



## **Influence of Culture on Health Insurance Uptake Among Patients at Chogoria Mission Hospital, Tharaka Nithi County**

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### **Abstract**

The government of Kenya plans to largely finance Universal Health Coverage (UHC) through the National Health Insurance Fund (NHIF). However, most of the Kenyan population do not have health insurance cover. Studies have identified four main reasons why individuals are not registered for any form of health insurance: affordability, value, relevance and process. 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 study used 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: Chieftaincy, religious beliefs that purchasing health insurance is a lack trust in the healing power of God and calling bad omen, patriarchal culture, traditional medicine use, peer influence in purchasing insurance and Harambe as factors that might have an influence on health insurance uptake. This study affirms the other studies on cultural influence on the uptake of health insurance. However, unique to this study; health insurance was associated with family and community dissociation. The results of this study need to be explored more in details in other settings. This study suggests that most reasons of non-enrolment are hinged on cultural motivation at various level and degrees.

**Keywords:** culture, health insurance

### **Introduction**

The world health organization stated that every human being in the world needs access to health care regardless of his or her income status. This 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 this 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 highest in Lower-Middle-Income Countries (LMICs) (WHO, 2015).

The concept of health insurance is growing in LMICs 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).

Kenya offers social National Health Insurance Fund (NHIF) to the informal sector besides the mandatory cover for the formal sector. (GOK, 2017). However, the uptake of health insurance is still low. 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 which ultimately funds UHC(WHO, 2010). Health financing system is an essential component of UHC but progress toward UHC also requires coordinated actions across the pillars of the health system.

Currently, only around 20% of the Kenyan population is covered by any form of health insurance, and of those covered 3% live below the poverty line. The low uptake was attributed mainly to affordability, relevance, value and process (Zollmann&Ravishankar, 2016). However, removing financial barriers does not necessarily translate into access and utilization of health care facility; perhaps, it may be complicated by other factors such as cultural beliefs and practices. Studies done in other countries on culture and social beliefs reinforce this assumption. (De Allegri, Sanon,&Sauerborn, 2006; Fenny, Kusi, Arhinful, & Asante, 2016; Asomani, 2014). In some cultures, taking up insurance or setting aside money for care is perceived as a bad omen (De Allegri, Sanon, &Sauerborn, 2006). Abibakar 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 behaviours and utilized both traditional and modern medicine options.

## **The Problem**

Health insurance was sought as key to financing UHC in Kenya, however, health insurance uptake is low. Zollmann&Ravishankar (2016) identified four main reasons as to why individuals are not registered for any form of health insurance: First, inability afford the monthly insurance payments. Second, perceived 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. Third, ignorance on the relevance of the scheme for themselves. For instance, some thought that health insurance was arranged for special people such as civil servants. Fourth, people were not willing or able to negotiate the administrative process of enrolment.

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 vendors/brokers at the hospital where insurance could be obtained. Uninsured patients are potentially at risk of catastrophic spending. This study sought an in-depth understanding of cultural practice and beliefs that affect enrolment in health insurance for practical solutions to minimize or if possible, eliminate them.

## **Objectives**



1. Describe cultural determinants related to health insurance uptake.
2. Describe the influence of culture on health insurance uptake.

## **Literature Review**

### **4. 1. Culture and health care**

Culture has various definitions in literature as captured by various authors. (James Spradley 1984; Redfield,1940; Spencer-Oatey, 2008) For this study, when we say culture, we mean cultural beliefs, behaviours and practices as derived from the UNESCO definition (2011). 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. (de C Williams, Willott, Wilson, & Woolf ,2014, p.1630). 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.

### **4.2 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. Studies have highlighted a cultural inclination that setting money aside for healthcare may be perceived as attracting diseases (De Allegri, Sanon, &Sauerborn, 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, Criel, &Van der Stuyft, 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 (Ama et al, 2016 and Akubakar et al, 2013). Kenya has several options in healthcare financing and advocates for social health insurance which prevents catastrophic healthcare financing (MOH, 2012). Despite this the uptake of health insurance in Chogoria is low.

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 was 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, 2013).

## **Methodology**

The study used a purposive sampling to recruit participants from inpatient and outpatient departments over a period of 3 months at Chogoria Mission Hospital. The study deliberately sought patients with and without insurance to more fully understand why patients chose to purchase insurance and why they didn't. 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. Recruitment of participants was done by direct contact with patients meeting the inclusion criteria. We included patients from medical wards, surgical wards and obstetrics–gynaecology wards and the outpatient clinic. Patient aged 18 years and above, medically stable as assessed by the primary caregiver or the triage nurse, able to communicate in either English, Swahili; and who signed an informed consent to participate in the study were included. The study excluded high school students and patients who did not reside in the Meru region. Only one patient was recruited and interviewed per day and total of 20 patients were interviewed.

Data collection was done through face to face interview using a voice recorder and semi structured guided questionnaire. Data collection was done by four research assistants who have been involved in previous research at the hospital but were also trained to how to conduct this research. The four-research assistant were local natives who understand both local culture and fluent in both Kiswahili and English languages used in this study. They were trained and supervised by the research author and co-authors.

A pilot study was done in order to evaluate the interview questions and prompts. The pilot study also evaluated the skill of the research assistants in conducting the interviews. A total of six interviews were done for the pilot study, two in English and four in Swahili. The pilot study helped refining questions and disqualified the main research from conducting the interview since not speak Swahili well. The original interview guide was developed in English and translated into Swahili by an English -Swahili teacher, verified by the research team for semantic meaning.

Data analysis was done using manual data analysis and inductive approach from raw material. The recorded data was transcribed and translated into English by professionals when required. 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,1998).

The researchers declared no conflict of interest. The Kabarak University Institutional Review Coard (IREC) approved the study as well as the National Commission for



Science, Technology and Innovation (NACOSTI). Participants were provided an information sheet, and an informed consent form was signed by the participant before starting the interview. 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.

## Results

### Bio 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. Sixteen participants were natives of the Meru region and four were either married to a Meru native or working in the Meru region.

Table 1: Bio Data

Characteristics		N
Gender	Male	12
	Female	8
Age group:	18-34	9
	35-50	7
	51-69	4
Marital status	Married	16
	Single	2
	Divorced	2
Religion	Christian	19
	Other	1
Employment:	Informal	13
	Formal	7
Origin:	Meru	16
	Other	4
Education:	Tertiary	5
	Other (primary and secondary)	15
Health insurance holder:	Yes	12
	No	8

### Emerging themes

After data analysis, the themes presented in the table below were generated.

Table 2: Emerging themes and sub-themes



Theme	Sub themes
1 Religious beliefs	- Religious beliefs do not conflict with health insurance -Insurance is a sign of lack of faith - Saving for health insurance is inviting evil
2 Harambee	- Health insurance is better than Harambee - Harambee as a backup plan when health insurance does not fully cover costs - Harambee is a community health insurance for old People
3 Patriarchal culture	-Husband is the provider, so insurance is unnecessary -Competing responsibilities preclude purchasing Insurance
4 Peer influence: Following other people's examples of purchasing insurance	
5 Chieftaincy	
6 Traditional healers	
7 Misconception of value	
8 Economic	
9 Absence or presence of health insurance affects social dynamics	

## 6. 2.1 Religious beliefs

### i) Religious beliefs support the purchase of health insurance

Many patients reported a connection between illness and religious belief. Some patient expressed that their religious beliefs supported the purchase of health insurance. They also acknowledged that some churches have played a crucial role in encouraging their church members to enroll in health insurance while others churches completely refuted the purchase of insurance.

*"...They are both very important. Even if you have a health insurance you'll still need to pray to God. Since you are admitted, and the health insurance will cater for the health care costs, but you still have to pray..."* Insured male patient.

### ii) Insurance is a sign of lack of faith

Several of the participants have witnessed churches and church members or other people who claim that acquiring health insurance is a sign of lack of faith in God.

*"...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..."* (Insured male patient)

*".... They say not to get a health insurance because God has insured you with the blood of Jesus..For example, there those in their churches they don't believe in visiting the hospital, in some part in Chuka there denominations known as 'karonokia' 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..."* (Insured male patient)



### **iii) Saving for health insurance is inviting evil**

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” (Non-insured female patient)*

*“It is just like my grandmother, she can’t get insurance because she believes that’s like calling sicknesses upon the family” (Non-insured male patient).*

*“... 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” (insured female patient)*

### **6.2.2 Harambee**

The participants to this study had mixed feeling about the local social solidarity known as harambee. Insured participants suggested that harambee can be used as a back plan in cases when the hospital bills are beyond what the health insurance covers. However, non-insured participants still often chose to pay their hospital bills by calling for a Harambe in their local community or through media.

*“...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”. (Insured male patient).*

*“I would call for aid using a harambee if the bill is too high or if you have a cow you can sell it...” (Insured male patient 3)*

*“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)*

One participant said that harambee is viewed by older people as a way 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... they hope for a harambee to come and help them...” MTP 3IM*

### **6.3.3 Patriarchal culture**



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. The culture empowers man and disempower women and make women dependent to their husband. Some insured participants were positively motivated by the fact they had the responsibility to provide for their families.

*"...Yes. I thought to myself that an emergency may occur to my child or me and 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*

*"...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*

Some patients experienced unpleasant consequences of depending on the husband for health-related expenses.

*"...My child got admitted in Nkubu hospital for a week, when I was told to pay for the hospital bill, I was unable, my husband had declined to make the NHIF contributions...I insisted for him to make the contributions to no success. 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*

#### **6.3.4 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.

*'...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)*

#### **6.3.5 Traditional healers**

While some participants did not approve of the use of traditional healers, others believed that they have a role to play in the health system especially when they are not associated with witchcraft. They mentioned that the use of traditional healers might be among the things hindering some people in the village to acquire health insurance, especially the elderly

*"...Depends with the situation. Where one cannot get health services and the healer is available then it's okay because both have the same 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)*

## **Discussion**

This study found described numerous cultural beliefs and practices that affect the uptake of health insurance. We organised the findings in category of 1) religious beliefs, 2) social solidarity locally known as harambee, 3) patriarchal culture, 4) Peer influence, 5) traditional healer. The findings of this study are consistent with studies done in other country where health seeking behaviours and practices reflect the social norms, religion of the members of the community.

Our findings regarding the influence of religious beliefs on health insurance are consistent with findings from studies done in other African countries. This was consistent with the findings by Asomani in Ghana where a sect called Gvikiikoko was teaching its followers not to enrol in health insurance because they believed it was associated with lack of faith in God. Asomani noted however that leaders from some other churches were encouraging their members to enrol in health insurance (Asomani, 2014). Baidoo and Bus observed the belief that buying health insurance implies inviting sickness (Baidoo and Buss 2012).

From the respondents of this study, it appeared Harambe was an acceptable sort of community health insurance or a kind of social solidarity. The participants said that these days some people were not willing to be invited for harambee since they have their own problems. Irrespective of this knowledge, noninsured participants in this study were still hoping for family and community contributions for their hospital bill. Asomani found that it was difficult for a sick person to get financial support from more distant relatives, even in a culture that believes that it is important to help the most vulnerable members of the nuclear family (Asomani, 2014). This is like the findings of Aboderin (2004) in which he agreed that traditional support networks were growing weaker.

Patriarchal culture in our studies empowers men and disempower women. Most of the participants who are insured were motivated by that cultural responsibility. Previous studies in some countries of Africa found similar beliefs. In Ghana, a study found that marital status 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 (Duku, Nketiah-Amponsah, Janssens, & Pradhan, 2018). 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 (Masengeli, Mwaura-Tenambergen, Mutai, & Simiyu, 2017; Akubakar et al, 2013)

This study found that some members were motivated to enroll or not in health insurance because of peer influence. The result is similar to others found in other countries. Cofie, in Burkina Faso, found similar results, that persuasion by friends or relatives was associated with health insurance uptake (Cofie, De Allegri, Kouyate, & Sauerborn, 2013). In Thailand the sustainability of health insurance was correlated with peer influence or family members' influence (Supakankuni, 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).



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. 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 non-insured 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 (Alexander, 2003). 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 only.

### Recommendations

The paper recommends the stakeholders to identify and use community champions (religious leaders, local authorities, traditional healers, insured champions) as agents and advocates of the National health insurance.

### Conclusion

Cultural beliefs and practices influence 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 culture on health insurance in various setting ups.

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