimbo:

Ishara ya Shahidi / Thumb Print:

Appendix IV: Interview guide in Kiswahili

Sehemu ya Kwanza: Maelezo ya Jumla

Nambari ya hospitali ya wagonjwa (ihifadhiwe siri):

Nambari ya Msimbo uliopangwa kwa Utafiti:

Maelezo ya Mawasiliano ya Baadaye (kuzingatiwa siri):

Umri:

Jinsia:

Kike: Kiume:

Eneo la nyumbani:

Hali ya ndoa:

Ndoa: Talaka: Moja:

Kiwango cha elimu:

Shule ya msingi: Shule ya sekondari: Chuo: wengine:

Ajira: isiyo rasmi: rasmi: hakuna:

Mapato: (Patia mabaki kwa uteuzi)

Dini:

Tribe:

Sehemu ya pili: Maswali

Q 1.Niambiekuhusu Maisha yako.

Q 2a. Unaugua Mara ngapi Kwa mwaka?

Q2b.. Una familia/Jamii?

Katikafamiliayako, watuhuugua Mara ngapi Kwa mwaka?

Mliwezajekulipagharama za hospital?(UnawezakuwekaKatikamakundi)

Q3a..UnajuaninikuhusubimayaAfya?

3b.. Je una bimayoyoteyaafya?

(kamaniHapanaNenda 3d) Kama Ni NdiyoNenda 3c)

Q3c kama Ni Ndiyo 3b.. Ni nini kilikuvutiakupatabimayaAfya? Ni sababu gani huwazuia watu kupata bima ya afya?

Q3d.. Kama Ni Hapana 3b) Ni sababu gani husababisha watu kutopata bima ya afya?

Q4..Ni Kwa sababu gani Huna bima ya afya?

Q5..Unafikiri nini kuhusu kuhifadhi fedha Ili uwezekupatabimayaafya?

Q6..Familia yako, au wazee, wanafikirininikuhusuuhitaji au umuhimupamojanafaida za bimayaafyaikiwadharulayaugonjwaitatokea?

Q7a..Je! Kunamila au mambo ya Kawaida yaki jamii, au imaniambayoinakuzuiakupatabimayaafya?

Q7b..Baadhi ya watu huamini kwamba kuhifadhi fedha kwa sababu ya bima ya afya ni sawa na kuita mambo mabaya katika maisha ya mtu. Wewe unafikiri nini kuhusuhilo?

Q8..Unaamini ninikatikarohoyakoKatikauhusiano, katiya MUNGU namiungu, au RohonaMagonjwa, namahitajiyabimayaafya?

Q9a.. Je! Harambee ni njiaNzurikulikobimayaafya?

Q9b..Wewe unaona harambee Ndio mpango wa bima ya afya Katika jamii?

Q10..Wewe una aminininikuhusuMagonjwa?

Q11..Wewe unahisijekuhusukutumiauponyajiwajadibadalayakuwanabimayaafya?

Q12..Kwa ninibaadhiyawatuhawanabimayaafya?

Q13a. Ungewezakulipakwanjiaganigharama za Matibabukamahungekuanabimayaafya?

Q13b..Ulilipashilingi ngapi KatikaMatibabuwakatiuliopita?

Q13c.. Una mpangowakulipashilingi ngapi KatikaMatibabuwakatiujao?

Q14 Je! Kuna ushauriwowote, au mawazo kuhusu bima ya afya ungependa kushirikisha Wengine?.

Appendix V – NACOSTI Research Authorization

NATIONAL COMMISSION FORSCIENCE, TECHNOLOGY ANDINNOVATION

Telephone:+254-20-2213471,
2241349,3310571,2219420
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When replying please quote

9thFloor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/19/77701/28551**

Date: **11th March, 2019**

Dr. Boaz Niyinyumva
Kabarak University
Private Bag - 20157
KABARAK.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of culture on health insurance uptake at Chogoria Mission Hospital."*** I am pleased to inform you that you have been authorized to undertake research in **Tharaka Nithi County** for the period ending **11th March, 2020.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Director of Health Services Tharaka Nithi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Tharaka Nithi County.

Appendix VI: IREC Approval

KABARAK UNIVERSITY

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

P.O. Private Bag – 20157 Kabarak M: +254 724 887 431 F: +254 51 343 529

www.kabarak.ac.ke/irecsecretariat.html E: irecsecretariat@kabarak.ac.ke

4th April 2018

Reference: KABU01/IREC/002/VoL1/2018

Formal Approval Number: KABU/IREC/002

Dr. Boaz Niyinyumva,
Department of Family Medicine and Community Care
Kabarak University. **KABARAK. KENYA.**

Dear **Dr Niyinyumva,**

FORMAL APPROVAL.

The Institutional Research and Ethics Committee reviewed your research proposal titled:

> ***"The influence of Cultural and Social beliefs on Health Insurance Uptake: A Case Study in Adult Hospitalized Patients at Chogoria Mission Hospital."***

Your proposal has been granted a Formal Approval Number**: KABU/IREC/002** on 4th April 2018. You are therefore permitted to start your study.

Note that this approval is for 1 year; it will thus expire on 3rd April 2019. If it is necessary to continue with this research beyond the expiry date, a request for continuation should be made in writing to KABU IREC secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you MUST notify the committee of any proposal change(s) or amendment(s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The committee expects to receive a final report at the end of the study.

Yours faithfully,

Dr Wesley Too,
Chairman
KABU Institutional Research and Ethics Committee.

C.C: - Registrar- Academic Affairs and Research
- Dean SMHS
- Director Institute of Postgraduate Studies
- HoD Family Medicine

Kabarak University Moral Code

As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Kabarak University is ISO 9001:2015 Certified

Appendix VII: Introduction Letter

INSTITUTE OF POST GRADUATE STUDIES

Private Bag - 20157
KABARAK, KENYA
E-mail: directorpostgraduate@kabarak.ac.ke

Tel: 0203511275
Fax: 254-51-343012
www.kabarak.ac.ke

21st Jan, 2018

The Director General
National Commission for Science, Technology & Innovation (NACOSTI)
P.O. Box 30623 – 00100
NAIROBI

Dear Sir/Madam,

RE: RESEARCH BY BOAZ NIYINYUMVA - REG. NO. GMMF/M/1203/9/15

The above named is a Master of Medicine in Family Medicine student at Kabarak University in the School Medicine and Health Sciences. He is carrying out research entitled **"Influence of culture on health insurance uptake at Chogoria Mission Hospital, Tharaka Nithi County".** He has defended his proposal and has been authorized to proceed with field research.

The information obtained in the course of this research will be used for academic purposes only and will be treated with utmost confidentiality.

Please assist him to obtain a research permit.

Thank you.

Yours faithfully,

Dr. Betty Tikoko
DIRECTOR - (POST-GRADUATE STUDIES)

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