

AN IN-DEPTH INSIGHT INTO THE HOUSEHOLD AND HEALTHCARE FINANCING IN RURAL AND PERI-URBAN HOUSEHOLDS IN KAKAMEGA AND KISUMU

A BASELINE QUALITATIVE REPORT OF I-PUSH PROJECT



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Acronyms and Abbreviations

APHRC	African Population and Health Research Center
AIGHD	Amsterdam Institute of Global Health and Development
AMREF	African Medical Research Foundation
CHVs	community health volunteers
IDI	In-depth interview
i-PUSH	Innovative Partnership for Universal Sustainable Healthcare
LEAP	mHealth learning platform
M-JALI	Mobile Jamii afya link
MTIBA	mHealth
MNCH	Maternal Newborn And Child Healthcare
NHIF	National Health Insurance Fund
UHC	Universal Health Coverage
SDGs	Sustainable Development Goals

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Executive Summary

About 100 million of the world's population is driven into extreme poverty due to ill health and lack of access to quality healthcare. Governments prioritize to ensure that the population accesses essential health services without facing financial hardships through a renewed international commitment to implement Universal Health Coverage (UHC). The i-PUSH program is a collaborative partnership between AMREF Health Africa and PharmAccess Foundation to actualize access to affordable quality healthcare by improving the healthcare infrastructure, community health volunteers' (CHVs) knowledge, and access to health insurance for the population in Kenya through innovative mobile technologies. This study aimed to provide a deep insight into the household and healthcare financing in rural and peri-urban communities in two Counties (Kisumu and Kakamega) in Kenya to provide evidence on the perceptions of populations to health insurance, saving for health, and health-seeking behavior of communities in such contexts. This was to provide a basis for more research on the feasibility and sustainability of health insurance use and impact on health outcomes for the populations in the study settings, as well as to inform the programming of the i-PUSH program and UHC implementation.

The key findings from the study showed that many women in the study sites did not have a steady income, which limited their decision-making power in the households on what to prioritize. This unsteady income influenced the saving culture, whereby most women only saved when the money was available. Household needs were mentioned as a major motivating factor for saving. The majority took no deliberate effort to save for healthcare as access to healthcare was for free due to UHC in Kisumu and Oparanya care in Kakamega, or use of Linda Mama (free maternal healthcare) that only required a registration fee (KES 100). Paying for healthcare insurance premiums was considered a challenge due to the low income of the population. Access and utilization of healthcare services were based on the perceived severity of the disease, affordability, availability of health services, and adequate healthcare staff. Cultural and religious contexts to healthcare utilization were also mentioned as determinants of seeking healthcare, where spiritual prayers, use of herbs, or herbalists could be preferred for some diseases/illnesses.

The implications of the findings include:

- The source of daily cash flow for the households influences the decision-making power of women in the households including what to prioritize.
- Saving culture is widely practiced but more prioritized for household needs than for health-related expenses.

- Willingness and ability to pay for health insurance are challenged by access to free healthcare and low-income earnings.
- Preference for specific healthcare pathways depends on social, economic, and cultural factors.

1. Background to the study

Under the Sustainable Development Goals (SDGs), there has been a renewed international commitment to Universal Health Coverage (UHC), which aims at ensuring populations have access to the health services they need without suffering financial hardship in paying for them. However, currently, there are significant resource shortages and service delivery gaps in many countries. As a result, more than half of the world's population still lacks access to quality health care [1] and about 100 million people fall into extreme poverty each year due to ill-health [2]. Governments need to undertake systemic reforms in both the management and organizational structure to translate commitments to UHC into a reality. Consequently, the Kenya Government has included UHC as one of its 'Big Four Agenda' points that will lead the country's health system transformation by 2022 [3]. The enabling conditions to achieve this premise of universal health coverage include low-cost health insurance schemes, e-health, and mobile health services.

AMREF Health Africa and PharmAccess jointly support the Government to achieve the goal of UHC in selected Counties in Kenya through its Innovative Partnership for Sustainable Healthcare (i-PUSH) program. i-PUSH is a collaborative program that provides the National Health Insurance Fund (NHIF) SupaCover at a subsidized cost to low-income women of reproductive age and their families in Kakamega and Nairobi Counties in Kenya. The program utilizes innovative digital tools developed by both partners to enhance access to affordable and quality health care. Community Health Volunteers (CHVs), who are the first point-of-contact for the program, make use of AMREF's Mjali (Mobile Jamii Afya Link) tool for digital registration of household information and the mobile phone-based LEAP tool for training. The LEAP employs an appropriate mobile learning approach to train and empower health workers using their mobile devices operating from any phone enabling the health workers to learn at their own pace, and with their own mobile devices while in the community, providing both interpersonal and community aspects of learning [4]. Through i-PUSH, women can save for health on their mobile phone, using PharmAccess's "health wallet". The health wallet runs on the digital platform—MTIBA. MTIBA records their health care utilization at registered clinics and allows for easier patient tracking, channeling of health funds, and ultimately doctor-patient communication. In Kisumu, moreover, the implementation of UHC, where registered households access healthcare for free in public health facilities using their UHC cards, PharmAccess has been supporting this initiative by registering households using MTIBA, and at the same time, developing a socio-economic mapping of the population.

To maximize the effectiveness of their program, AMREF and PharmAccess need to have a deep understanding of access to health services, households' health-related decision-making, and out-

of-pocket health care expenditures in their target populations. The main aim of the study is to understand in-depth the health care utilization, in particular related to maternal and child health, and financing of out-of-pocket health care expenditures as Kenya rolls out UHC in Kisumu and is supported by the i-PUSH program of PharmAccess and AMREF in Kakamega.

In the i-PUSH program, households receive 100% subsidies of the NHIF insurance premium totaled at KES 6000 per household. In the second year, the households receive 50% subsidies of the NHIF premium and they pay 50% using the money saved in the Mtiba health wallet. In the third year, the program expects the households to have saved enough to take up the 100% payment and continue thereafter. The 100% subsidies in year one are expected to show households the benefits of insurance. The 50% co-payment and the support for savings are expected to install a habit of savings. Nevertheless, findings from implemented i-PUSH areas show that only a few of them saved enough for the next year. AMREF and PharmAccess are working on new approaches that could be more effective in targeting subsidized health insurance to those who cannot afford the full premium, while at the same time introducing new incentives to save for co-payments for those who can afford them.

2. Study objectives

Main objective

The main objective of the overall study is to understand in-depth the maternal and child health (MNCH) health care utilization and healthcare financing in the two study areas of Kisumu and Kakamega.

The main aim of the qualitative component of the study is to gain a deeper understanding of the perceptions and behaviors of low-income reproductive-age women on financial savings, health insurance, and health care utilization. The qualitative data shed light and more understanding of the motivations, drivers, and obstacles to MNCH healthcare utilization and healthcare financing in the target population in Kakamega and Kisumu Counties.

Specific objectives

- i) Describe the saving culture of the populations in the UHC implemented area in Kisumu and i-PUSH area in Kakamega
- ii) Explore the perceptions of women to health insurance use in the intervention areas in Kisumu and Kakamega.

- iii) Highlight the health-seeking behavior of households in the two intervention sites in Kisumu and Kakamega

The key themes guiding the qualitative component are how people save, how they pay for healthcare services, their perception of saving and use of healthcare insurance, and if this affects their healthcare-seeking behavior.

3. Methods

Study approach

The study was conducted in September 2019. The methodology consisted of in-depth interviews (IDIs), and focus group discussions (FGD) with women who were either pregnant or had a child less than 2 years in the two study sites – in line with the i-PUSH eligibility criteria. A total of 20 IDIs and 3 FGDs based on saturation level were conducted. The study used purposive sampling and worked with community health volunteers (CHVs) to mobilize the participants who were eligible and willing to participate.

Study site

The study was carried out in two Counties, Kakamega and Kisumu. In Kisumu, the team carried out the interviews in Kisumu East and Kisumu Central. In Kakamega, the team carried out the interviews in Butere, an area where i-PUSH had been implemented since 2018.

Sampling and sample size

The CHVs mobilized eligible women in the two study areas. The women who were willing to participate were grouped either into a focus group discussion or into a one-on-one interview. The project team carried out interviews in a convenient place for the participants and in an environment that provided privacy and confidentiality.

The table below shows the sampling size for qualitative data collection

Study area	FGDs	IDIs	Total Participants
Kisumu	2	10	27
Butere, Kakamega	1	10	20

Instruments

The exploratory qualitative study used semi-structured guides for the FGDs and the IDIs. The questions focused primarily on providing depth on the daily cash flow for households, perceptions of saving, saving specifically for health, healthcare-seeking behavior, perceptions on MNCH healthcare utilization, and gender dynamics in decisions on healthcare insurance and utilization. The semi-structured guide is provided in the appendix section.

Training of field workers and piloting

The project team interviewed and trained qualified individuals from the study area on qualitative data collection methodology, research ethics, and the review of data collection tools. The trained field workers carried out a pilot of the tools in the two study areas to ensure that the tool flowed well and the field workers were able to conduct the interviews successfully. Debrief after the pilot was done to discuss and address any arising issues on the tools, the participants, or the field environment. The tools were adjusted accordingly.

Management of data quality during fieldwork

The project team supervised the piloting of the qualitative tools and the initial data collection. One individual in Kisumu and one in Kakamega who showed leadership skills was put in charge of the team for the remainder of the data collection. The project team carried out consistent monitoring of the data collection process to ensure that the field team adhered to the guidelines set. Qualified transcribers were tasked with transcribing the audio-recorded discussions verbatim. The project team conducted a data review workshop to review the transcripts and to compare coding. This ensured consistency in the application of the codes in the codebook. The codebook is attached in the appendix.

Qualitative data analysis

The project team developed a codebook using the qualitative guide as the main theme. The transcripts were uploaded to the Nvivo software. The project team revised the codebook based on the recurring information (themes) in the transcripts. The transcripts were coded under themes (primary/parent nodes) and sub-themes (sub-nodes). Any emerging information was coded under emerging themes. Different analyses were done including queries using different sources and nodes. The data was presented in the form of charts, treemaps, weighted averages, and coded quotes.

Ethical considerations

The study received approval from APHRC's internal ethical review committee and AMREF AFRICA Ethical and Scientific Committee for external review of the protocol. The field team received training on research ethics and the conduct of research among human subjects. All researchers working on this project had training on ethics in research to ensure that all protections expected of study participants are accorded to the participants and the information they provide. All interviews were conducted in privacy and no identifying information was included in any analysis or reports; all data was anonymized to protect the identity of respondents. The participants received a unique code during the analysis.

Informed consent

To adhere to the protection of the rights of humans in research, the field team administered an informed consent that detailed the research and asked for their consent to participate. Participants were given or read for an information sheet describing key project information, the purpose of the research study, possible risks and benefits to them as participants, details of confidentiality to expect, dissemination plans for the data, and contact details if they required further information.

Voluntary Participation: Under the ethical process, the project team ensured that the participants understood that their participation was voluntary and that they were free to refuse to participate, with no risk of repercussions, free to withdraw at any time during the data collection process, free not to answer any question that they deemed uncomfortable to answer.

Confidentiality: The participants were informed that the information they provide would be treated with the utmost confidentiality. The information collected from the participants was anonymized using a unique identifier. The data is only accessible to the project team and kept in a password-protected computer.

Risks and measures to minimize them:

We did not anticipate any risks to the participants as the information required was mainly on the health service delivery, financial savings, and health insurance utilization. We however managed to minimize the risks by being as forthcoming as possible on the project description and the ethical process. In the case of minimal discomfort as a result of personal and sensitive questions, the field team endeavored to ensure that the participant was given ample time to compose themselves, reassure them of confidentiality and ability to stop the interview if they were not able to continue with the interview.

4. Findings

General description of the women interviewed in terms of the socio-demographic characteristics is highlighted below

Socio-demographic characteristics	Kisumu	Kakamega
Average Age	20-40 years	15-35 years
Marital Status	Married (18), Single (9)	Married (12), Single (8)
Pregnant or with Child	Pregnant (5), With child<4 (22)	Pregnant (10), (With child< 4 (10)
Employment status	Mostly small business owners or casual laborers	Mostly farmers and small business owners

The findings are presented in the 4 key themes as highlighted above

Daily cash flow

This section describes the source of daily cash flow for the households interviewed. The source and quantity of the daily cash flow depended on the type of employment the respondents engaged in and the financial support they received.

In Kakamega, 12 out of 17 women indicated that family members, mostly parents, and siblings, were the main sources of daily cash flow. Nine women indicated that they received additional financial support from their spouses or their baby's father. The spouses were reported to engage in casual employments such as being hired to farm other people's land, motorbike riders, construction workers, or in small businesses (e.g., Jua Kali traders (informal sector traders). Three women engaged in small businesses including selling food items and four women engaged in casual livelihood activities (e.g., house help and hired to farm other people's land). Married women used their earnings to supplement household needs. Most women indicated that they made their own decision on how to spend their earnings.

“Let me tell you, for me no one monitors me on money because I look for money even when my father comes, he just adds me I also tell this is what I have saved but everybody decides for himself/herself (IDI mother, Kakamega).

However, a few mentioned that either they decided jointly with their spouses or the spouse or parent decided on the use of the money.

“Moderator (M): Okay. When he gives you this money, how do you spend it or who decides on how it should be spent in terms of what to buy...Respondent (R): It's him...M: It's him that tells you what to buy with that money! R: Yes...M: There is no day that you have

decided to buy this and that in the house? R: I decide but I tell him like buying baby clothes...M: Okay but it's him who dictates what to buy...R: Yes (IDI mother, Kakamega)

In Kisumu, the daily cash flow for the households mainly relied on the spouse as most of the women were married. Most spouses engaged in the Jua Kali business (informal traders), though one spouse was formally employed. Women participants indicated that they supplemented the needs of the household by engaging in small businesses such as tailoring, selling cooked food, selling clothes, and washing clothes for other people. Three participants were formally employed, though two had left their jobs after getting pregnant and giving birth. Nine participants indicated that they were supported by their families—parents and siblings. These women were either single or lived with their parents. Some of the women interviewed experienced financial challenges including losing their jobs/businesses after getting pregnant or giving birth leaving them no option but to rely on their spouses or family for daily needs in households.

“Sometimes men are stubborn and they cannot leave anything in the house, and since we were disadvantaged, I did not go to college, and not well off, so I do ask for help from my parents, my uncles, they understand me” (FGD participant, Kisumu).

“We have other men, who when they give you money he budgets for it, and we have others who don't give you any money, he buys flour or food by himself. When he leaves KES. 10. that is for water, then when he comes in the evening, he comes with everything” (FGD participant, Kisumu).

One participant who was a single parent indicated that she relied on loans whenever she did not have money and repaid when she got some money.

“It's me who hustles for the money when I get even a hundred bob I will plan with that but sometimes my budget overpowers what I have. I will be forced to take items on loan then pay later” (FGD participant, Kisumu).

14 out of 25 women mentioned that they were the ones who made the decisions on how to spend their earnings. This group included either married women or those living alone or with family. Seven participants indicated that they made the decision jointly with their spouses.

“You know, a mother is the one who knows she doesn't have a spoon, saucepans, chair clothes, you are everything. So when he gives you even KES.300, It is you to decide and use around KES.250 then you save KES.50 in the Chama. So that you can buy even a basin or a sufuria” (FGD participant, Kisumu)

Household cash expenditure ranged from KES 50 a day to KES 250-500 per week both in Kakamega and Kisumu.

The culture of savings

This section provides an insight into the saving practice of the participants and their households. It categorizes the saving practice into those who do not practice it and reasons why they do not and those who practice it, and why they practice it, and how they achieve it.

Petty savers

Petty savers put something little whenever they get money. One participant indicated that she used to save occasionally in her handbag, as this would enable her to save for business but also support financially in case of needs in the household. Another participant who was a student indicated saving her pocket money on her phone (Mpesa/Mshwari) for a rainy day. Another participant indicated that she saved to support her family in the future.

“I save money so that in case I separate with my husband I can go back home and start a business. Like now we are not on good terms, I am staying at the mother-in-law's place...I save little because you know, currently, he has another wife. So the little I get I buy the babies soap” (IDI participant, Kakamega).

Planning savers

These were those savers that knew why they wanted to save and committed to saving. Some participants in Kakamega indicated saving for the future and keep saving either daily, weekly, or monthly in Chamas, Bank, Mpesa, or Mshwari. They were also motivated to save to cover school fees, healthcare expenditures, and household needs.

“Savings helps because you never know about tomorrow like there was a day I got very sick, my pressure was very high and I had to go to Kisumu and I could not work so I had my savings which I just went and withdrew and used for treatment. Even when its school fees you will not have to wait for someone to send you but instead you will use what you have like I said I do business I can afford two hundred shillings per day therefore when I have nothing I simply take my saving and start again” (FGD participant, Kakamega).

“There is a Chama (savings group?) that we play, whereby, we save 100/= on Saturday and 100/=on Wednesday...then I receive 1200/= at the end of the month...R: the challenge is that sometimes you fail to get that 100/= for paying the Chama...I use it to buy my household items” (IDI participant, Kisumu).

Those women who relied on their spouses for daily cash flow saved away some of the money from what was given for household use, thus they kept the savings secret. Some felt that if the spouse knew about the savings, they would take away the money, or stop giving them money. In one instance, one participant mentioned how after the spouse found out about the saving, she had no choice but to use the savings for household use as the spouse indicated that he did not have any money.

“You know when men know that you have money they will even stop giving you money so you do it silently the only person you can tell that you are saving is your mother because a mother is a mother” (FGD participant, Kakamega).

Extreme savers

Some participants did not have access to constant cash flow but went ahead to save the little they received from the different sources including family and spouse. These participants were committed to saving practice and only encountered challenges when they lacked money.

“I save in my bag in the house...because I know I might have a problem with which I will use the saving to help solve the situation... maybe I may lack something in the house like a matchbox, salt, oil soap and I just buy... I can save up to two hundred and fifty shillings weekly...when my husband gives me money I take part in it and save while I tell him that I have used (IDI participant, Kakamega)

A participant in Kisumu indicated that she used to save without knowing the reason for saving and as such she would use the amount saved haphazardly. This changed when she identified the purpose of saving. She was currently saving in preparation for the delivery of her unborn baby.

“I can say that it's tough to save when you don't know why you are saving, yeah... like me, I used to save but I didn't know why I was saving so I used to withdraw and use it differently. I used to save in Mshwari...but now since I know that I save for a certain purpose, I save in a lock savings account...but saving is not easy. Like I save as little as 20 shillings whatever I get I send it there” (FGD participant, Kisumu)

“I use the other money (savings) to buy more stock for clothes, and if I see it is a little amount, I keep in Mpesa so that I can collect more and keep. When it reaches a good amount I use it for buying more stock” (IDI participant, Kisumu).

Willingness and ability to save

Only one participant in Kakamega indicated that she did not save. Her reason was lack of money as she relied solely on her sister who left money for the exact needs in the house.

“All the money that I am left with is normally budgeted for with no balance, not even five-shilling...M: You said you don’t save? R: Yes...because of lack of money” (IDI Participant, Kakamega)

In Kisumu, one participant indicated that she did not work and did not have money to save. The money given to her by the spouse was used for household needs. The spouse who was in a stable job practiced saving in the bank. The savings supported the household during emergencies including illnesses.

“No, I do not save. I wanted to start saving but I will start next year. My husband is the one who saves. It is difficult to save when you have a small child because you will need to buy him clothes or other things...” (IDI participant, Kisumu)

Informal versus formal savings

The benefits of savings went beyond receiving cash in bulk to savings translated to acquiring assets. For instance, one participant mentioned that the Chama (savings club) she belonged to purchased whatever a member needed rather than giving cash. This was seen as a good investment because the participant could sell the sheep in case of financial challenges.

“In the Chama, we had a rule that when you get the KES.2000, they don’t give you cash, since we are in the market, they buy for you sheep even if is the small sheep... So, sometimes if I get problems, I can sell the sheep to earn the money” (IDI participant, Kisumu).

The perception of health insurance use

Health insurance was not a foreign word, all the women were able to identify one or more health insurance schemes. The one common convergence in perception was that healthcare insurance needed one to have some source of income. Willingness to pay for insurance was pegged on one being able to pay. The availability of free healthcare services at public health facilities lessened the motivation for women to pay for health insurance. The findings are categorized into those who use it, those who do not, and their perceptions.

Know about Insurance but not able to pay for it:

Knowledge of healthcare insurance, willingness but lack of ability to pay for the health insurance contributed to some of the participants not using healthcare insurance. In Kakamega, for example, one participant who was not using health insurance indicated that she was not able to save for anything as she did not have a source of income. She was a young unemployed woman, relied on the family for provision including healthcare needs. She attended public health facilities that provided free health services for her (Ante-Natal Care) and her 3-year-old child. In the case where she got ill, the family bought medication from 'over the counter' sources in case it was not available at the hospital.

In another case, the participant who identified herself as a casual laborer, and her spouse as a motorbike rider, indicated that though she had heard about NHIF and Linda Mama, she had not registered for either. She mentioned that the household paid out of pocket for any healthcare expenditure.

A participant in Kisumu, who had worked as a casual laborer with a spouse that was formally employed indicated that the household has been surviving on out-of-pocket expenditures. In the case when there was an illness incident, the participant opted to go to the prison hospital that was nearby, or in most severe cases, diverted money from household needs to healthcare expenses. The household had just been registered on NHIF and the participant was optimistic that they would not need any more out-of-pocket healthcare expenditures.

"In that case when the child is sick and I do not have money, I go to the prison hospital where they treat for free and prescribe for you medicine to buy...sometimes when the child is sick, I go without eating just to make sure the child gets well" (IDI participant, Kisumu).

For those participants who knew about health insurance and its benefits, the ability to pay for health insurance impeded access and the use of health insurance.

"I would prefer NHIF, only that I am not capable of saving on NHIF. Another reason of preference is that when you have NHIF you can visit a good hospital, not these other weak hospitals" (FGD participant, Kisumu)

If I don't have anything to pay for treatment, I can borrow the madam whom I normally wash clothes for her. Then work for her next time for free to repay the debt...or, I borrow from the rich people, then I tell them next time I will wash clothes for free (IDI participant, Kisumu).

Benefits of health insurance

22 women out of the 27 interviewed indicated using healthcare insurance. The preferred health insurance was the ones available from the Government including Linda Mama for maternity care and Oparanya care which, was initiated by the Kakamega County Government. The participants indicated being motivated to save and use health insurance by the benefits they got such as savings from healthcare expenditure and increased finances for household needs and the freedom to visit any health facility as this had initially been impeded by financial constraints.

I would say that it has helped us especially when it comes to maternity because some of us could not afford then we could stay in the hospital for long just because of lack of money to pay for the service, so the Linda mama is helping (FGD participant, Kakamega)

“The changes that I have seen are that the money we used to spend in Hospital day in day out, it’s not the case anymore since I use Mtiba. I am not lazy to go to the hospital anymore like I used to be those days. It was a must that you have cash during those days” (IDI participant, Kakamega)

Three participants who had registered with NHIF under i-PUSH indicated that it helped, as they did not have to pay for health services upfront.

“Do not care about insurance”:

Among the participants In Kisumu, one participant who sold second-hand clothes, and the spouse was formally employed, indicated that they pay for healthcare using cash. The participant further indicated that she had savings on Mpesa and used it in case of a healthcare emergency. She seemed to know the benefits of using health insurance, especially the UHC, though the household was not currently using any. She mentioned that the spouse had registered for UHC but was yet to pick up the card.

Challenges in health insurance use

There were many challenges mentioned that impeded the use of health insurance. The inability to pay the premium for health insurance by some of the participants who were not financially stable. There was also the perception that health insurance was unreliable, with one participant giving the example of a health facility indicating that the insurance was not adequate to cater for their health treatment.

“I used NHIF when I was sick until it reached a point where I was told NHIF cannot help me...I was using my Mum’s NHIF and we were told that she had not been paying. I was asked if I had KES 100 to register for Linda Mama and I did...Linda Mama is good, it doesn’t have many questions like when did you last pay” (FGD participant, Kakamega)

“NHIF has a lot of challenges, sometimes you are suffering from pressure or any other ambiguous disease and you will be told it only covers 10% yet you don’t have any other means..(FGD participant, Kakamega)

“I had saved for my firstborn child in Mtiba, when he got sick I took him to Butere and I was told that the cards had not come and I asked them why yet the money was paid. They (Mtiba people) had paid 9000 shillings and I was to continue and so far I had paid 1500 shillings and they insisted that there were no cards, that is when I started experiencing challenges with Mtiba” (FGD participant, Kakamega)

The challenges of using digital platforms were mentioned by two of the women interviewed. This included not being able to access healthcare through the insurance system and the possibility of paying into the wrong number for mobile payments.

“You can easily miss out on a digit and go to someone else when paying through the phone especially when using an android phone. Some penalties come with late contributions of 250 shillings, so that is why people who are of low standards like us find that money being too much. You can be paying for a full year without using it instead you are just paying for other people, yet when you go to the hospital you are told that money is not enough to offer certain treatment” (IDI participant, Kakamega).

“Even, I was thinking, since I am in the (Chama), I want to register for it then I start paying the money. Because I missed the one for the government (UHC). So I want to have the NHIF card...because I went to ask if they can register me for UHC but they said the registration is over. Even if I register and get the card here at Kisumu when I go back to Homabay, the side of Oyugis the card will not be used, so it is better when I register for NHIF because I will use it even when I go back to Oyugis”.(IDI participant, Kisumu)

Perception of healthcare financing

One key finding on saving was that competing needs in the household especially for food had taken precedence followed by health. In seeking care, participants opted to go where they could afford it. In some cases, depending on the type of illness and its severity, the participants opted

for health facilities where they could get the care needed and in good time. The majority of the participants used free healthcare insurance and only used savings or out-of-pocket money in circumstances where a service was unavailable under a specific type of insurance.

As for me, there are some diseases where I visit Russia (Public hospital) for treatment...whereby it is free. For some diseases, I visit Doctors plaza (hospital) for treatment because my child suffers from asthma and when he gets pneumonia, they will do all the tests and treat faster than Russia...when I visit Doctors plaza (Hospital) I use cash” (FGD participant, Kisumu)

“We receive free treatment but when you have complications like which I did and it required a scan I did, I had to pay...I don’t save for treatment, in case of anything I just get money and use it. I also use Linda Mama and I have not seen any challenges” (FGD participant, Kakamega)

Healthcare utilization and health-seeking behavior (pathways to healthcare)

Participants used different pathways to seek care during episodes of sickness for themselves and their families. The majority of the participants indicated that the first point of care was usually the use of drugs available at home or purchased over the counter. The decision on where to go for healthcare depended on the nature and severity of the illness, who was sick and financial capability. The pathways are shown below.

In one pathway, some participants resorted to first use drugs purchased over the counter and if the severity increased, the sick individual was taken to the health facility

Home  **over the counter medication**  **Health facility**

“For instance, if the child refuses to go to school, I will let him sit back home then I monitor him for a while, when I discover that the condition is getting worse, I go with him to the chemist to given painkillers. After two days when the situation is still bad then I take him to the hospital” (FGD participant, Kisumu).

“There are drugs that I must have in the house so that when the child has malaria, I can easily give him. I bought them in the hospital”. (FGD participant, Kakamega)

Other participants who felt like some of the illnesses were either not so or believed that prayers worked best, used the following pathway. The participants who used this pathway only sought healthcare in the health facility when the illness persisted.



“I don’t like visiting the hospital because of the long queues, so I always pray first in the house, since some sickness is not normal. So I just pray, when it gets worse that is when I visit the health facility. (FGD participant, Kisumu).

“My husband does not go to the hospital when he is sick, since he is a pastor, he will just pray and go to work. In the evening, he comes back saying he is feeling okay...when the pain has persisted, that is when even if he was away, he will just text me on how he is feeling and I will pray for him” (FGD participant, Kisumu)

“For me, I go for prayers and when you have faith that problem, disturbing the baby will just disappear” “My Three-year-old baby used to cry a lot and I was told to take her for prayers, which I did and now she is doing well”. (FGD participant, Kakamega)

For other participants, the type of health problem experienced influenced their health-seeking behavior. Some opted for over-the-counter medicine and or the use of home therapy like taking of warm or hot water. These options appealed more when the illness episode occurred during the night when access to a health facility was not possible. The health facility was also an option when the illness persisted



“You can buy Panadol to get relieved from the chemist...when it’s a stomachache you can boil water with salt then drink, It reduces pain...If it persists you will have to go to the hospital” (IDI participant, Kakamega)

“When my baby has a fever I give her Panadol if it’s at night though I don’t like giving the baby drugs without being tested from the hospital when morning comes I go to the hospital” (FGD Participant, Kakamega)

“For me, I have used when the baby was born and was crying and you are told to give warm water I had to do so” (FGD participant, Kisumu)

According to a few participants, majorly from Kakamega, some conditions could not be treated at the health facilities. In such cases, the participant would either use herbal medicine only or go to the facility and if the condition worsened, seek a herbalist.



“If the child is suffering from Vihoho (evil spirit), during breastfeeding his/her mouth is very hot. As a mother you will feel it...the child will not eat but crying every time...this creates swelling and a wound in the child’s mouth that even he cannot eat. I just search for herbal medicine from the garden. When the pain exceeds, that is when I take her to a herbalist. It is not advisable to take the child to the hospital when he/she has those conditions because they might inject him/her, and the child might leave you (die)” (IDI participant, Kakamega)

Decision making in healthcare use

The majority of the women in both study sites indicated that they were the ones who decided to seek healthcare, especially when it involved the health of children. The decision of the spouse or the family was prioritized mostly whenever cash was required to pay for the treatment, in the instances the spouse was not in a position to pay, they sought care in public health facilities that offered free healthcare services.

“I can decide and also my husband can decide...but my husband decides mostly... M: Is there a difference between husband and wife making decisions? R: Yes...because he might tell you to first wait, not knowing the child is very sick. As a mother, I am the one who will have known the condition of the child. when the child is sick, I have to take him to hospital, because he will pay the bill, but if the child is sick and I have not taken him to hospital, he will be slow in giving money for health expense” (IDI participant, Kakamega)

“I decide because a mother understands her children well and she is around them all the time. The moment one falls sick she will easily identify that my child has a problem. When I discover that my child is sick I will make the decision” (FGD participant, Kisumu)

Preference in healthcare Utilization

Participants from Kisumu preferred to attend facilities for various reasons including availability of services, staff attitude, and duration to be treated. The facilities visited were either public or

private. Preference for public health facilities was due to the free services offered under UHC in Kisumu or Linda Mama insurance applicable to both Counties.

The participants who preferred private health facilities mentioned the availability of timely and quality services as a major factor in their decision.

Mine is an example, my brother fell sick of amoeba and we took him to Russia referral hospital. At the hospital, they carried out several tests for a long time while we were waiting. But just after finishing the tests, he was given Amoxylin and Panadol. I cried. Therefore, another person was just told to go to the Oasis (private hospital). So we went to Oasis, they did the tests afresh, that is when he got healed (FGD participant, Kisumu).

I go to Russia (Public) hospital, but you can wait for long hours. For instance, they just give patients numbers, from 1-30, if you receive number 31 onwards, they tell you to come the next day. Again the following day they do the same, so you might find at the end of the day that you cannot access health care due to the long Queue (FGD participant, Kisumu)

“ Right now there is an anti-malarial drug for the children that are supposed to be given out, but I doubt if that dispensary has it, the doctors are not there the doors are open but with no doctors, I have taken my baby there thrice but there were no services given” (FGD participant, Kisumu).

For the participants in Kakamega, Oparanya care introduced by the County Government of Kakamega enabled the women to access free maternal health services. The main reasons given for preference of a health facility were availability, affordability of services, and accessibility to the facility.

“Treatment is also good because my baby was sick one day and took him to Shistava. For two days the baby was playing while the next two days the baby is sick again so when I took the baby to Butere I was told the baby has no enough blood and the baby was added blood and got well” (FGD participant, Kakamega)

“I go to Shistava...It is near and getting drugs is easier because they give you for free... Butere has long Queues and the road to shitsava is good” (IDI participant, Kakamega).

5. Implications of the Findings

Daily Cash Flow

Women in the two study sites do not have stable and steady cash flow and the majority rely on their spouses or small businesses such as farming for other people and selling vegetables and cooked food. This reliance on other people's income means that the decision power on how the money is spent in the household is partially made by the provider of the steady cash flow. It would also be good to note that majority of women were empowered to make or contribute to decisions in the household on the usage of the daily cash flow.

Financial savings

The majority of the participants practiced saving. This was mainly in a group (Chama) or through Mobile banking. A few saved inside their households. Due to the nature of their source of income, saving was done in small quantities depending on the little someone received during the week. The group saving assisted in bigger savings as it was more structured. Most of the savings used were for household and healthcare expenditures. Competing interests in the households meant the participants did not have flexibility in what they saved.

Some of the participants indicated saving in secret, this enabled them to grow their savings as opposed to when their spouses knew that they were saving. Considering the spouses were the source of the cash saved in some cases, it indicated that savings were not a mutual agreement or a family priority in some of the households. This means has an impact on their saving culture and availability to save due to competing interests in the households.

Health Insurance use

The majority of the participants used free healthcare insurance (Universal health care in Kisumu, Linda Mama in both Kisumu and Kakamega, and Oparanya care in Kakamega). NHIF and Mtiba were used only by a few who could afford to pay for the premiums. Saving for healthcare was not widely practiced because of the willingness and ability to pay. With the accessibility to free healthcare, there was limited willingness to pay for insurance. For the services not available under free healthcare insurance, the participants paid mostly out of pocket using the savings. It is thus important to consider the willingness and ability to pay for health insurance.

Health seeking behavior and healthcare utilization

The severity of illnesses influenced the health-seeking behavior of the participants in the two study areas. Participants opted for spiritual, herbal, and home therapy as alternatives to seeking care

in health facilities. Preference of a particular health facility depended on availability, affordability, and accessibility to health services. In capturing healthcare use and improving maternal, newborn, and child healthcare utilization, it is thus important to factor in the health-seeking behavior and the preferences for healthcare utilization.

References

- [1] World Health Organization, "Tracking Universal Health Coverage: First Global Monitoring Report - World Health Organization - Google Books," 2015. [Online]. Available: [https://books.google.co.ke/books?hl=en&lr=&id=d140DgAAQBAJ&oi=fnd&pg=PP1&dq=WHO,+Tracking+universal+health+coverage,+in+joint+WHO+/%27World+Bank+Group+report+&ots=zpKS5fJVSA&sig=1An1Dt4F6-EWFRjUK6V6QygUg5U&redir_esc=y#v=onepage&q=WHO%2C Tracking Unive.](https://books.google.co.ke/books?hl=en&lr=&id=d140DgAAQBAJ&oi=fnd&pg=PP1&dq=WHO,+Tracking+universal+health+coverage,+in+joint+WHO+/%27World+Bank+Group+report+&ots=zpKS5fJVSA&sig=1An1Dt4F6-EWFRjUK6V6QygUg5U&redir_esc=y#v=onepage&q=WHO%2C+Tracking+Unive.) [Accessed: 17-Jun-2019].
- [2] A. Wagstaff *et al.*, "Progress on catastrophic health spending in 133 countries: a retrospective observational study.," *Lancet. Glob. Heal.*, vol. 6, no. 2, pp. e169–e179, 2018.
- [3] E. Wangui and C. Kandie, "Refocusing on quality of care and increasing demand for services; Essential elements in attaining universal health coverage in Kenya," 2016.
- [4] AMREF Health Africa., "Leap, the mHealth platform." [Online]. Available: <https://amref.org/enterprises/our-products/leap/>.

Appendix 1 – Interview guide

In-depth interview/FGD guide-KAKAMEGA

Thank you for giving me time for conducting an in-depth interview. The interview is about 1) people's experiences in their financial lives including financial knowledge, health savings, health care expenditures, and 2) their experiences in the use of healthcare facilities and other healthcare providers for general health and maternal and child health (if indicated).

We are in particular interested in:

- (a) Knowledge of financial savings and insurance
- (b) Healthcare seeking behavior

Warm-up/Ice breaker question

As a **warm-up** will we would like to first ask some questions related to the composition of your household and the ways you are financially connected.

How are you? How far are you in the pregnancy (if indicated)? How old is the baby (the younger one)? How many children do you have? How many children live with you in the household? Do your parents live in your household? Do all household members share their meals or do you have separate pots?

Topic – Day-to-day cash flows

Please tell me how you get by day to day financially? *Probes: How do you make a living? Do you work? What kind of work? Does your money come in regularly or irregularly?*

I would like to find out how you spend this money and who determines how the money is spent
Probe: Decision making on spending; different ways in how money is spent

Does anyone else in the household earn a living? *Probe: the kind of work, regular or irregular payments, and the contribution of this money to the household*

Please tell me if you get financial support from other people and in what circumstance the help is given *Probe: Do you receive remittances from family members living elsewhere*

How do you normally receive the payment or financial support and the benefits or challenges of using such methods to receive payment or financial support *Probe: Mobile money, Cash, through a bank account, Mtiba account)*

Topic – Knowledge of financial savings

I would like you to tell me your opinion/s or view/s on saving money

Probe: *Different ways of saving money; Reasons for people saving money; Mechanisms of saving e.g banks, Chama, Mobile banking; Challenges and Benefits of savings*

We have just discussed what you know about saving. Now please tell me your own experience in saving money and how you go about it.

Probe:

- *Main reasons for you to save or not save*
- *Prioritization of savings e.g. healthcare, household spending*
- *Challenges you encounter in your effort to save?*
- *Where do you save (if you save), at what intervals, and what amount do you save?*

How do you manage financially when you suffer financial hardship due to for example major illnesses, food shortage, lack of employment, death in the household?

Probe: *Own savings, Relatives' contributions, Loans, Harambee (how often does this occur in the community? Do you ever call a Harambee? Do you ever contribute to a Harambee? What are the reasons to contribute/not to contribute), Income*

Topic - Healthcare Seeking Behavior

In this section, we will ask about major illnesses you suffer from, your healthcare-seeking behavior, and your expenditure on major health problems.

Please describe common illness (es) you and/or your family suffer from and how you get relief before deciding to go and seek healthcare services

Probe:

- What are the common illness (es) you suffer from?*
- Who else in the household suffers from this illness (es)?*
- What are the common ailments that affect the children in the household*

-What do you do to find relief from the illness (es) before seeking healthcare? E.g. herbal remedy, natural remedy (diet, soups), spiritual healers

Please tell us your experience in accessing healthcare services and where you go to access the health services you need *Probe: Health facilities including (formal healthcare settings (public and private facilities), Informal healthcare settings including traditional healers, spiritual healers, over the counter medicine at chemists or local shops).*

How do you choose where to go? What are the reasons why you prefer certain providers over others? *Preference factors including; better quality (good services, staff attitude), affordable and accessible, travel time, availability of medicines, and recommendations by significant others*

Topic – Decision-making for health care utilization

Please tell me who decides on utilizing healthcare in the house when you or someone else is sick

Probe:

- *Who generally decides on whether and where to seek care when someone is ill?*
- *Is there a difference between husband and wife in decision-making?*
- *What about health-seeking behavior for the children? How do these decision-making processes within your family affect access to health care? ...Of yourself and your children?*

Please tell us your experience on how you pay for health expenses when you or someone else in the house is sick (*other methods apart from health insurance*)

Probe:

- *Do you save for health expenses?*
- *How do you save for health expenses?*
- *What are your likely sources, if you can't pay for health expenditure?*
 - o *Do you get remittances for paying this expenditure?*
 - o *Have you ever received any support from others – e.g., loans, gifts, Harambee*
 - o *Would you borrow money from others? Who would you borrow from?*
 - o *Is it easier to raise money for specific expenditures than others (e.g. hospital bills vs. medication vs. pregnancy-related)?*
 - o *Is it easier to raise money for specific household members than others (e.g. children vs working adults vs old-age people)?*
- *Do you usually help out others with health costs – e.g., gifts, loans?*

- Please tell us your perceptions concerning health insurance? *Probe: Benefits vs challenges; knowledge on health insurance*

Topic –Health insurance (To be asked to participants who are under health insurance)

This section will discuss the topic of health insurance and the payment of healthcare expenditures.

Please tell us your experiences or views on health insurance *Probe: information on health insurance; benefits and challenges of health insurance, types of health insurance available; willingness to pay for insurance*

Please tell us your experiences on paying the health insurance premium *Probe: the ability to save for insurance premium; challenges you encounter in saving or to pay for insurance; the motivation/s for saving; mechanisms/ways you use to save for the premium*

Please tell me the changes you have seen in your health and that of other family members as a result of using health insurance *Probe: Healthcare facility attendance; Confidence in visiting a health facility for illnesses; Sickness episodes; Healthcare provider attitude.*

Please describe the changes you have seen in your household expenditure as a result of health insurance. *Probe: Responsiveness to caregiver role; Affordability of essentials in the home; Marital/intimate relationships in the home*

What would be your recommendations on how best you can be supported to use insurance for healthcare? *Probe: specific support needed; source of support needed*

How did you or have you managed to pay for healthcare before you received the health wallet and were enrolled in health insurance? *Probe: Out-pocket, Community contributions, Free government services, Family contributions, Health insurance*

Topic – Maternal and child Health utilization

Please tell me how your knowledge of MCH services has changed since the CHV started visiting you with information on maternal and child health services *Probe: improved knowledge on ANC, PNC, Delivery services, child care, hygiene, and sanitation.*

Please tell us your experiences in accessing and using the following MCH services:

- ANC

- *Counseling on danger signs of pregnancy*
- *Counseling on complication (if any) readiness of pregnancy*
- *Delivery services*
- *PNC*
- *Counseling on breastfeeding and vaccination*
- *Counseling on family planning*
- *Counseling on the management of child illnesses*
- *Counseling on maternal mental illness*
-

I would like us to talk about access to maternal and child health services. Please tell me your experience in accessing MCH services since your enrollment into the i-PUSH program? *Probe: Affordability, better services, staff attitude, more facility selection*

What recommendations do you that needs to be put in place to improve MNCH access in the community?

Please tell me any recommendations you have on the issue of access to health insurance and the use of MTIBA. How easy is it to use when going to a health provider? Do you have any suggestions for improvement? Any suggestions for additional support?

As we finish up, do you have any questions on what we have discussed?

In-depth interview/FGD guide-KISUMU

Thank you for giving me time for conducting an in-depth interview. The interview is about 1) people's experiences in their financial lives including financial knowledge, health savings, health care expenditures, and 2) their experiences in the use of healthcare facilities and other healthcare providers for general health and maternal and child health (if indicated).

We are in particular interested in:

- (c) Knowledge of financial savings and insurance
- (d) Healthcare seeking behavior

Warm-up/Ice breaker question

As a **warm-up** will we would like to first ask some questions related to the composition of your household and the ways you financially support one another

How are you? How far are you in the pregnancy (if indicated)? How old is the baby (the younger one)? How many children do you have? How many children live with you in the household? Do your parents live in your household? Do all household members share their meals or do you have separate pots?

Topic – Day-to-day cash flows

Please tell me how you get by day to day financially? Probes: How do you make a living? Do you work? What kind of work? Does your money come in regularly or irregularly?

I/we would like to find out how you spend this money and who determines how the money is spent *Probe: Decision making on spending; different ways in how money is spent*

Does anyone else in the household earn a living? *Probe: the kind of work, regular or irregular payments, and the contribution of this money to the household*

Please tell me if you get financial support from other people and in what circumstance the help is given *Probe: Do you receive remittances from family members living elsewhere*

How do you normally receive the payment or financial support and the benefits or challenges of using of the methods you use to receive payment or financial support *Probe: use of mobile money, cash, through a bank account, Mtiba account, etc)*

Topic – Knowledge of financial savings

I would like you to tell me your opinion/s or view/s on saving money *Probe: Different ways of saving money; Reasons for people saving money; Mechanisms of saving e.g banks, Chama, Mobile banking; challenges and benefits of saving*

We have just discussed what you know about saving. Now please tell me your own experience in the issue of saving money and how you go about it.

Probe:

- *Main reasons for you to save or not save*
- *Prioritization of savings e.g. healthcare, household spending*
- *Challenges you encounter in your effort to save?*
- *Where do you save (if you save), at what intervals, and what amount do you save?*

How do you manage financially when you encounter for example major illnesses, food shortage, lack of employment, death in the household? Where do you get the money?

Probe: *Own savings, Relatives' contributions, Loans, Harambee (how often does this occur in the community? Do you ever call a Harambee? Do you ever contribute to a Harambee? What are the reasons to contribute/not to contribute), Income*

Topic - Healthcare Seeking Behavior

In this section, we will ask about common illnesses you suffer from, your healthcare-seeking behavior, and expenditure on major health problems.

Please describe the common illness(es) you and/or your family suffer from and how you get relief before deciding to seek healthcare services

Probe:

- What is/are the common illness(es) you suffer from?*
- Who else in the household suffer from this/these illness(es)?*
- What do you do to find relief from the illness(es)? E.g herbal remedy, natural remedy (diet, soups), spiritual healers/prayers*

Please tell us your experience in accessing healthcare services and where you go to access the health services you need *Probe: Health facilities including (formal healthcare settings (public and private facilities), Informal healthcare settings including traditional healers, spiritual healers, over the counter medicine at chemists or local shops). Preference factors including; (better quality (good services, staff attitude, affordable and accessible), and recommendations by significant others)*

How do you choose where to go? What are the reasons why you prefer certain providers over others? *Preference factors including; better quality (good services, staff attitude), affordable and accessible, travel time, availability of medicines, and recommendations by significant others*

I would like to ask about informal payments, did you give the health provider any other form of gift or appreciation, were you asked to give an extra payment by the healthcare provider *Probe: does it happen often, in what form, which type of providers and what do people think about it*

Topic – Decision-making for health care utilization

Please tell me who decides on utilizing healthcare in the house when you or someone else is sick

Probe:

- *Who generally decides on whether and where to seek care when someone is ill?*

- *Is there a difference between husband and wife in decision-making?*
- *What about health-seeking behavior for the children? How do these decision-making processes within your family affect access to health care? ...Of yourself and your children?*
- *Does this differ by the person who is ill (i.e. husband, wife, children, etc.)?*

Topic –Health Insurance vs Universal Health Coverage

This section will discuss the topic of health insurance and the payment of healthcare expenditures.

Please tell us your experience on how you pay for health expenses when you or someone else in the house is sick and who decides on how much to spend on healthcare expenses

Probe:

- *Who decides on how much to pay for healthcare expenses when someone is ill?*
- *Do you or your household save for health expenses?*
- *How do you save for health expenses?*
- *What are your likely sources, if you can't pay for health expenditure?*
 - o *Do you get remittances for paying this expenditure?*
 - o *Have you ever received any support from others – e.g., loans, gifts, Harambee*
- *Do you usually help out others with health costs – e.g., gifts, loans?*
- *What do you think about health insurance?*

Please tell us your experiences or views on health insurance *Probe: information on health insurance; benefits and challenges of health insurance, types of health insurance available*

Please tell us your experiences on how to save and to use the health insurance premium *Probe: the ability to save for health; challenges you encounter in saving or to save for healthcare; the motivation/s for saving; mechanisms/ways you use to save*

Please tell us your experiences of using universal health coverage (UHC) *Probe: access to health facilities, quality of care, healthcare expenditure*

Please tell me the changes you have seen in your health and that of other family members as a result of using health insurance and or universal health coverage *Probe: Healthcare facility attendance; Confidence in visiting a health facility for illnesses; Sickness episodes; Healthcare provider attitude.*

Please describe the changes you have seen in your household expenditure as a result of health insurance and or universal health coverage. *Probe: Responsiveness to caregiver role; Affordability of essentials in the home; Marital/intimate relationships in the home*

Which one would be you prefer to use for access to healthcare services between health insurance and universal health coverage? *Why would you say so? If none of the two, which other method do you prefer?*

Recommendations on how best you can be supported to access quality healthcare? *Probe: specific support needed; source of support needed*

How did you or have you managed to pay for healthcare before you received the UHC card? *Probe: Out-pocket; Community contributions; Free government services; Family contributions; Health insurance*

Topic – Maternal and Child Health (MCH) utilization in the Universal Health Coverage

I would like us to talk about access to maternal and child health services. Please tell me your experience in accessing MCH services since your enrollment into the UHC program? *Probe: Affordability, better services, staff attitude, more facility selection*

Please tell me how the MCH services were before UHC was introduced and if you have seen any difference in the services after UHC *Probe for delivery of services, health facility attendance, affordability, and accessibility* (this is critical for those not under UHC)

Please tell me where you get information on MCH services and the kind of information you get *Probe: (Health Facilities, Community health volunteers, community barazas, relatives, media); (knowledge on ANC, PNC, Delivery services, child care, hygiene, and sanitation).*

Please tell us your experiences in accessing and using the following MCH services:

- ANC
- *Counseling on danger signs of pregnancy*
- *Counseling on complication (if any) readiness of pregnancy*
- *Delivery services*
- PNC
- *Counseling on breastfeeding and vaccination*
- *Counseling on family planning*
- *Counseling on the management of child illnesses*
- *Counseling on maternal mental illness*

Please describe any other benefits or challenges of using UHC to access maternal and child health services. Please tell me more

In your opinion, how do you think UHC can be improved to ensure that you and the community get access to quality healthcare?

I would like you to tell me about any emotional or mental stresses you have had during the pregnancy to motherhood period and how you have coped with these stresses. *Probe: Did you share your experiences with others? What are/were the enabling factors to disclose your experience/s? Is/was there any barrier not to disclose? Please tell me more*

In your opinion, would you comment on any psychosocial (emotional) support that you have received during the pregnancy to motherhood period? *Probe: Did/have you received sufficient support? Who provides/s this support (e.g., family, spouse, community, health facility)?*

As we finish up, do you have any questions about what we have discussed?

Appendix 2: CODEBOOK

1. Daily cash flow
 - i) Financial support for day-to-day living
2. The topic of financial savings
 - i. Opinion on Savings
 - ii. Importance of saving
 - iii. Challenges of saving-Disadvantages of the saving mechanisms
 - iv. The decision on how savings/money is/are used
 - v. How savings are used
 - vi. Forms of savings
3. Emergencies management strategies
4. Health-seeking behavior
5. Healthcare utilization
 - Decision making for healthcare
 - Preferences for the choice of health facility
6. Health Insurance
 - Views on health insurance (Mtiba, NHIF, and UHC)
 - Willingness/Ability to pay
 - Motivation for saving
 - Changes because of health insurance use
 - Support to ensure health insurance use
7. Maternal and Child Healthcare utilization
 - Accessibility to MCH services
8. Mental stresses and coping strategies
9. Recommendations for better MCH utilization