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Stakeholders' Views on the Strengths and Weaknesses of Family-Based Maternal Health Financing in Kisumu

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Abstract

Even with the commitment of pledges like Vision 2030 and Universal Health Coverage (UHC), considerably high maternal mortality is reported in Kenya. The purpose of this study was to structure stakeholders' perspectives on strengths and weaknesses of family-focused financing for maternal health services in Kisumu County against the background of Health Belief Model and Resource Dependency Theory. The study adopted qualitative methodology with purposive selection of 150 informants through focus group discussions (FGDs) and key informant interviews (KIIs) to yield data that were thematically analyzed. Findings reveal that financing for maternal health services is mainly informal or semi-formal modes: personal savings and families' support, or organized savings through "chamas (rotating savings groups), Male partners, extended family, community health volunteers (CHVs), church, and the local administration were identified as key stakeholders. The research found that, although formal schemes to finance maternal health care such as SHIF exist, their use is minimal, primarily due to a lack of awareness. The financial constraints prevent women, especially those from low-socioeconomic households, from timely care-seeking, while the initiative in chamas increases access to care. Ethical protocols offering informed consent and ensuring confidentiality were used to ensure that these findings arose. The family financing of maternal health care has potential; however, it is constrained by barriers linked to little use of formal financing schemes and diminishing support for CHVs role in maternal health care. The study recommends raising awareness of SHIF, including chamas in county programs, engaging males, and enhancing the work of CHVs to improve maternal health care uptake and outcomes.

*PhD.

Subject Areas

Business Finance and Investment

Keywords

Stakeholders, Maternal Care, Family-Based Maternal Health Financing, Funding Mechanisms, Health Outcomes

1. Introduction

The global attention being drawn to maternal health has been transformed into a public health priority and comprises a significant part of Sustainable Development Goal 3 which targets reduced maternal mortality and universal health coverage. For instance, through government-funded or subsidized healthcare systems, Canada, UK, and Australia have been able to record major improvements in maternal health outcomes [1] [2]. However, dispersed and inequitable insurance systems cause access inequalities in maternal care not only in developing countries but also in the highly developed ones like the US [3]. Some Asian countries like India, Bangladesh and Thailand have also laid new strategies in financing maternal health [4]. A case in point is India's Janani Suraksha Yojana (JSY) which combines conditional cash transfers with free maternal services in reducing the financial burden [5] [6]. These global testimonials affirm that much is needed in setting up sustainable and inclusive financial models to ensure that maternal health becomes accessible to the underserved pools.

Maternal health in sub-Saharan Africa is poor indeed. The region accounts for 69% of all maternal deaths worldwide and has a reported ratio of 531 deaths per 100,000 live births [7]. Hemorrhage, hypertensive disorders, infections, and unsafe abortion contribute to maternal morbidity, which is further aggravated by poor healthcare infrastructure and financial inaccessibility [8]. A majority of households resort, instead, to informal means like borrowing, community savings groups or asking for kinship support [6]. Some countries like Ghana have implemented free maternal health policies: however, the challenges associated with the implementation of these policies often limit their effectiveness, especially among rural and economically deprived communities [9] [10]. Kenya has made strides towards improving maternal health financing in its programs, such as the National Health Insurance Fund (NHIF) and the new Social Health Insurance Fund (SHIF) that was recently launched under the Taifa Care model to introduce a tiered contribution system for greater inclusivity [11]. However, possible future phasing out of donor support including that from USAID raises fears of long-term sustainability for these schemes [12] [13]. Despite the reforms going on, various stakeholders from the healthcare providers to community leaders to policymakers have different perceptions regarding the strengths and weaknesses of both formal and traditional financing systems.

In Kisumu County, economic barriers significantly hinder access to maternal healthcare for women in rural and peri-urban areas within Kisumu County. There are household financial systems such as remittances from relatives, occasional income from NGOs or government subsidies, and "chamas" which are informal savings groups [14]. However, these adaptation strategies often fail to ensure that maternal services are accessed in a timely manner. There is a well-documented literature on infrastructural issues and service delivery pertaining to maternal health [13] [15], but the perception of stakeholders, about how effective and equitable of governmental and non-governmental financing models are in maternal health at the grass-roots level, has largely been understudied. This gap calls for more research into the perspectives of stakeholders on existing financing systems, including mothers, male partners, community health workers, local administrators, and facility managers.

The study gathers these perspectives as a means of revealing operational strengths and systemic gaps within family-based maternal health financing in Kisumu County. By having an analysis of stakeholder perspectives, the study will contribute to the design of more inclusive health financing schemes which are contextually relevant. Its significance arises from supplying input to the field that includes the real-life experiences and perceptions of main stakeholders, information often neglected in existing research.

This study focuses on the concrete problems women face in receiving maternal healthcare and the complications surrounding family-based approaches to financing. The work therefore provides greater insights into the maternal health financing complications of resource-poor settings. The importance of adaptation of the existing grassroots models that could be a pathway to improving equity of access to healthcare is pronounced. Ultimately, these findings would provide a basis for the development of pruned and inclusive maternal health financing options that empower vulnerable populations with safe motherhood supports.

2. Problem Statement

Access to maternal healthcare services remains a significant barrier in many low- and middle-income countries, like Kenya, which face financial constrains that affect women's choices to seek timely and appropriate care. The problem is still persistent in Kisumu County, with governmental interventions such as free maternity services and the Taifa Care model being introduced under the Social Health Insurance Fund (SHIF) to promote access to healthcare for the underprivileged [14]. Many households depended on informal family arrangements to fund maternal care in a climate of deepening poverty, informal jobs, and low insurance coverage [16]-[18]. As donor-funded programs, previously supported by USAID, have been withdrawn, the overall environment has worsened, pressing more gaps, and additional stress on households and local health systems to finance maternal healthcare [19]. Informal methods remained central; however, there has been scant research examining their effectiveness, sustainability, or larger ramifications

within the unique socio-economic terrain of Kisumu County All the same, limited research has been conducted to evaluate these informal mechanisms in terms of their effectiveness, sustainability, or larger ramifications within the unique socio-economic terrain of Kisumu County.

While research has offered pertinent insights into formal health financing systems [17], it nonetheless has tended to focus increasingly less on these systems within institutional frameworks and policy-level analyses while disregarding the lived realities of those community members who daily engage within these systems. Nginya [20] concluded that contextually oriented inquiries that highlight the perspective of different stakeholders-those people and groups with direct or indirect involvement in decisions concerning maternal health financing-were to be prioritized. The contextual memories, feelings, actions, and social experiences of these stakeholders developed a unique perspective from which to view the financing mechanisms and their interpretation and experience at the ground level. Still, the literature on maternal health financing has glaring gaps concerning how such family-based systems were perceived regarding their strengths and weaknesses. Thus, the current study was designed to say something meaningful about the perspectives of stakeholders on family-based maternal health financing mechanisms within Kisumu County so as to create evidence for the enactment of locally responsive and socially anchored reforms.

3. Study Objectives

The specific objectives were to:

1) Identify the stakeholders involved in family-based maternal health financing in Kisumu County.

2) Establish the family maternal health funding mechanisms currently employed in Kisumu County.

3) Explore the perceived effects of such funding mechanisms on maternal health outcomes in Kisumu County.

4) Gather suggested reforms on the family-based maternal health financing mechanisms in Kisumu County.

4. Literature Review

The importance of maternal health care access was studied in this chapter, and an exhaustive literature review provided within the framework of family-based maternal health financing. The beginning of an exploration of the theoretical framework positioned these dynamics with regard to stakeholders, culminating in an empirical review of selected literature showing how different actors act and are acted upon, respectively, within maternal health financing arrangements. Throughout the literature, salient gaps were identified, particularly in relation to the strengths and weaknesses of informal and community-driven financing mechanisms.

4.1. Theoretical Framework

4.1.1. Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychosocial model that was developed to explain attitudes and beliefs of individuals in terms of their health behaviors. The model was developed by social psychologists , Hochbaum and Rosenstock in the early 1950s in order to better explain low levels of participation to screening and immunization programs [21]. It includes the six basic components: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy [22]. These constructs became important in understanding why families in Kisumu County engaged or delayed in seeking maternal health care services, particularly with reference to informal and family-based health financing. The model gave considerable insight into how perceptions shaped behaviors in access to maternal health services.

Barriers concerning the lack of financial resources were found to be the most critical factors affecting health-seeking behavior in the study. The barriers were interlinked with personal experiences, both adverse and affirmative, as well as community referrals. These beliefs and incentives, framed under the impact of economic conditions, nicely fitted into an HBM paradigm, explaining why families would not seek formal health care. It was, therefore, obvious that the understanding of individual motivations would be embedded within the larger picture of health financing.

In the design of the research, HBM was used to provide guidance on how to form the interview and focus group discussion guides to reflect the participants' perception of health risks and their understanding of how the health-care schemes worked. Such an approach would empower the researchers to explore the cognitive determinants of health behavior and thus narrow down the investigation to exactly those beliefs concerning maternal health care that were influencing decision-making behavior. By anchoring the design of the research in HBM constructs, the study was then in a position to inquire about how these perceptions really affect families' interactions with the existing health financing options.

In a data analysis exercise, thematic categorization derived from HBM constructs, which provided a systematic framework to appraise data. This method enabled the identification of perceived barriers, such as costs, lack of awareness of health insurance, and accessibility to care, that prevented families from taking up formal health care services. The analysis equally revealed perceived benefits: good health outcome and community intervention, which were key motivating factors for families toward accessing formal maternal health care services. This consideration of barriers and benefits thus relates to HBM assertion promoting the idea that perceived benefits precipitate health-related actions and affect care-seeking behavior.

The findings verified that financial barriers were most limiting for seeking care and delaying treatment. This acknowledgment reinforced the premise within HBM that perceived barriers substantially deter health-seeking behavior [23].

Likewise, community initiatives, as exemplified by savings groups, were seen as mechanisms of ameliorating such financial constraints and thereby increasing the perceived benefits of formal health services. This perspective portrays how local-organization-induced incentives enhance engagement with maternal healthcare, thus showing the applicability of HBM in appreciating the complex interplay between the perceived barriers and benefits in the Kisumu context.

However helpful the HBM was, its limitation was in failure to cover wider inquiry-path, especially being narrow in framing motivations and decision-making. The model did not adequately consider more systemic objectives along the lines of structural features of family financing for maternal healthcare and their perceived effects on health outcomes. The HBM did well in addressing individual motivations related to saving, borrowing, and community assistance, but did not expose the complex stakeholder dynamics underpinning maternal health financing. To bridge this gap, Resource Dependency Theory (RDT) was introduced into the study, which by its tenets provided a subtle understanding of interdependencies and power relationships among the stakeholders concerned with financing maternal health as illustrated in subsequent section.

4.1.2. Resource Dependency Theory (RDT)

Resource Dependency Theory (RDT) was propounded in 1978 by Jeffrey Pfeffer and Gerald Salancik, representing an adequate theoretical anchor for explaining access to maternal health care services, especially for those elements that cannot be addressed well by the Health Belief Model. Indeed, the HBM seemed to concentrate on household perception and individual motivation; the RDT emphasis is the external surroundings-assessment of power relations and resource flows determining access to maternal health services. This perspective demonstrates a comprehensive viewpoint on infrastructural and extrinsic conditions that shape family-based maternal health financing in Kisumu County. According to the RDT, influenced maternal health financing is a result of negotiated strategies by households and external agents such as government agencies, NGOs, community organizations, and informal lenders [24].

The utilization of the theory enhanced maternal health financing through qualitative research design focusing on key influences and resources impacting upon maternal health financing. Application of the model informed the key questions framing those that emerged from Key Informant Interviews and Focus Group Discussions. Data collection tools were exquisitely designed to cover household experiences as well as the wider power dynamics and interdependencies with external actors. For instance, KII guides included debate questions on the roles and influence of community leaders, NGO representatives, and health officers over resource allocation to maternal health financing. Similarly, questions for FGD were aimed at community narratives regarding access, negotiations, dependencies, and coping strategies in the various financing modalities. In this way, the research ensured that all interactional spectra, from scarcities of resources to power negotiations crucial for understanding maternal health care access through

an RDT lens-were explored.

RDT helped organize and interpret the data during the data analysis. The analysis was thematic and RDT concepts such as resource dependency, power asymmetry, external negotiating, and alliance building were used to guide the analysis. Codes evolved on how households leverage relational linkages with local savings groups, Taifa Care programs, donor-funded health interventions, and informal lenders to overcome maternal health financing barriers. It confirmed that both official and informal strategic alliances were important survival tactics, which is in keeping with RDT's argument that actors develop interdependent relationships that will mitigate vulnerability to resource deprivation [25]. Thus, in this way the study systematically investigated external factors' influence on decisions for maternal health in regard to the context beyond individual or household factors.

RDT also brought to light the power relations in Kisumu County between different actors. According to the theory, those who control scarce but necessary resources are powerful. In this case, NGOs and donor programs exerted power, rightfully so, over the terms of funding and eligibility of benefiting communities. Local government structures at the same time limited access to national insurance schemes like Taifa Care in beneficiary selection. High-interest rates from informal lenders, although flexible, showed that their credits often put households in precarious situations of debts. The conclusions showed that the differential resource access fertilized by strategic exertions of power, which is RDT's core postulate. Understanding those power structures was critical to understand who accessed maternal health care financing and who has historically been kept out.

RDT most certainly has been earnestly used in a number of studies on health access focusing on low-resource environments. For example, the work conducted by Abdi [26] in Isiolo and Imathius [27] in Samburu showed that issues of resource dependence and stakeholder dynamics determined access to health care. These studies confirm that RDT is even relevant in situations similar to that of Kisumu, thus affirming its applicability for understanding the intricacies surrounding maternal health financing.

Throughout, RDT has been beneficial, but also with limited advantages on the stability of the resource environment and inter-organizational strategies. This theory, however, still assumes relatively stable conditions that have never been the case in Kisumu owing to sporadic donor funding, countries' government programs, and exploitative informal lending-the highly dynamic scenario defied sustainability. Unstable scenarios threaten long-term sustainability for maternal health financing. Such recognition reinforces the need for multi-theoretical approaches, where RDT provides the entry to stakeholder dynamics, and HBM underpins the household-level factors driving health-seeking behavior. Such an integration allows for a much broader understanding of family-based maternal health financing systems in Kisumu County while allowing for fine-grained understanding of individual motivations and the broader structural forces at play.

4.2. Empirical Review

The section essentially explores the diverse modalities through which families finance maternal healthcare services, how such amasses ultimately enable or disable access to maternal healthcare services, and the challenges that such households experience. It also investigates the effectiveness of these interventions that have apparently been put in place to improve care delivery. The review is funnel-shaped in design starting from global, regional, national, into local studies by identifying and highlighting key themes and elements in the composition. Trends are also indicated while revealing the gaps behind such studies to dovetail emerging implications on such issues.

4.2.1. Stakeholders Involved in Family-Based Maternal Health Financing

The analysis and findings of the research conducted by Lodenstein, Ingemann, Molenaar, Dieleman and Broerse [28] on the social accountability of maternal healthcare services accessed from rural Malawi, revealed many stakeholders such as the health workers, women who are using maternal services, health committees, and community members, particularly those acting as intermediaries. These stakeholders are vital in communicating, giving constructive input, and bringing about the proper functioning of the healthcare system concerning creating maternal health outcomes. While a health worker directly appreciates a woman with health committees usually receive complaints indirectly; they talk to someone else, not the health worker, when a health worker misses work or behaves poorly with the patient. Complaints will even get forwarded through the above group of intermediaries to the district authorities or even other related bodies, ensuring that the complaints are considered or taken further towards service delivery improvement. This point brings to light the understanding of community-driven feedback systems, not only for motivating health service providers but also by improving the responsiveness of the health system. The uptake of this study at such a level would make it more effective at the local level with limited resources because both health workers and community members play significant roles in making maternal health services accessible and of good quality. Family members, especially spouses, and community-based groups such as "chamas" and Community Health Volunteers (CHVs) act as intermediaries in Kisumu County for the family contribution towards financial support for maternal care access. It has been shown in both studies from Malawi and Kisumu that these local community-driven mechanisms assess the importance of bringing the local stakeholders into the wider healthcare system to ensure that maternal health as a whole becomes more sustainable and outcome improving.

4.2.2. Existing Financing Mechanisms

Critical among the healthcare financing mechanisms are the maternal healthcare access models, which vary regarding support offered to vulnerable groups. In Kisumu County, a family-based financing approach is becoming an important access mechanism towards maternal healthcare. Previous research like the compar-

ative analysis of healthcare systems by Moisidou [29], has examined the Bismarck and Beveridge models of healthcare financing and revealed critical information on how different systems affect out-of-pocket costs and thus the accessibility of healthcare. The Bismarck model, for example, has higher out-of-pocket costs, and creates a barrier to health services for its target population-the low-income. On the contrary, the Beveridge model whereby health is tax funded and state-provided reduces such financial hurdles as out-of-pocket expenses and, theoretically, increases accessibility. However, while it can be noted that these studies provide valuable insights, they might not necessarily engage in the deep lived experiences of patients, especially in low-resource settings such as Kisumu County.

Studies analyzing the effects of universal healthcare coverage mostly examine developed countries and would be relevant to the designing of financing strategies in low-income settings. One of them, Ham [30] points out in some of her findings that the universal health coverage such as the NHS in the UK has positively pursued accessibility and equity. However, such findings often do not hold as much importance in resource-constrained settings such as Kisumu County, where informal financing mechanisms out-of-pocket payments, community savings groups, and household contributions are mostly used instead of involving a more formalized approach. Alatinga *et al.* [10] argue that government policies meant to ensure free access to maternal health services have often failed with women of countries such as Ghana still incurring out-of-pocket expenses for maternal healthcare services. This speaks a worrisome trend, for it indicates the distance between policy expectation and reality, which is indicative of systemic issues that hinder its effectiveness. In Burkina Faso, Meda *et al.* [31] also observed that economic constraints and inadequate health infrastructure further aggravated the financial burden of women seeking maternal health care. These findings demonstrate the sale limitations of formal healthcare policies which do not take into account other financial burdens for women in low-income countries.

The present study builds on these prior findings by focusing on the stakeholders involved in family-based maternal health financing in the county. Previous studies have explored formal and informal financing mechanisms but often leave out the view of the diverse stakeholders directly involved in the family-based financing method. This study addressed this by engaging a broad range of stakeholders including community leaders, healthcare providers, and policymakers in an effort to better understand the pros and cons of family-based financing in Kisumu. Thus, including these perspectives enabled the study to present a comprehensive picture of how family-based financing mechanisms impact access to maternal healthcare especially in terms of designing more effective and relevant policies around formal and informal barriers to care.

4.2.3. Funding Mechanisms and Maternal Health Outcomes

Various financing mechanisms have affected maternal healthcare service access in Kisumu County; however, the effects on both use and health outcomes remain

paradoxical. While it is generally held that health insurance schemes reduce financial barriers and hence facilitate access to care, some research such as that of Erlangga, Suhrcke, Ali and Bloor (2019) [32] argue that though such schemes increase service use, it does not always translate into better maternal health outcomes. For instance, in Kisumu County, it has been established whereby household financing mechanisms promote increased frequency of ANC visits without guaranteeing better outcomes such as increased SBA utilization or lowered maternal mortality rates. The current study sought to examine how these household financial strategies access maternal health care as well as quality, thus providing a localized perspective of these dynamics within the Kisumu context. As a result, incentive mechanism in Kisumu has been developing result-based financing (RBF) strategies in service delivery although the current research shows that these financial incentives do not guarantee enhanced quality of care within the same setting.

The introduction of RBF, from other settings including Zambia, has generally increased the uptake of services but did not improve the quality associated with maternal healthcare services [33]. Therefore, this indicates that even if one increases the utilization rates, the actual issues remain unaddressed-for example, health care worker competency, facility infrastructure, or patient-provider interactions, but these are significant in improving one's outcome in maternal health. This results in an important aspect concerning Kisumu County, which is reflective of the notion that access to service should also accord quality care with its health outcomes. It was found that vouchers have another financial mechanism that creates an incentive for an increase in facility deliveries within Kisumu County.

Similarly, Oyugi, *et al.* [34] in Kenya, found that vouchers created more access to services, but they did not guarantee an increase in ANC attendance or skilled birth attendance. The mixed-methods approach helped in developing a deep understanding of voucher programs impacting on service utilization and quality. Access to care has improved, but for long-term improvements in maternal health outcomes, more systemic issues need to be addressed. As it becomes clear, findings further strengthen the direction of broader and much more sustainable financing, to take account of considerations that go beyond financial access to include the broader determinants of maternal health outcomes.

The present study found that the impact on maternal health outcomes was more complex. While research, such as Diang'a [18], highlighted the benefits of previous scheme like NHIF in increasing access to healthcare services, the increased enrollment and access to healthcare services, challenges in policy implementation and the narrow focus on coverage affected the scheme's ability to significantly improve maternal health outcomes in Kisumu County. The study concludes that a more holistic approach, which combines various household financing mechanisms, was needed to improve both access to and the quality of maternal healthcare services. By examining multiple mechanisms and their combined effects on maternal health, the present study provided valuable insights into how financing strategies can be optimized to enhance both service utilization and health outcomes in resource-constrained settings like Kisumu County.

5. Research Methodology

5.1. Study Criteria and Recruitment

This qualitative research was conducted from May to September 2024 in the seven sub-counties of Kisumu County: Kisumu East, Kisumu Central, Kisumu West, Seme, Muhoroni, Nyando, and Nyakach, to understand stakeholders' perceptions regarding family-based financing mechanisms for maternal health, how these are implemented, and their implications for maternal health status and outcomes. Under the qualitative method of research, 150 participants drawn randomly were included in the study. This is because qualitative research emphasizes various rich contexted understandings rather than statistical generalization [35]. Out of the 150 participants enrolled, 100 women of reproductive age (15 - 49 years) were currently pregnant or had recently given birth.

The 100 participants were involved in 10 focus group discussions (FGDs) of 10 members each. The FGDs were purposely stratified by parity (first-time mothers versus experienced mothers) as well as by rural-urban dwelling to maximize diversity in childbirth experiences, financial coping strategies, and access to maternal healthcare services [36]. Notably, special consideration was made to ensure each FGD was homogenous with regard parity but diverse in terms of socio-economic background to trigger richer discussions.

The other 50 had participated in 20 key informant interviews (KIIs) with diverse stakeholders, such as healthcare providers, community health volunteers (CHVs), facility managers, local administrators (chiefs and village elders), and even policymakers within the county level. These KIIs contributed much towards understanding the policy framework, programmatic efforts, and community-level structures that have bearing on the issue of maternal health financing. Recruitment of participants was done using purposive and proportionate stratified sampling method, aided by local health structures and administrators, to represent as widely as possible geographically and institutionally around the maximum variation sampling principle of capturing all possible diversities and contrasts of stakeholder perspectives [35].

FGD and KII guide development relied on the model of Health Behaviour or Health Belief Model (HBM) and Resource Dependence Theory (RDT). Initial questions then analyze cognitive perceptions (such as what the barriers or gains are perceived to be with regard to maternal health financing) as well as structural factors (e.g., resource dependencies, stakeholder influences).

For FGDs, initial guide included broad open-ended questions like: "*How would you describe how the families in your community pay for maternal health care services*?" "*What are the difficulties that families have in mobilizing funds for delivery or antenatal services*?" "*How do community savings groups or health insurance schemes influence your decision to seek care*?"

It was apparent from piloting that several participants needed more concrete prompts to elaborate on their experiences. Hence, refined versions included fol-

low-up probes such as: "*Can you share a personal example or a story you have heard from a neighbor*?" "*What happens if a family does not have enough money during childbirth emergencies*?"

For KIIs, the initial guide focused on structural questions such as: "*How would you describe the existing support structures for maternal health financing at your level*?" "*To what extent do local organizations or the county government enhance the accessibility of maternal health services*?" "*As per your experience*, *what are the significant gaping holes in the existing models for financing maternal health*?"

Piloting indicated the need for more questions concerning power dynamics and negotiation processes because insights generated through the RDT lens emphasized these areas. Therefore, the following additional questions were added: "*How do power relations between government*, *donors*, *and communities affect maternal health financing*?" "*Have you seen households access and negotiate for maternal health services differently based on their income status or connections*?"

The draft guides for FGDs and KIIs were piloted on two small groups: one group of mothers and a few local administrators outside the main sample, from Siaya which boarders the study area. Feedback from the pilot emphasized, the need for simplicity and cultural relevance in some questions for FGDs, the importance of sequencing of questions from general to specific for comfort and engagement of participants, and the need to include much more clear probes around informal financing mechanisms such as borrowing, saving groups, and in-kind exchanges.

Thus, based on findings, revision and rewording of guides took place. The questions of FGD were reformulated to be more conversational such as changing "*describe maternal health financing mechanisms*" to "*how do families here manage to pay for health services when a mother is pregnant or giving birth*?" Similarly, KII questions were adapted to include more dynamic questions on institutional relationships for instance, "*Describe a time when a donor program changed how maternal health services were accessed in this area*."

Thus, such repeated refinements ensured that the tools would be sensitive to participant realities, deeply grounded in the theoretical frameworks, and capable of generating the rich, nuanced data needed for thematic analysis. Indeed, the combination of piloting, feedback integration, and theoretical alignment offered an exceptional value, making the whole study methodologically rigorous and relevant to the objectives under research.

5.2. Data Collection

The data were collected from semi-structured FGD and KII guides which aimed at giving descriptions of key stakeholders' roles in household level maternal health financing mechanisms, perceived impacts on maternal health as well as recommendations towards improvement. Inductions open-ended questioning and flexible probing to elicit well substantiated responses as well as participants led discussions [37].

The 10 FGDs were organized as follows: 5 FGDs for the first-time mothers (3 peri-urban, 2 rural) and 5 FGDs for experienced mothers (3 peri-urban, 2 rural). Each FGD had 10 participants, which made a total of 100 women. The discussions took place in Kiswahili, English, or Dholuo based on the participants' preference and were held in safe, private, and familiar community venues to minimize social desirability and interviewer bias. Twenty key informant interviews were conducted one-on-one confidential settings to permit in-depth exploration of institutional experiences surrounding maternal health financing policies and their implementation at the facility and community levels. All interviews and FGDs were conducted by research assistants trained in qualitative methods. The debriefing took place every day to discuss the elicited themes, modify the strategies of interviews, and note the saturation of data. The presence of a researcher in the select sessions acted to spice up the application of best practices in qualitative inquiry.

5.3. Data Analysis

Thematic Analysis was the primary method employed for analyzing qualitative data, following Braun and Clarke's (2006) six phases [38]. The first phase, familiarization, involved the researchers immersing themselves in the data by reading and re-reading the transcripts meticulously. This initial engagement allowed them to gain a deep understanding of the content and context of the participants' responses. In the second phase, the researchers systematically generated initial codes, identifying key features of interest across the dataset. This coding process was crucial for capturing the significant elements present in the data.

During the third phase, these initial codes were organized into potential themes that reflected broader patterns relevant to the research objectives. The emerging themes were then subjected to rigorous review and refinement in the fourth phase, ensuring internal coherence and clear distinctions between them. This step involved checking that each theme accurately represented the coded data and contributed meaningfully to the overall narrative. In the fifth phase, the researchers defined and named the finalized themes, succinctly representing their essence and capturing the core insights derived from the data. The final phase consisted of producing a comprehensive analytic narrative, supported by direct quotations from participants, to illustrate the findings vividly.

To enhance analytical rigor and ensure inter-coder reliability, the two researchers conducted manual coding independently. This approach maximized the depth of analysis and minimized individual bias. Any discrepancies in interpretation were resolved through discussion and consensus, fostering a collaborative environment that strengthened the reliability of the findings [39]. This structured approach allowed for a nuanced understanding of diverse perspectives from service users and stakeholders, providing valuable insights into the key enablers and constraints within the current family-based maternal health financing system in Kisumu County.

In addition to the analytical process, a reflexivity statement regarding the re-

searchers' positionality was crucial for enhancing transparency and understanding throughout data collection and analysis. Both researchers acknowledged their backgrounds and potential biases, recognizing how their experiences and perspectives might influence the interpretation of the data. For instance, their familiarity with the local healthcare context and community dynamics may have shaped their engagement with participants and interpretation of the findings. By actively reflecting on their positionality, the researchers aimed to mitigate any biases and ensure that the analysis remained grounded in the participants' voices.

Overall, the systematic application of thematic analysis, combined with a commitment to reflexivity, provided a robust framework for understanding the complexities of maternal health financing in Kisumu County. This methodological rigor not only enriched the findings but also contributed to the credibility and reliability of the study.

5.4. Ethical Considerations

Ethics integrity was observed throughout the study and also informed the participants on the objectives of the study, voluntary participation and their right to withdraw at any time. Consent was obtained for audio recording and confidentiality was insured by destroying identifiers and storing audio files securely. FGDs were structured by parity and locality to minimize power imbalances, where stakeholders were interviewed separately to promote openness. Psychological distress was avoided where possible. Ethical approval was granted by St Paul's University Ethics Review Board, adhering to principles of autonomy, non-maleficence and beneficence.

6. Findings and Discussions

6.1. Introduction

This section highlights and interprets the findings of the study on stakeholder views regarding family-based maternal health financing in Kisumu County. The results are organized according to the four study objectives: 1) Identification of key stakeholders; 2) Existing family funding mechanisms, 3) Perceived effects of these mechanisms on maternal health outcomes; 4) Proposed reforms. The data obtained was from in-depth interviews and focus group discussions (FGDs) with women, healthcare providers; community health volunteers (CHVs), local administrators, and representatives from community groups and NGOs.

6.2. Stakeholders Involved in Family-Based Maternal Health Financing

The study has revealed that maternal health financing in Kisumu County is supported by different actors at household and community levels. Primarily, key stakeholders include immediate family members-mostly spouses-extended relatives, rotating savings and credit associations (ROSCAs/chamas), religious insti-

tutions, community health volunteers (CHVs), and health service providers. NGOs and local administrators play pivotal roles, especially in times of emergencies. The following participant quotes illustrate the existing stakeholders involved in family-based maternal health financing:

From Kisumu East, one FGD participant stressed the important role of male partners in financial decision-making regarding the mother's care:

"*In most cases, the husband decides when and where the woman goes for care. We have to wait in case he does not have the money.*" (FGD participant, Kisumu East, 2024).

From Muhoroni, a member of a "chama" stated:

"*Our chama has come through for many women in our village. We contribute on a monthly basis and support one another during emergencies like childbirth.*" (FGD, female participant Muhoroni, 2024)

The other health volunteer from Nyando explained their role:

"*As a CHV, I often talk to families about where they can get help, especially if they are not insured. Sometimes, churches also step in.*" (CHV, Nyando, 2024)

A network of stakeholders supports family-centered financing for maternal health in Kisumu County, where each serve contextually different but interdependent roles in enabling access to maternal health care. Male partners are mainly viewed as the key decision-makers in households regarding the health-seeking behavior of women. This interplay has been reinforced by gendered roles concerning financial control, placing fathers in dominating positions in health expenditures. Cultural anchors prescribe men for the household economy, which limits women's autonomy in seeking health care.

Patterns just about similar to this are observed when comparing with other counties in Kenya, especially in Turkana and Taita Taveta, where economic hindrances also obstruct prenatal health care access [34]. The same holds true for such men persistently imposing leverage upon the financial decisions on maternal health issues. However, distinguishing Kisumu are somewhat developed networks of "chamas" that assist the raising of emergency funds for childbirth in a more community-oriented way than applies in other counties. By stark contrast, counties such as Nairobi have better access to organized health insurance schemes, thereby highlighting imbalances in availability of resources in differing socioeconomic contexts.

Within these gender dynamics exist unequal distributions of power that show how women's health decisions very often rely on their partners' financial capability and willingness. This indirect dependency postpones timely access to care, especially when male partners show unwillingness or are incapable of giving finances for maternal health needs. While male partners would rather be seen as protectors, that very kind of protection limits women's agency in their health matters.

The "chamas" already defined as informal saving groups, provide maternal emergency funds in situations of a critical nature at childbirth. They provide

means of collective saving with the aspect of unity and financial accountability. But male-female dynamics within the community could disrupt these association activities, which can pressure some women into securing support from their partners in joining such institutions or face cultural settings that despise women's economic independence.

Community Health Volunteers are important intermediaries linking families to existing support in the case that formal coverage is inadequate. They inform families about existing resources and help them navigate the landscape of maternal health financing. By championing women's health, CHVs might counteract barriers erected by male-dominated decision-making routes, thus giving women a voice to their health concerns.

The religious institutions' position is likewise salient in terms of rendering moral support and even funding in emergencies. Their involvement opens up very interesting avenues for discussion on the intersection of culture and health financing, especially since faith organizations do promote communal backing for maternal health. However, within the same institutions are perpetuation of stereotypical gender roles that limit women's agency over health decisions and thereby sustain existing power inequalities.

The findings from this study support observations made in rural Malawi, highlighting the roles of family members, CHV, and local organizations in maternal health financing [28]. In both contexts, male partners influence financial decision-making. However, in addition, the present study highlights religious institutions as having a significance in Kisumu other counties in Kenya may not have, necessitating consideration of contextual factors when defining successful maternal health financing strategies.

In summary, the findings enforce that community stakeholders must necessarily be brought into some kind of funding strategy for maternal health, in order to achieve sustainability and equitable distribution of resources, especially in resource-poor settings. Gender dynamics must be contextualized to understand how power differentials and cultural norms impact decision-making on maternal health expenditures. Addressing these concern areas will help ensure funding strategies are catered to meet the needs of all community members, strengthening inclusive approaches to maternal health financing in varied socio-economic contexts across Kenya.

6.3. Family-Based Maternal Health Financing Mechanisms in Use

It has been established that most of the informal and semi-formal channels of financing are the major avenues through which families in Kisumu County cater for maternal health care. In personal savings, many households take personal savings as their first consideration. Further, many families seek to borrow from relatives or neighbors because they depend heavily on social networks for the financing of medical expenses. Further, pulling savings and credits into "chamas" contributes to offering collective financial support during emergencies, such as child-

birth. Yet another form of assistance is religious or community donations, where local religious institutions sometimes offer both moral and financial support.

Even though SHIF, is a formal health insurance scheme, its uptake among residents of Kisumu County remains lamentably low. This is because of reasons such as high premium costs, low levels of awareness amongst the public, cultural misconceptions, and barriers to registration. This finding determines the continued importance of informal mechanisms in the financing of maternal healthcare in the face of ever-increasing inaccessibility or unaffordability of formal insurance schemes to most households.

Thus, just as Kisumu is typical of other counties, such as Kakamega and Kilifi, in the country in which informal community-based financing remains the main channel of mobilization for health care costs owing to similar obstacles of high cost, lack of trust, and bureaucratic impediments to accessing formal insurance, what sets Kisumu apart is having more rotating credit groups (chamas) integrated as main maternal health financiers as compared to counties like Kilifi, where community-based health funds linked to NGOs hold more prominence. Table 1 below summarizes the common Family-Based Financing Mechanisms in Kisumu County.

Table 1. Common family-based financing mechanisms in Kisumu County.

Financing Mechanism	Description	Common Among
Household savings	Savings set aside from daily income	All households
Chamas	Rotating savings and credit groups	Rural/peri-urban women
Relatives' financial help	Borrowing from extended family members	Low-income households
Church/mosque support	Occasional donations or emergency support	Religious communities
SHIF	Formal insurance schemes with limited uptake	Formal workers, a few farmers
Community health volunteer referrals	Link families to subsidies, clinics, or NGO support	Widely used across sub-counties

Quoted below are some remarks made by participants on family-based maternal health financing mechanisms in Kisumu County:

A mother from Seme described support from family as most vital during the birthing process:

"*When I went into labor, we had to borrow money from my brother because we hadn't saved enough.*" (Mother from Seme, 2024)

A village elder from Kisumu West explained that the understanding by community members regarding the Taifa Care scheme is limited in scope, thus stating:

"*Most women here don't understand how SHIF works; they think it's only for salaried people.*" (An Elder from Kisumu West, 2024)

A nurse at Nyakach lamented at the challenges a family had owing to the little insurance coverage.

"*Even with NHIF some hospitals ask for extra payments, so families still strug-*

gle," *she said*. (Nurse, Nyakach, 2024)

These findings sit nicely with evidence from other low-income settings, complementing broader studies on the finances for maternal healthcare. Internationally, the situation in Ghana and Burkina Faso presents an analogous scenario where, as stated by Alatinga *et al.* [10] and Meda *et al.* [31], significant out-of-pocket expenses persist despite the presence of free maternal care policies. Arguably, these hidden expenses, transport, drugs, informal payments, and lost income, remain formidable barriers to accessing maternal healthcare, following the pattern seen in Kenyan counties like these two, Migori and Kitui.

In the context of maternal health, the obverse examples of higher-income nations, such as the UK, under the National Health System (NHS) model described by Ham [30], demonstrate that universal coverage can efficiently surmount financial barriers and allow maternal health to be accessed equitably, regardless of economic status. The contrast thus underscores the limitations of fragmented or insurance-reliant schemes under lower-income settings like Kisumu, where informal and communal financing structures effectively address institutional gaps. Indeed, women and their families in Kisumu County, just as in Kakamega and Turkana, have had to innovate hybrid financing strategies, balancing personal savings with community loans, religious support, and occasional formal insurance access, to manage maternal health costs.

Thus, it is contended that for maternal health financing approaches to be productive in environments like Kisumu, they must interweave a formal insurance component with a strong, local community-based support framework. From the conclusion draw, these must be open to participation, affordable, culturally suitable, and responsive to the socioeconomic realities confronted by vulnerable households if they are to bring any tangible improvements in maternal health.

6.4. Perceived Effects on Maternal Health Outcomes

The study found that the character and sustainability of maternal health financing mechanisms in Kisumu County had profound effects on maternal health outcomes. Women relying on informal methods, mainly personal savings or emergency loans—were particularly vulnerable to delays in seeking skilled care, missed antenatal visits, or even resorted to home deliveries since care was too expensive. Such barriers were compounded among the low-income households without support.

Women belonging to better-organized 'chamas" (rotating savings groups) were found to have improved access to maternal health care thanks to their financial preparedness, allowing them to go for private care when public facilities were lacking. Poor enrollment into formal schemes like SHIF, in addition to inadequate compensation, meant that even women with insurance would often still incur sizable out-of-pocket payments thereby aggravating their already restricted access to timely and quality care.

A respondent from Kisumu Central narrated how insufficiency of finances was

the reason for the delay in treatment seeking. He said,

"*We delayed going to the clinic since we hadn't got enough money. It was risky when I reached there the labor was already at a very dangerous point.*" (FGD participant, Kisumu Central, 2024)

In Nyando, another participant underlined the importance of solidarity among the people in the chamas. She stated that,

"*My chama paid for me to deliver in a private clinic. The public hospital had no medicine that day.*" (Participant, Nyando, 2024)

A healthcare provider at the Kisumu East Sub-County Hospital raised the concern of slow access to healthcare services due to financial restrictions which remained unaddressed. The matter he raised was:

"*A lot of women will be late as they may still be hunting for money.*" (Nurse, Kisumu East, 2024).

These remarks reveal that informal and community-based methods of financing are very important and at the same time risky with regard to household dependency on maternal health care as they could easily fail to provide the needed resource at some point in time.

Similar trends have been revealed in the various counties of Kenya, for instance, in Bungoma where low-income women relied on self-help groups for financing maternal care though collective savings were found to be inadequate [13]. These and others, such as transport costs and scarcity regarding facilities like Kisumu, forced many women-including those in formal insurance schemes-into heavy out-of-pocket expenditures for postpartum care in Kilifi County, which are also characterized by very high out-of-pocket expenditures for their residents, unlike Kisumu. Indeed, Kisumu County is characterized by a more structured and a wider culture of chama membership among women, therefore improving its resilience in the informal component relative to the more marginalized areas, like Turkana County, where access to organized savings groups is very much limited because of pastoralist mobility and sparse population.

Such statements are similar to findings from other poorer settings questioning the sustainability of such dependence on family or informal financing for maternal health. For instance, they would alert one to the fact that while voucher systems brought access to delivery services, they would not sustain improved maternal health outcomes over a longer timeframe owing to financial discontinuity [34]. In the Kisumu situation, this finding resonates because informal adaptations, while critical, remain reactionary and seldom ensure a continuity of antenatal-to-postnatal care.

Such have been the attributions regarding health costs: family size, per capita income, availability of health facilities, government funding available for the treatment, and dependency of families on drawing costs in medical bills borne by members in the family, or the informal financing channel as discussed by Alatinga *et al.* [10]. Women still rely on families or informal networks because other costs such as those related to transportation, medications, and informal fees remain

hidden. So it is with Kisumu that finally mirrors such West African contexts, though there is a bit more organization albeit narrow with structured saving groups.

Higher costs and informal coping mechanisms continue increasing delays in securing care, thus adding discomforts for maternal health. Yet again, this did set Kisumu apart from the other two counties, Kilifi and Turkana, where the maternal health support systems are usually weak or less formalized but are combined with high usage rates of chamas and relatively better involvement from community health volunteers [34].

Findings above lend credence to the call for more inclusive and integrated financing approaches that would strengthen both formal systems such as Taifa Care and community-based mechanisms. However, real-life household situations require direct attention by policymakers and programs, including health literacy campaigns, support for community-driven savings initiatives, and investment in affordable transport systems to clinics. Such strategies would enhance financial resilience, while maternal health outcomes would also be improved because families would be better prepared to take care of their full continuum of maternal care needs.

6.5. Suggested Reforms to Enhance Family-Based Maternal Health Financing

As part of improving access to household maternal health financing in Kisumu County, several institutional reforms and community level changes have been suggested by participants at the study seminar. The main recommendation among them is to execute targeted communication campaign and make the SHIF registration simple for everyone. Here, the whole issue is to demystify SHIF for the local community, which has limited understanding, coupled with its perception of bureaucratic complexity, has hindered enrollment.

Another suggestion was to formalize the link between community-based savings groups ('chamas') and programs of maternal health at the county level. Participants envisioned that integrating chamas into public maternal health initiatives could create dual safety nets, allowing women to mobilize resources quickly during emergencies without over-relying on out-of-pocket financing. Establishing local emergency contingency funds at the ward level clearly emerged. Such funds could cushion against delays caused to a woman at labor or in complications arising therefrom by financial bottlenecks. The seminar also called on inclusion of men in the mothers' health education programs as informed male partners would arguably turn out to be important supporters in household financial planning for maternal care. Key sentiments from the FGDs and KIIs can be summarized as follows:

"*Let the government involve chiefs and CHVs in SHIF sensitization and registration. Most locals neither have a clear idea of how the fund works nor are they confident in the difficult process of registration.*" (*FGD participant from Kisumu*

East)

"*Every ward having a contingency fund means that women do not need to wait for money to come in times of labor. Immediate help could save lives.*" (NGO officer from Kisumu West, 2024)

"*When men are made aware of the dangers and expenses, they turn out to be good planners and supportive during delivery.*" (A community health volunteer (CHV) from Muhoroni, 2024).

These show that in Kisumu, there exists a system for financing family-based maternal health that is fairly vibrant in its informal use of tools like chamas, but rather there is need for deliberate effort to formalize these support mechanisms and expand financial literacy for all. The result also points out that even though SHIF could have a better safety net, its possibility is not fully utilized due to low enrollment, misinformation, and procedural hurdles.

Similar challenges and recommendations have been observed across different counties, providing a broader understanding of maternal health financing dynamics. For instance, in Bungoma County, studies have shown that despite the availability of free maternity services in public facilities, informal payment demands and drug shortages forced women to resort to chamas and family borrowing [13]. But in Bungoma unlike Kisumu, community groups had fewer formal linkages with health programs, meaning there were fewer organized fallback options for women in emergency situations. Dependency on private savings and seasonal incomes made women particularly vulnerable at the time of maternal emergencies in Kilifi County. Just as Kisumu, Kilifi participants also recommended ward-based emergency funds, although the chama structures were weaker and less widespread in terms of Kisumu, mainly due to poor social cohesion [19] [34].

Kisumu County stands out uniquely in that it has a very strong presence and organization of women chamas, which are already embedded within the fabric of the financial culture and therefore present entry points for health program linkage. Proximity to urban centers for Kisumu further increases the likelihood of scaling up SHIF enrollment as opposed to harder-to-reach rural counties like Turkana. However, similar to Bungoma and Kilifi, Kisumu still has its own problems in terms of limited male involvement in health financing and hidden costs in health care that ornament the advantages earned from the already existing financial schemes.

Overall, these findings indicate that improving maternal health financing in Kisumu requires a hybrid approach, strengthening the formal financing systems such as SHIF while also leveraging and institutionalizing community-based saving groups. These reforms should therefore entail localized health insurance sensitization, establishment of ward-level emergency funds, and inclusive health education programs aimed at men. A multi-layered financing model that acknowledges realities of household economies while establishing formal safety nets will dramatically improve maternal healthcare access, equity, and outcomes, not only for Kisumu, but for similar socio-economic settings across Kenya.

6.6. Limitations of the Study

Framing the qualitative study into family-based maternal health financing in Kisumu County has the potential to unlock mileages in the understanding of maternal health financing in Kisumu County. However, the study is limited in some aspects that might have affected the findings. While it was purely qualitative, capturing very rich details within the context, it raises some issues about the generalizability of results. Although the study has drawn a sample size of 150 participants, the opinions captured here mainly reflect those who could participate in focus group discussions (FGDs) and the key informant interviews (KIIs). Therefore, the opinions of groups marginalized by other barriers, such as lower socioeconomic status or cultural restrictions, have not been covered. Therefore, how generalizable these findings would be to the rest of Kisumu County remains debatable.

The self-reporting of data is further affiliated to bias, which may possibly adulterate results. Participants might give socially acceptable responses when it comes to sensitive topics like financial decisions or maternal health practices. For instance, the dependence of women for health-seeking behaviors on male partners might have possibly been downplayed, as society forbids openly discussing dynamics. Thus, gender roles and women's agency in maternal health decision-making could be skewed, reducing this study's depth and accuracy.

To optimally achieve diversity, FGDs were probed according to parity as well as rural-urban origin. Nevertheless, this might not be adequate in portraying the complexity around family dynamics or women in particular socioeconomic contexts. An exclusive focus on the relevant stakeholders such as health providers and community health volunteers might also result in missing such important women's voices within the much-simplified diverse financial mechanisms and barriers they encounter in accessing maternal health care.

In the future, it would be good to add quantitative approaches to enhance applicability and add more participants for broader perspectives. Another possibility of enhancing nuance in understanding barriers and facilitators that impact maternal health financing would be to explore the interconnectedness of gender, socioeconomic status, and cultural norms. More marginalized voices would build a more robust argument and richer findings that could directly inform efficacious maternal health policies through mixed methodology.

7. Conclusions and Recommendations

7.1. Conclusions

Kisumu County stakeholders know well the necessity of a family-based healthcare system for the well-being of families, even as they view it as one more vulnerability. The study highlights the use of informal and semi-formal mechanisms of financing maternal care that plug-in chamas, personal savings, and family support systems. Mobilization and encouragement of care-seeking anomalies include but are not limited to male partners, community health volunteers, religious institu-

tions, and local administrators. Weaknesses also include little participation in formal health plans such as the Social Health Insurance Fund (SHIF), mainly because they are poorly informed about it or that it is poorly structured and doesn't cover many aspects of people's needs. Many of the poor households incur expenditure when seeking treatment, and this usually delays the care they receive in turn adversely affecting their maternal health. Though CHVs further play a vital role in the link to resources to the family, such are usually limited in performance and capacity for lack of structural support and thus incentives.

The findings also indicate the very complex influences of gender dynamics, power differentials, and cultural norms affecting maternal health financing and decision-making. It is often the male partner who primarily decides health expenditures, reflective of traditional gender roles in which male authority prevails, thereby delaying care if finances run short. Norms then would almost obligate women to get money from a male partner for health purposes; thus, limiting their autonomy and agency over health matters. Although Chamas keeps such women afloat, they are limited by the prevailing gender dynamics since own membership usually requires approval from the male partner.

7.2. Recommendations

This paper advises infusing maternal health financing in Kisumu County with gender perspective in a strong manner, as this is multi-faceted. The County Government of Kisumu needs to carry out grassroots awareness campaigns about the SHIF, paying special attention to reducing the registration barriers for the underserved populations. Community chamas should be pooled into maternal health programming, adhering to technical support, and linkages with the emergency maternal funds at the ward level. Involving male partners in decision-making is very important when considering maternal healthcare. This can be achieved through targeted education that focuses on shared financial responsibility and involves them in the process of supporting women's health. The interplay of the above recommendations will create an alliance of stakeholders geared toward the timely provision and quality of maternal health care while also addressing gender power imbalances so as to facilitate equitable access to services in Kisumu County.

Conflicts of Interest

The authors declare no conflicts of interest.

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