Effects of poverty on utilization of health care facilities in Kawangware Semi-Urban Settlements, Nairobi, Kenya

By

Million Mesfin

This Dissertation is submitted in partial fulfilment of the requirements for the award of a Master of Development Studies (MDS) from St. Paul's University

August, 2016

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DECLARATIONS

This dissertation is a product of my own work and is not the result of anything done in collaboration. It has not been previously presented to any other institution. I agree that this thesis may be available for reference and photocopying, at the discretion of the university.

NAME OF STUDENT _____ STUDENT NUMBER_____

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WORD Count: _____

I confirm that the work reported in this thesis has been done by the student under my supervision.

NAME OF SUPERVISOR _____

SIGNATURE OF SUPERVISOR _____ DATE _____

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DEDICATION

I dedicated this to my mother Lemlem Berhe and my lovely wife Abeba Taddesse for their kindness and devotionally being with me on their endless prayer and support when I needed it at most.

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ACKNOWLEDGEMENT

First and foremost I want to thank my family in Kenya, Abebe Kifetew and Shitaye Temam, for sharing my happiness when starting this masters' class and following with encouragement and support throughout my years of study and through the process of researching and writing this thesis when it seemed too difficult to be completed. I would have probably given up without their unconditional love, support and example on what to do when you really want something. I always acknowledge them for their selflessness to support me.

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ABSTRACT

Poverty is a major problem that affects many individuals in Kenya. The study aimed at assessing the effects of poverty on utilization of health care facilities in Kawangware Semi-Urban Settlements, Nairobi Kenya. The study was guided by the following objectives; to identify available health facilities/care in Kawangware, to establish the common reported cases of ailments among Kawangware semi-urban settlement dwellers, and to determine the effect of household's income levels on use of health care facilties in Kawangware. The study relied on survey design. The objectives of the study were achieved through various methods of data collecting which included face to face interviews and use of questionnaires. In total, about 113 respondents took part in the study. The study revealed that the most common health services in Kawangware division are ante natal and post natal care, maternal care and family planning. Results of the study highlighted that the most common illnesses is malaria, respiratory tract infections and Typhoid. The study also established that income levels play significant role in the use of health facilities. Income levels influence decisions on whether to seek treatment and where to the seek treatment. Households with low income levels prefer services of traditional healers while households with high income prefer to go to health facilities. The study concluded that most of illness in Kawangware division seems to be associated with the living conditions and surrounding environments including contaminated water supply and unsanitary human and household waste disposal. The study recommends that appropriate action be taken to improve and expand on the available health services in the Kawangware. The study also calls for the need to have prevention and control strategies of various prevalent illnesses in the study area. Lastly, there is need for policies that standardize charges for specific health services which the government does not offer freely, such as x-ray and laboratory charges. Alternatively, programs for encouraging economic empowerment of the population need to be considered.

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LIST OF ABBREVIATIONS

APHRC	African Population and Health Research Center
GOK	Government of Kenya
HBM	Health Belief Model
MDG	Millennium Development Goals
NCDs	Non-Communicable Diseases
NCSS	Nairobi Cross-sectional Slums Survey
PPAs	Participatory Poverty Assessments
SDGs	Sustainable development Goals
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Diseases
WB	World Bank
WDI	World Development Indicators

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CHAPTER ONE: INTRODUCTION

1.1. Introduction

This chapter presents the background of the study, statement of the problem, objectives of the study, research questions, and significance of the study. The chapter also describes the scope of the study and study limitations as well as operational definition of terms.

1.2. Background of the Study

Poverty is considered one of the greatest threats facing the world today. It can be conceptualized as an unacceptable deprivation in human well-being which can comprise both physiological and sociological deprivation (World Bank, 1997). In other words, it is concerned with the non-fulfillment of basic material or biological needs such as inadequate nutrition, health, education and shelter (Gaskin, Nielsen, Willie, & Durant, 2014). Therefore, one is considered poor if his or her consumption or income level goes below the poverty line or a minimum level necessary to meet basic needs.

In recognition of the gravity of the problem, poverty eradication has become a top priority and overarching objective of development, as reflected international agreements (Ravallion et al., 2009). Eradication of poverty for all people anywhere in the world, which is currently conceived as living on less than $1.25 per day, is the first aim of Sustainable Development Goal (SDG). This was reached following a meeting on September 25, 2015 by the United Nations General Assembly in New York. The SDG targets eradication of extreme poverty for all people everywhere, with a view of reducing at least by half the number of people of all age groups living in poverty by 2030 (Costanza, et al., 2014).

According to the World Bank's much cited "dollar-a-day" international poverty line, which is $1.25 a day, about one billion people or approximately one sixth of the global population are poor and three-quarters of these people live in rural areas where they depend mostly on agriculture for food and livelihood (Kanbur & Sumner, 2011). It is a disturbing fact that more than half a century of international commitment to development and the Declaration of Universal

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Human Rights in 1948, poverty still thrives in many countries around the world, especially in Sub-Saharan Africa as the Kenyan case reveals.

Although there have been significant progress on reducing poverty over the past decades, the number of people living in extreme poverty globally remains stubbornly and unacceptably high with most of these people residing in Sub-Saharan Africa (SSA). According to the World Bank's much about 17 percent or 1.4 billion of people in SSA lived at or below $1.25 a day, in 2011, a decline from the 1.9 billion in 1981, this figure is still high. These estimates would even be higher in SSA if poverty was viewed beyond economic terms (Sahn & Stifel, 2002). This is partly attributed to the fact that poverty has strong social and political dimensions, with high concentration among African population. One could obtain a more comprehensive and accurate account on the issue of poverty when it is examined from a structural position, where not only economic (income) but other non-economic dimensions of poverty are considered as core in any poverty profile (Khan, 2005).

The increase in poverty rate across the globe has been coupled with a correspondent increase in the incidence of diseases and deaths. Data from the World Development Indicators (WDI) show that life expectancy at birth for SSA has declined over the past 15 years from 49 years in 1990 to 47 in 2005, and infant mortality rates increased in many parts of the African continent where poverty remains pervasive (World Bank, 2016). According to Earickson, some 14.5 million children die every year in developing countries (Earickson cited in Sindiga, 2005); while (10) per cent of all births end up in death by the first birthday and (20) per cent by the fifth birthday (Caldwell cited in Sindiga, 2005). Perhaps most alarming, is that poverty, which in previous centuries was greatest in scattered rural areas, is now heavily concentrated in cities particularly in semi-urban settlements. World Health Organization (WHO) estimates that in 2010, about one third of urban dwellers or nearly one billion people lived in semi-urban settlements (WHO, 2010). Out of this, more than 90 percent were found in SSA. Most people in semi-urban settlements suffer disproportionately from poor health as most of them forego the most basic and essential care for financial and other reasons. This may be attributed to social and living conditions. Despite considerable gains in economic growth in the last decade, prospects for

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reducing poverty in Kenya like the rest of African countries seem uncertain in the near future. For instance, the 2013 World Bank (WB) global monitoring report indicated that the country was likely to reduce poverty in 2050 (World Bank, 2013). This is far beyond the timelines given in the SDGs of reducing poverty by 2030

The above statistics is worrying because poverty is inter-related to other problems especially in rural areas where the poverty is the highest and semi-urban settlements areas where poverty is also very significant. In rural and urban areas, aspects of poverty can be very different. In rural areas there is often poor access to education and other essential services but people usually live in healthier and safer environments due to absence of factories and overcrowding (Weber & Jensen, 2004). In urban areas people often have access to better health and education. Situation is much worse in semi-urban settlements where the majority of Kenya's urban poor live (GOK, 2007). These areas are usually characterized by overpopulation/overcrowding, unhygienic conditions, pollution and unsafe houses. There are no stable and regular jobs for urban dwellers and therefore they do not have regular income. They cannot afford adequate and decent housing. This notion is quite relevant to Kawangware semi-urban settlement, which is the focus of this study. According to GOK (2007), urban residents utilize roughly twenty five percent of the incomes they get on housing or paying rent. Irregular and inadequate income result in to poor education and nutrition and these in turn make the urban dwellers to be at more risks of poverty's conditions. People's health status is likely to be negatively affected by such conditions. In addition, ambiguous processes of getting credit for the purposes of doing businesses or housing and other problems like evictions and tenure insecurity complicate vulnerability of poor urban dwellers among others.

Utilization of health care facilities is one of the things which may be affected by poverty. This is partly why the World Health Organization (WHO) supports nations to design and implement effective pro-poor health policies which prioritize and respond to the needs of poor people in those countries. These supports include global advocacy, regional initiatives and direct support to ministries of health in developing nations. Health and poverty issues differ markedly from country to country contexts, with countries emerging from and affected by conflicts presenting a

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particular challenge. WHO database on health in poverty reduction strategy papers, ensures that the health perspective is reflected in poverty reduction strategies, medium term expenditure frameworks, and helps to develop sector-wide approaches (Blakely & Bradshaw, 2002).

The Kenyan government has and is still trying to promote equity and access to health care system with the aim of effectively alienating human suffering and improving life-styles of all her citizens. The question of what Health Policies are Pro-poor is central to the current policy and strategy developments in Kenya; it has acted as a guideline for the Kenyan government and its partners in devising and determining health-care strategies. For instance, the current health policy dubbed the Kenya Health Policy 2012-2030 (Kibui et al., 2015), gives guidelines aimed at ensuring momentous improvement in health status of Kenyans. The Kenyan government also tries to offer some health care free of charge or sometimes at subsidized price for individuals. For-instance the free maternity care for women, free condoms and antiretroviral drugs (ARVs) in all heath facilities is also a good illustration of its commitment to improve access to healthcare.

Despite the above interventions, the poor especially those living in semi-urban settlement, of which the area under study is a part, continue to grapple with health challenges. This may imply that either there is inadequate health care facilities or the residents are under-utilizing the facilities.

Therefore, knowledge about utilization of health-care facility of a given area is important for calculating population-based rates of disease and for performing other important analyses. To a higher degree, factors like level of education, place of residence, environment, income level, genetics, relationships with family and friends greatly impact on the health of an individual. For instance, higher social status and higher income level are associated with good health. Health consequences tend to grow with the rising gap between the poor and the rich. In previous researches, socio-economic status such as low education levels has been linked to poor health, more stress and lower self-confidence. Factors which contribute to good health have been identified from previous research works as clean air, healthy work places, safer water and houses, better roads and individual of communities who are employed are healthiest and

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specifically those who are able to control the working conditions they are in. Furthermore, traditions, beliefs and customs in the society affect health (WHO, 1995).

Despite possible linkages between poverty and utilization of health facilities, only little research based on empirical data has been found to understand the existing link between the two. The few studies available have only highlighted the significant disadvantages faced by poor people in semi-urban settlement with respect to morbidity, and mortality as well as access to health services (Taffa, Chepngeno and Amuyunzu-Nyamongo, 2005; Ziraba et al., 2009). They have also focused more on the magnitude of health inequities between the urban poor and other groups but have clearly shown how poverty affect use of health care services/facilities. It is against the background of the growing importance of poverty in shaping national health and socioeconomic indicators, and the knowledge gaps noted above that the study is formulated.

1.3. Statement of the Problem

Health is an important factor in any economy in the world. Health related problems can be delayed if good health care is accessed and utilized. With this in mind, Kenya has signed on to several regional mandates regarding health. For instance, the government participated in and committed to the 2001 Abuja Declaration, pledging to commit at least 15% of the national budget to health care (GoK, 2007).Currently, Kenya Health Policy 2012-2030 offers guidelines to ensure momentous improvement in health status of every Kenyan, in line with the provision of the new constitution of Kenya 2010, Vision 2030, and other global commitments (Ministry of Health, 2012).

Despite the government's commitment towards improving the health of every Kenyan, a good number of the populations still exhibit poor health. The urban poor in Kenya are much more disadvantaged. In Nairobi, semi-urban residents constitute over half the capital's population yet are crammed into only 5 per cent of the city's residential area and just 1 per cent of all land in the city (Mitullah, 2003). Most residents of Nairobi's semi-urban settlements do not have access to public water supplies, which are available to other residents of the city. In 2007, by the

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government's own admission, "sustainable access to water drops to as low as 20 per cent in the settlements of the urban poor where half of the urban population lives" (Kabiru et al., 2010).

Like any other semi-urban settlement, Kawangware is dominated by low income earners who live in shanty housing conditions. Residents therefore face serious challenges in accessing, and management of personal health. This is made worse by the fact that they are likely to ignore disease symptoms to avoid missing out on their working hours since each hour counts, in terms of putting bread on the table. It is intereting to find out how these circumstance relate to functional accessibility and use of health care facilities services in the area.

Although there are a number of studies done on utilization of health services (Madise, Banda and Benaya, 2003; Sule, Ijadunola and Onayade, 2008; Nketiah-Amponsah and Hiemenz, 2009), most of these studies are conducted in regions whose context is different from that of Kenya. Some attempts have been made to study utilization of health care facilities among semi-urban residents within the Kenyan context, in particular, Nairobi (Taffa et al., 2005; Kabiru et al., 2010; Mutua and Kimani-Murage, 2011). However, they focus on the significant disadvantages faced by the semi-urban poor with respect to their health relative to other population sub-groups, including rural residents while ignoring the dynamic inter-linkages between poverty and health. Therefore, the proposed study seeks to fill the existing knowledge gap by assessing the effects of poverty on utilization of health care facilities in Kawangware semi-urban settlements, Kawangware Division-Nairobi County.

1.4. Main Objective

The main objective of this study is to assess effects of poverty on utilization of health care facilities in Kawangware semi-urban settlements, Kawangware Division-Nairobi County.

1.5. Specific Objectives

1. To identify available health care services offered in the health care facilities in Kawangware
2. To establish the commonly reported cases of ailments among Kawangware semi-urban settlement dwellers.

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3. To determing the effect of houshold's income levels on use of health care facilties in Kawangware

1.6. Research Questions

1. What are the available health care services offered in the health care facilities in Kawangware?
2. What are the common cases of ailments among Kawangware semi-urban settlement dwellers?
3. What is the effect of household's income levels on use of heath care facilities in Kawangware?

1.7. Justification of the Study

In the recent past, poverty has become a focus of research for most scholars and professionals in the world. However, social research in developing nations, Kenya included, has been majorly directed towards poverty reduction. In contrast, there has been very little attention on the effects of poverty on utilization of health care facilities. The study is meant to assess the effects of poverty on utilization of health care facilities in Kawangware semi-urban settlements. The study is hoped to unearth the relationship between poverty and utilization of health care facilities among semi-urban settlement communities.

The information on utilization of health care facilities and preferences can be used to improve the appropriateness of the health care services offered within the community. The findings will be expected to aid in the formulation of sustainable measures and strategies to enhance utilization of health care facilities especially among the semi-urban settlement communities. This would assist the government and other stakeholders to come up with new approaches of dealing with poverty and come up with measures to curb challenges posed by poverty on health.

Lastly, the findings from this study can be used to improve the body of knowledge that exists regarding health care seeking in developing countries. It will provide useful insights for future research on the subject under investigation.

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1.8. Limitations of the Study

One of the limitations is that study respondents might be too pre-occupied in their daily chores to have time to give information. This will be countered by ensuring that the questionnaires and interviews are precise to avoid taking too much of their time reassuring them that the interviews will be brief.

A further limitation of the study will be that the researcher does not have enough resources in terms of time, money and manpower as a result of being a student. The researcher will maximize on time to be taken for the study, use less manpower and hence use less money, while at the same time ensure that all the target respondents will be reached with ease.

The issues of illiteracy and language barrier were a problem where respondents were not able to read or write leading to some misinterpretations of the questions. In such situations, the researcher trained research assistants from the community to interpret the questions for the respondents, thereafter filling in appropriately as they provided answers.

1.9. Operational Definition

Health: This is conceived as the general condition of one's mind and body enabling a person to adequately function.

Poverty: This is defined as inability to meet or cater for basic physical and social needs.

Poverty level: This is the basic measure for identifying economic poverty usually conceived as an arbitrary income measure expressed in constant dollars (less than $1.25 per day) for estimating the number of people who exists at bare level of subsistence.

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CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The chapter reviews the existing literature by different scholars and personalities on poverty and utilization of health care facilities. The aspects addressed in this chapter will include how concepts of poverty and health have been defined by other scholars and presentation of Poverty in perspective. The link between poverty and health is also reviewed including health promotion strategies available. In addition, this chapter presents a review of studies based on semi-urban settlement communities. Here, problems faced by semi-urban communities, their health status and nature of poverty are presented. Lastly, the study discusses theoretical framework upon which this research will be founded as well as the conceptual framework of the variables evaluated.

Empirical review

2.2.1. Definition of Poverty and Health

2.2.1.1. Poverty

According to the quantitative method of poverty measurement, a poor person can be defined as one who is unable to cater for basic food even non food items. Qualitative approach also known as Participatory Poverty Assessment concludes that individuals define, view experience and perceive poverty in different ways. Based on 2001 report of PPA, people majorly view poverty as being unable to meet basic needs. In this line, poverty is linked with features like unemployment, not having land, not being able to feed oneself and the family, inadequate housing, poor health and nutrition, unable to educate children and cater for medical bills. Although different individuals and communities have varying definitions of poverty, poverty is generally linked with inability in meeting basic needs.

Definitions of poverty are also multifaceted and contextual as well as engendered. In study by Page and Simmons (2000) in Kajiado County in Kenya, youths perceive poverty as not having income, not being employed and lacking vision which is summarized as being next to death. Women on the other hand, view poverty as lacking livestock, not able to provide certain basic needs, lacking water, no income source and not having children. Men on the other hand, define poverty as having nothing, inadequate livestock, lack of grazing land, childlessness, inadequate

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water, unemployment and a poor economy. However, no matter the context and the gender, poverty is a form of deprivation, and for the purpose of this research the deprivation of concern is access to health care.

Data from qualitative survey show that poverty is manifested in illiteracy, malnutrition, hunger, lacking shelter and failure to accessing certain vital social services like health, education, sanitation and water. Even though poverty is associated with lacking basic needs, it is also implies lacking or deficiency in provision of human. Cultural, social and economic rights which are perceived as being important for the survival of human beings, (Ridge, 2002).

The measurement of poverty is usually based on incomes or consumption levels, and individuals are considered poor if their consumption or income levels go below the poverty line, which is the minimum level necessary to meet basic needs. It should be emphasized that for the analysis of poverty in a particular country, the World Bank bases the poverty line on the norms for that society, (WHO, 1995).

2.2.1.2. Health Defined

Although defining health seems difficult due to divergent views, common dimensions have emerged. One of the most influential definitions of health is that of World Health Organization (1946) where it is conceptualized as the level of functional or metabolic efficiency of a living organism. From this perspective, health of human beings connotes the general condition of an individual's mind and body, which means being free from illness, injury or pain (WHO, 1946). Health also expresses state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity Life (WHO, 1946).

Generally, the context in which an individual lives is of great importance for both their health status and quality of their life (WHO, 1946). It is evidently being recognized that health is not only maintained and improved through the advancement and application of health science, but also through good lifestyles choices and efforts of an individual. WHO (1946), health is mainly determined by physical, economic and social environments and behaviors and characteristics if an individual. This therefore form the main basis of this research which seeks to evaluate utilization of health facilities in the economically poor population.

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According to World Health Organization's Bangkok Charter for Health Promotion in a Globalized World, Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (Williamson and Drummond, 1998).

As the above quotation implies, health promotion is arguably one of the most ambitious health-related enterprises of the 20th century, and advocacy is seen as one of its key strategies (WHO, 1997). Health promotion has been described, from a global perspective, as a necessary and timely reconsideration of public health rather than a new and separate discipline (Kickbusch, 1986), but in practice the two may differ at the practitioner level. Health promotion practitioners are to be found working in a wide range of agencies and sectors and their efforts can be directed towards improving the health of entire populations, defined communities or groups, and single individuals (Mechanic, 1999). In recent years, health promotion has increasingly sought a role in the development and implementation of healthy public policy at the local, national and global level (WHO, 1988). This has been, in part, a response to the perceived over-emphasis on curative medicine and the behavioral approach to disease prevention that has characterized much health policy development. Health promotion is therefore a multi-level, multi-sectorial and multi-disciplinary activity. It also evinces characteristics of a visionary movement, concerned with equity and justice in society as well as environmental protection on a global scale (WHO, 1997). In this line of thinking, it implies that health promotion strategies such as improving living conditions in housing, quality of living environment and health services is essential to improving the health of people residing in deplorable areas such as semi-urban settlements. But this must be accompanied by detailed information about types of ailments and patterns of health

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seeking behaviours as well as an assessment of available health facilities. This is all what the study is about.

2.3. Health Care Services Offered in the Health Care Facilities

2.3.1. Types of Health Facilities/Care

The type of health facility/care can be well understood in relation to its accessibility/ availability to prospective users. This would also include the level of expertise, and care assumed from the type of facility available, that is, a hospital versus a dispensary, private or public facilities, and formal or informal health facility. If public health facility is either not accessible or unavailable, then private ones can be used by potential users. Again, this may raise the issue of levels of income since most of the private facilities are relatively expensive (Tuan, Dung, Neu, & Dibley, 2005).

The question of availability of health facilities/care has been documented by a number of previous researchers in both developed states and developing nations (Andrews, 2001; Mehrotra & Jarrett, 2002). Many more studies report combination of treatments and services in the developing Nations (Mehrotra & Jarrett, 2002; Taffa et al., 2005). This system of care seeking shows that public providers of this care are majorly consulted in regard to any illness, private providers follow. However, informal care still exists in some proportion (Mehrotra & Jarrett, 2002).

Public sector normally is perceived under the care of state (Birungi et al. 2001) while everything outside it is considered to be private. For instance, private healthcare or facilities can include health centers, hospitals, dispensaries and clinics which are under the administration of non-governmental organizations like mission hospitals. Formal healthcare on the other hand is defined as conventional medicines in registered setting like government hospitals or private hospitals. Informal health care is associated with traditional healers, self-medication and other health services which are non-sanctioned (Msiska et al., 1997). Using one service type over another is as a result of many factors. One facto is physical accessibility to healthcare or facility such as the distance, transport availability and roads conditions. In many instances, distance

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between healthcare and individuals is the essential stumbling block to utilization of the facility and especially among semi urban dwellers that have low income (Noorali, Luby & Rahbar, 1999).

In most cases, informal and formal health care usage is dependent on social and economic status. According to Thapa (1997), rural individuals in Nepal more often rely on traditional medicines or informal systems. A study by Taffa et al., (2005), found that in Nairobi slums households which are headed by single female rely heavily on informal and private clinics. But, people with specific diseases like tuberculosis are more likely to go to traditional healers in Nepal, (Yamasaki-Nakagawa et al., 2001). Another study by Msiska et al., (1997) found out that in relation to sexually transmitted diseases or infections, people utilize diverse cares which are in the community such as self-care, market medicines, traditional healers, households' injections, health centers, private clinics and hospitals among others. This study thus want to know if there is adequate healthcare/facility whether public or private and if health facility is coping with heath services/care or the private industry is taking over, and the profession/expertise each is responding with?

2.3.2. Health Promotion in advent of poverty

Recently both development partners and governments have been placing more focus or attention on dealing with heath's determinants. Definition of health promotion as contained in 1986's Ottawa Charter has been found to be a vital public health's element. Due to this, health promotion addresses factors causing ill health and thus enhancing population's health. Poverty and health's nexus is reinforced by United Nations Millennium Development Goals. Health is the main importance that these goals have. According to WHO (2003), raising the poor's longevity and health is itself one of the fundamental goals of development particularly economic one.

Jobless economic growth's situation which enhances income inequalities and leads to low employment levels for low income generating groups constitute a greater threat to well-being for many people in most of the countries in the world. Weber & Jensen (2004) assert that in order to efficiently deal with poverty problems, there should be broader technology and education access

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among the marginalized groups and particularly among girl child and women. Enhancing education attainment for women impact more positively on well beings of families/households and thus improving girl child education is one of the vital foundations for raising health of population. Moreover, measures need to be taken in ensuring that information technology's revolution benefits the marginalized groups. This should start in schools.

According to Warren (1999), advocacy is among the main strategies of realizing goals of health promotion, other strategies include mediation and enablement. Health advocacy can be defined as a combined social and individual actions which are designed in a way to realize political commitment, social acceptance, support of policy and system support in relation to specific health program or goal, (WHO, 2003). Actions like these can be implemented on groups or individual's behalf in order to make living conditions good or conducive for health promotion (Nutbeam, 1998).

Factors influencing Health Seeking Behaviours

Gender is one of the factors believed to affect health seeking behaviours. According to Prosser (2007) gender not only to affect illness reporting, but also the decision to choose a health care provider and how much to spend on a sick child.

Commonly Reported Cases of Ailments in Semi- Urban Settlements

2.3.1. Semi-Urban Settlement Communities

Semi-urban settlements consist of diverse interest groups and individuals of various social, cultural or religious status, political interest, livelihood activities and needs to be fulfilled. According to the ethnic composition of most residents in semi-urban settlements are quite diverse, though two or three tribes generally dominate in each settlement depending on the location (Oxfam, 2009). Ethnic allegiance may give cohesion in a community among people from same tribe particularly when they are confronted with diseases. But, traditions and cultures' diversity can sometimes results into conflicts especially in situations where there are competitions among people for limited natural or natural resources.

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Semi-urban settlement communities suffer from a wide range of problems. For instance, the living conditions for the vast majority of semi-urban settlement communities are deplorable, with high rates of malnutrition, communicable diseases, and exposure to violence (Bagheri, 2012). In other words, these communities suffer from challenges of accessibility, the absence of vacant land and open spaces, overcrowding and insufficient infrastructure and services (World Bank, 2008). According to Viegas (2006), communities living in semi-urban settlements embark on a vicious cycle in which poverty and illness lead to hospital admission and subsequent readmission and/or death as a result of extreme poverty and lack of adequate coping mechanisms. The researcher is curious on whether these assertions hold true in the case of semi-urban settlements communities in Kawangware Division.

The other challenge facing semi-urban settlement communities is the dubious nature of their legal status. This is compounded by the bureaucratic natures of granting land ownership. Payne (2005) notes that the procedures for granting land ownership and implementing urban development plans frequently take decades. Giving an example of Tanzania, Payne argues it may take at least seven years to identify an area for the implementation of urban planning (Payne, 2005). It would be interesting to find out whether challenge such as illegality of semi-urban settlement communities has any bearing on their income status and by extension utilization of health facilities and services in the context of semi-urban settlement communities in Kawangware Division.

It is documented that the health conditions of people living in semi-urban settlements in developing countries is in many ways worse than that of corresponding rural groups (Rossi-Espagnet,1984; Viegas, 2006). Rossi- Espagnet (1984) has argued that semi-urban settlement communities are at the interface between underdevelopment and industrialization and their disease patterns reflect the problems of both. According to the author, people living in semi-urban settlements tend to carry a heavy burden of infectious diseases and malnutrition. The health status of communities in semi-urban settlements has also been established in epidemiological studies. Most of these diseases are associated to living conditions and surrounding environments. For instance, Ballesteros (2010) indicates that housing environment

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results into or raises specific diseases' incidences. For example, overcrowding enhances airborne illness' risk, water contamination supply and bad household wastes disposal leading to gastro intestinal problems, typhoid, and cholera and skin ailments among others.

On the contrary, Moser (2011) believes that poor people in semi-urban settlements also suffer from non-communicable diseases (NCDs) such as cancer, diabetes and stroke. The author argues that these increasingly lead to a double burden of these poor households. From these studies, it is apparent that findings are mixed; scale health needs are also conflicting. It is therefore interesting to identify the most common ailments found among residents of semi-urban settlements especially in Kawangware Division.

Nature of Poverty of semi-urban settlements communities is quite different from other areas especially rural areas. Disaggregating poverty by various socio-economic characteristics, poverty tends to take a gender dimension. For instance, a study by Oxfam (2009) established that the prevalence of poverty among male headed households was lower than female-headed households. In turn, married-female headed households in urban areas have a lower incidence of poverty compared with female-other households defined as single, separated, divorced females.

Another feature of poverty among semi-urban settlement communities is that it is linked to environmental degradation as noted in the previous sections. The main asset of the poor is labour but bad environment makes this asset vulnerable to poor health and mental stress. The impact on physical and mental health reduces the productivity of the poor, causes fragile family relations due to irritation and frustration, poor school performance of children and higher vulnerability to commit crimes and violence.

2.3.2. Common Ailments in Semi-Urban Settlements

One common attribute of semi-urban settlements is the fact that they are virtually a "no man's land", and in most cases, have no adequate services including health. In addition, these areas are usually unhygienic. Hand-washing at critical times is not always practiced owing to lack of water and the linkage of hand-washing to preventing diarrhea and the transmission of infectious agents

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is poorly understood (Marimuthu, Hemanta Meitei, and Sharma, 2009). With this in mind, diseases such as diarrhea, dysentery and typhoid fever are commonly reported. The health hazards of the Semi-Urban dwellers are directly linked to poverty and a polluted and stressful environment. In general, most people living in these areas are more vulnerable to communicable diseases and malnutrition while at the same time many are susceptible to greater risk of accidents at work (Marimuthu et al., 2009).

Effects of Household's Income on Use of Health Care Health Care Facilities in Semi-Urban Settlement

2.3.1. Poverty in Perspective

As already noted, poverty is multidimensional phenomenon which can be conceptualized in various ways. This is perhaps best exemplified in semi-urban settlements. Not only are these areas characterized by inadequate income but also by inadequate asset base, shelter and provision of public infrastructure (UN-HABITAT, 2003). It is documented that most of the poor individuals and households adjust to the challenges of urban life in the city by mobilizing resources, assets and opportunities (Davis, 2006; Ojong, 2011). Sverdlik (2011) in his work about ill-health and poverty explains that many households living in semi-urban settlements have higher chances of becoming sick, suffer from injuries and premature death. The author attributes this to poor-quality housing and lack of infrastructure in these settlements which pose grave threats to individual's health. Although he provides insightful background information, it is not based on empirical facts and therefore may not be accurate. Besides, the author does not bring out clearly the aspect of utilization of health care facilities. It is in this context that the current study seeks to assess the level of income among residents of Kawangware semi-urban settlements to find out whether or not they influence utilization of health facilities.

Monetized economy is also a key feature of areas which exhibit high poverty rates such as semi-urban settlements. Beall and Fox (2007) write that the urban poor are often forced to pay more for urban goods and services, are more vulnerable than the rural poor to changes in market conditions, and are more reliant on uncertain wage labour. Sverdlik (2011) furthers this argument highlighting on the influence of user fees or under-the-table payments within these settings. It is

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documented that monetized economy has some influence on the utilization of health facilities and services. The situation in India is a case in point as reported by Islam, Montgomery & Taneja (2006). According to the report poor people, having endured their illnesses until care cannot be put off any longer; finally present themselves in a more debilitated condition than they would otherwise have been. It is also reported that most of the poor people are likely to abandon courses of prescribed medication to save on the costs of purchasing medicines, or may economize by buying less than what was prescribed, let alone adhering to follow-ups and assessments of progress. The same is likely to be the case for residents of Kawangware semi-urban settlements. According to Muriithi (2013), wealth and user fees are the main determinants of patients' choice among alternative medical treatments. He therefore recommends for policies geared towards improving health information among the semi-urban households.

The poor disproportionately suffer from adverse effects of environmental degradation which also enhances their poor state in a vicious cycle (Nkonya et al., 2011) Awareness and concern about environmental degradation have grown globally over the last few decades and are currently shared by individuals of different nations, cultures, religions, and social classes. Throughout the developing countries, the poor always rely on natural resources to meet their basic needs through agricultural production and gathering resources essential for household maintenance like water, firewood, and wild plants for consumption and medicine. Therefore, the depletion and contamination of water sources directly threaten the livelihoods of those who depend on them and hence poverty (Blakely & Bradshaw, 2002).

In their article about Environmental degradation and poverty in Less Industrialized Nations (LIN), Thomas & Mwangi wa Githingi (1994) explains that the poor are not only perpetrators of environmental damage, but are also among its most unfortunate victims. They argue that environmental degradation worsens the plight of the poor primarily through its adverse health effects through water contamination, indoor air pollution, and outdoor air pollution. Ballesteros (2010) describes semi-urban settlements in Philippines as the most unsafe places on earth. The author adds that these areas are heavily populated areas with substandard housing in a physically deteriorated environment that lacks or have poorly maintained infrastructures such as water, sewage system and garbage disposal. A similar situation is likely to prevail in Kenya as one of

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the less industrialized nations. Therefore the study intends to extend this analysis on causal relationship between poverty and environmental degradation but with a focus on utilization of health facilities among the residents semi-urban settlement in Kawangware Division.

Unemployment and low wages is a major a cause of poverty both in urban and rural areas. Although many people have completed college education, many have failed to make safe important employment due to lack of opportunities and skills for gainful employment and lack of crucial resources for production such as electricity. Lack of credit due to the inability to obtain collateral is also a hindrance to self-employment. For women, access to credit is conditional upon their husbands' consent and this hinders their development. Furthermore women tend not to own land or other tangible forms of security to secure a loan. Corruption and nepotism have worsened the situation as poor households are often unable to pay the bribes demanded by potential employers. Lack of employment implies lack of income necessary for meeting the basic needs such as food, shelter, clothing, education and medical services (Weber & Jensen, 2004). A study by Bagheri (2012) about the Socio-Economic Disparities exhibited in semi-urban settlement found that lack of meaningful employment and economic facilities in Iran not only enhanced poverty trend but also increased social harms like drug addiction among the youth. This is likely to be the experience of semi-urban settlement residents in Kawangware Division which is the scope of this study.

Landlessness is also seen as a major underlying cause of poverty in many communities. In rural areas in different countries, people depend on land for production. But, the majority has been rendered landless or squatters and this lowers production. The causes of landlessness vary from nations to nations. While in some nations it is a result of high population growth, while in others it is due to poor land tenure systems such as communal land ownership. For example, in North Eastern part of Kenya, farmers and pastoralists usually clash over grazing and watering points, thereby causing poor utilization of the land resources. In the coastal region in Kenya, many households do not have land title deeds. Lack of land increases women's vulnerability to low incomes and poverty. Ownership and access to land in rural areas is a critical factor influenced by the interplay of customary and civil law. Related to landlessness is the fragmentation of land

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into small uneconomical units in parts of the Kenya (Government of Kenya, 2007). According to Torres (2007), landlessness is manifested in the form of dubious nature of their legal status; land tenure is often not granted because of the invasion of public or private land or the construction of dwellings that fail to meet urban planning regulations. On the same line of reasoning, Woods (2003) argues that most residents in semi-urban settlement live in close proximity to each other thus exposed to elevated risks from water and air-borne diseases. A fact, the author partly attributes to inadequate land. However, this conclusion may not uphold because it is difficult to partition the overall risks facing slum-dwellers into the risks attributable to poverty and the additional risks produced by the spatial concentration of residents and neighbor due to inadequate land or utilization of health facilities. This study therefore intends to clarify on the real effect of poverty on utilization of health facilities among residents of semi-urban settlement in Kawagware.

Poverty is also attributed to apathy. According to Patel, Rodrigues and DeSouza, (2002), apathy leads to poverty and that apathy is when people do not care, or when they feel so powerless that they do not try to change things, to right a wrong, to fix a mistake, or to improve conditions. In some instances, individuals feel so unable to achieve something to the extent that they are jealous of their own family relatives or fellow people of their community who attempt to do so. They therefore seek to bring the attempting (individuals) achiever down to their own level of poverty. It is okay to believe that God decides our fate, if we accept that God may decide that we should be motivated to improve ourselves. According to a Russian proverb, we should pray to God, but also row to shore, and this demonstrates that we are in God's hands, but we also have a responsibility to help ourselves.

2.3.2. Effect of Income on Health of Communities

In Bridging the Gaps, the World Health Organization (1995) says that the world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty. This statement emphasizes the essence of poverty as a variable adversely influencing health. As postulated earlier, poverty is a multidimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education and poor health. Poverty can be both intrinsically alienating

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and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioral and psychiatric problems.

Many threats, deficits and obstacles to quality health have been reported to be as a result of poverty. Normally, it is the poor people who are living in dangerous environment and therefore they are at higher risks. Kaplan et al., (1987) noted that the inverse relation between disease risks and socio economic level is one enduring and pervasive observations in the public health. For a long time it has been observed that people who earn the lowest income are at greater risks of diseases. Moreover, individuals who are at lowest social economic class are experiencing more stress due to their life circumstances. Most researchers have focused on how poverty relates to poor health of communities but not on how poverty relates to utilization of available health facilities and services. This is an intriguing aspect of analyzing poverty in relation to enhancing health of communities.

The causal relation between income and health has been an important research issues for many years. Moreover, in medical and sociological literature, the existing association between state of health and poverty is now broadly recognized. Poor individuals lack voice, power and representation and this makes them more vulnerable to ill health, illiteracy, unemployment, disasters or violence. The question that remains unanswered is how this relationship between poverty and health relates to utilization of health facilities. This is what this research seeks to unearth. Thus poverty remains a pervasive national problem presenting formidable challenges that call for urgent action.

According to American Lung Association reports (2007), the poor live in regions with worse air quality. The American Lung Association reports that low-income and minority Americans live in areas with worse air quality. This is because poor people are more likely to live close to sources of pollution, like industrial plants that emit harmful particles. To make it worse, certain low-income populations can also suffer from medical problems that make air pollution even worse for their health. For example, the elderly, African-Americans, Mexican-Americans, and people who live near a central city have far higher rates of diabetes and asthma; both conditions that are

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exacerbated by bad air quality. Scientists also link air pollution to kidney problems, lower birth weights and higher levels of infant mortality.

Economic insecurity generally has devastating effects on individuals' mental and physical health. Poverty greatly impact on people mental health more than the warfare. A new research has found out that mental stress of people who are poor is one of the main reasons why they experience many cases of high blood pressure, diabetes, obesity and cholesterol and the long term stress lead to hormones which compromises immune system thereby enhancing weight gain. The poor health trends actually begin in the wombs of mothers since mothers who are stressed up during pregnancy have higher chances of giving birth to children who are predisposed to diabetes and obesity which are developing. Mothers who are very poor and cannot get access to enough diapers are normally depressed or suffer form mental illnesses which are in turn passed on to children. The result is that these children's health is negatively affected and their school is also poor, (Weber & Jensen, 2004).

According to Wilkinson (1997), he believed that income inequality produces psychosocial stress, which results to deteriorating health and higher mortality over time. But, the association between income inequality and life expectancy is slowly disappearing and is no longer widely accepted. Individuals who live in poor/deprived communities, where there is under-investment in the social and physical infrastructure, experience poor health thus leading to higher mortality for those of lower socio-economic class. The impacts of income inequality also spread over into wider society, causing stress, frustration and family disruption, which then increase the rates of crime, homicide and violence. Wight, Thampi & Michelle, (2011), says that poverty and social inequalities in childhood have great impacts on the health of children, and their effects on health continues to reverberate throughout the life course into late adulthood. Worldwide and historically, poverty has been the great determinant of child and adult health and, even in wealthier countries like United State of America, it remains a major cause of ill health with huge public health consequences. The rapidly growing and developing fetus and child seem to be particularly vulnerable to the profound effects of poverty providing a further powerful argument for policy initiatives designed to protect children from its worst effects. This situation is not

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different in developing countries, Kenya included. It is likely to be even worse of due to the general economically poor states of these low income countries.

Tuberculosis, diarrhea, malaria, HIV and communicable respiratory disease such as pneumonia kill many individuals in poorest countries. Malaria, pneumonia and diarrhea are responsible for almost half of children who die globally. Neglected tropical diseases have negative impacts on over one billion people, almost all in the poorest and most marginalized societies. Diseases such as lymphatic, leprosy, schistosomiasis, soil transmitted helminthes, trachoma and onchocerciasis can result into lifelong disabilities and severe pain and mean enormous productivity losses. These make the poor Nations to be even poorer as their productivity is greatly reduced by poor health conditions of it people (World Bank Group, 2004). Such situations make poverty and health state of populations inter-lockingly related and those aspects form a vicious circle.

While there is a great concentration of poverty in semi-urban settlements, it should be noted that not every inhabitant is poor. Nevertheless, these areas are both an expression – and a practical result – of deprivation and exclusion. It should also be noted that although dwellers in semi-urban settlements bear a disproportionate burden of mortality and ill health, not all are equally disadvantaged, thus reinforcing the importance of the current study.

But even as the poor succeed in receiving health care facilities, a question worth asking is whether the service rendered is of sufficient quality to make an effective difference to their health. Some studies seem to raise some doubts on this score. For-instance, urban quality-of-care study in New Delhi by Das and Hammer (2007) reveals that some people living in semi-urban settlements tended to seek care for illness at least as often as the non-poor. However, the quality of care available in the poor neighborhoods was so low that the authors could fairly describe it as money for nothing. A recent study by Effindi (2015) on health situation of informal settlements in Karachi, Pakistan found no government hospitals in the vicinity of the Bhattiabad slum and the nearest private hospital so far away that travel costs are prohibitive for low-income families. This study reports that primary health care is nonexistent in the informal settlement and

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majority of people relied on informal, unregulated practitioners who asked for high out-of-pocket payments before offering their services.

Similar challenges noted above may be found in Kenyan semi-urban settlements. For instance, Fotso, & Mukiira (2012) in their study about the quality and access to health facilities among poor urban women in Kenya found that most women seeking health services were served by privately owned, sub-standard, usually unlicensed clinics and maternity homes. The study further established that there was inadequate supervision or adherence to required standards of services. Lastly, employees at these facilities were often unfriendly and unwilling to give prenatal counseling. This raises the question on whether available of enough health facilities or the type of response from health employees have a bearing on the health seeking behaviours among residents of semi-urban settlements including Kawagware Division which is the focus of this study.

Theoretical Framework

In this research, there are a number of theories have been found to be relevant. This research will however focus mainly on Health Belief Model due to its ability to address issues raised.

2.3.1. Health Belief Model

Health Belief Model (HBM) is a psychological model that attempts to explain and predict health seeking behaviors. It was originally proposed by US researchers in the 1950s to explain why people were reluctant to take part in programs aimed at preventing and detecting diseases particularly health checks and immunization programs. Since then, it has been substantially developed and modified for application for other types of health behaviours. The model uniqueness lies in its emphasis on perception and motivation. This framework provides the concepts and theoretical lens that may explain the effects of poverty in utilization of health facilities and services among semi-urban settlement residents in Kawangware.

The HBM is based on four major constructs namely: perceived susceptibility, severity, benefits, and barriers to action (Janz, Champion and Strecher, 2002). Basically, the HBM holds the view

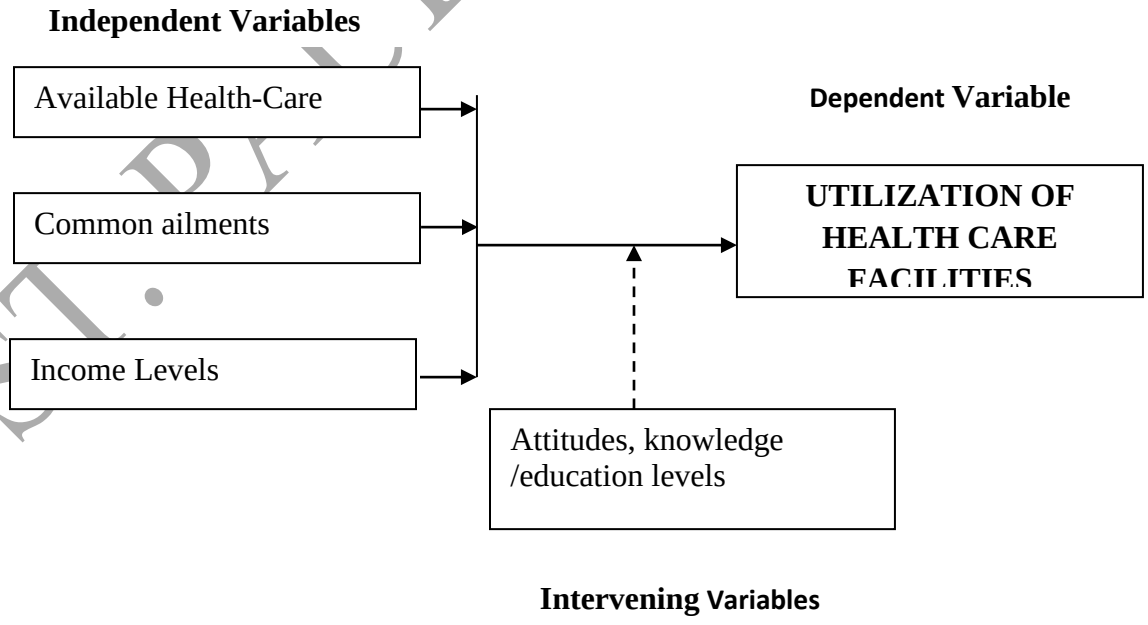
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that in order for an individual's likelihood of taking a particular action is determined by his or her (i) perception about the illness as having 'at least moderate severity'; (ii) perceived susceptibility of the disease; (iii) believe about specific benefits linked with a given action such as whether the illness will be effectively prevented or cured; and (iv) believe that there are no major 'barriers'-such as cost involved, impeding his/her taking that action (Janz et al., 2002).

2.3.2. Relevance of the theory

Economic influence has been shown to have a great bearing on utilization of health facilities and services (Zang, 2007). The HBM provides a unique interconnection among constructs that can explain health seeking behaviour (Atkinson & Permuth-Levine, 2009). The choice of HBM is based on the fact that utilization of health facilities is based on the perceived benefits and cues to action. Key concepts and assumptions of the HBM include individual perceptions and modifying factors that influence the likelihood of an action (Glanz, Rimer, & Lewis, 2002). In the context of this study, modifying factors such as socioeconomic status becomes relevant. Therefore, the study benefits from the model since it provide the framework for examination of participant susceptibility and socioeconomic status as a cue to action which is the utilization of health facilities and services.

2.3.3. Conceptual framework



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Figure 2.1: Conceptual Framework

Source: Generated by the researcher-Million Mesfin (2016)

In the fortified framework above (Figure 2.1), used in the analysis of this study, available health services, income level, coupled with types of ailments are taken as independents variables and all have some effects on utilization of health facilities among residents of Kawangware semi-urban settlement. Poverty such as low income level limits opportunities for healthcare accessibility as a result of economic disempowerment. It enhances people's vulnerability to ill-health since they may be forced to live in areas environments with in adequate clean water and without good sanitation as decent shelter. Poverty is denied people access to reliable health services and affordable medicines. It may enhance people's vulnerability to ill-health since they may be forced to live in areas environments with in adequate clean water and without good sanitation as decent shelter. In some cases, one may well ignore the health facilities altogether.

Utilization of health facilities depends on the available health services. For instance, where there are no enough health facilities one may be left with the option of having to travel to other areas, which most usually involves long distances. This may reduce demand and utilization of healthcare services.

The type of ailments is yet another independent variable especially in relation to the severity of the ailment. In case of less serious illness, one may ignore services of health facilities. However, ailments which are unbearable forces one to use the health facilities. In other words, only serious ailments may be considered legitimate reasons for utilizing a given health care service or facility. The figure shows that the overall effects of the independent variables on utilization of health facilities (the dependent variable) are further controlled by the intervening variables. For instance, education makes people literacy, and well informed about health risks thus improving their health seeking behaviours. In terms of gender, women may be more restricted and may not find time to visit health facilities because of their gender roles such as childcare and other household tasks, which demand a lot of their time. Old age is also associated with special

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concerns, higher rates of morbidity, much more difficulties in accessing health care facilities and other challenges.

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CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

The chapter is an overview of the methods and techniques that the researcher will adopt to gather information required to achieve the enlisted objectives of the study. Key concepts under this chapter are; research design, study area, target population, sampling techniques, sample size, data collection, data collection instruments, pre-testing, validity and reliability of data collection methods and tools and methods of data analysis, data analysis and information presentation, logistical and ethical considerations.

3.2. Research Design

Research design is a detailed plan of how the researcher hopes to carry out the study. According to Messah and Kigige (2011), a research design is a program to guide the researcher in collecting, analyzing and interpreting observed facts. This study will adopt a descriptive survey design to assess effects of poverty on utilization of health facilities in Kawangware Division Nairobi County. It entails the process of collecting data in order to test hypothesis or to answer questions concerning the current status of subject in the study. According to Orodho (2009) survey design involves collecting of information though interview or by administering questionnaire. It determines and reports the way things are and attempts to describe the state of affairs as it exists (Mugenda and Mugenda 1999). Main purpose of this type of design is to determine independent factors as they influence utilization of health facilities in Kawangware semi-urban settlement without any manipulation of the variables. An ex-post facto research design is a systematic empirical inquiry in which the research has no direct control over the independent variables due to the fact that either their manifestation has already occurred or they are not inherently manipulated (Kerlinger, 1973).

This approach has been found appropriate because it will help the researcher to gather data based on opinions, attitudes and perceptions of people on effects of poverty on health and particularly on utilization of health facilities.

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3.3. Study Area

The area of study is Kawangware Division in Nairobi County. Kawangware is a semi-urban settlement in Kenya and it is about 15km west of the city centre of Nairobi (National Census, 2009). From the same census Kawangware has an annual population growth rate of 4.8 % with the current population being 113,286. Kawangware neighbors Kangemi to the north, Lavington to the East, Riruta to the south and Uthiru to the west (See Appendix III). Aside from what the census shows, the population constantly keeps on swelling due to migrants from other places. Kawangware is one of the largest and among the most well-known semi-urban settlement in Nairobi. It is also one of the oldest semi-urban settlements in Nairobi.

According to (Mwangi, 2014), most people in Kawangware live in sub-standard houses in terms of a number of criteria such as overcrowding and the density of housing structures. He also asserts that the slum is characterized by poor drainage system and poor waste disposal. Coupled with this is the fact that most toilets are shared among different households. Such poor sanitary conditions are likely to expose the Kawangware Semi-Urban Settlement dwellers to a myriad of environmentally related infections.

In terms of economic activities, (Mwangi, 2014) noted that most people are employed as casual labourers, or engage in hawking business as well as mini groceries. A vast number of the residents in this area are unemployed. Given such poor socioeconomic status, affordability and access to health care services for the residents of Kawangware Semi-Urban Settlements may pose serious challenges. It is against such a background that this researcher chose to assess how poverty affects the utilization of the health facilities in this region. Given its environmental conditions as noted earlier, and the low social economic state of the residents, there is likelihood that health seeking behaviours of the residents may be negatively affected, hence this study.

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3.4. Population

Population refers to the entire group of individuals, objects, items, cases, articles or things with common attributes of characteristic (Mugenda, 2008). The population for this study will be all household heads in all the Semi-Urban Settlements in Nairobi County.

3.4.1. Target Population

According to Mugenda (2008), a population is a complete set of individual cases or objects with some common observable characteristics. For this study the target population will be all household heads in Kawangware semi-urban settlements.

3.5. Sampling and sampling techniques

The term sampling refers to a selection of part of the elements in a population. Such selection can be used to make conclusions that can be applied to the entire population. The advantages of such selection across board include the fact that it makes studies cheap, quality and saves time.

On the other hand, sampling techniques are the methods used by researchers to select the participants for their sample (Mugenda and Mugenda, 2003). These techniques aim at minimizing cost whilst maximizing generalizability. This study will adopt two sampling techniques namely purposive and multistage sampling techniques. Multistage sampling is a technique whereby the researcher divides the target population into stages, samples the stages and then re-sample, repeating the process until the desired sampling units are selected at the last of the hierarchical levels (Goldstein, 1995). According to (Ma et al., 2006) multistage sampling is generally applied when it is costly or impossible to form a list of all the units in the target population. The choice of this method is informed by the fact that it is often more precise than a simple random sample.

Multistage random sampling was therefore used for this study to arrive at the particular villages targeted since Kawangware division was quite vast as noted earlier. Therefore, the researcher divided the target population into stages .Division, Locations, Sub locations and Villages. The first stage sampled locations within Kawangrware division. In the second and third stage, the researcher considered sub-location and villages respectively which were then sampled to arrive at desired sampling units. The researcher selected four locations using random sampling.

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Kawangware division has four locations, from these four locations again, two sub locations were selected randomly from the four locations after which four villages namely: Stage Two village, Coast, Macedonia and Kabiru Villages were sampled as shown in figure 3.1

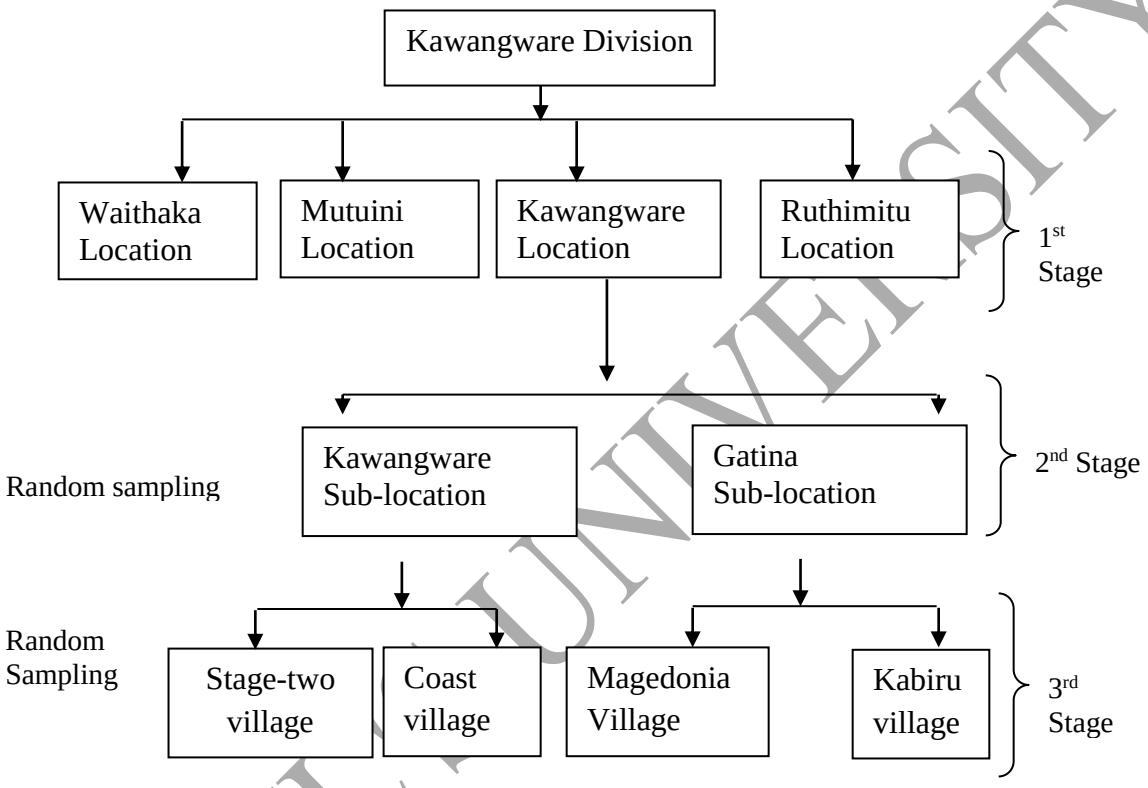


Figure 3.1: Sampling Procedures

Source: Generated by Mesfin (2016) from Government records

From the sampled villages the researcher sampled the respondent household heads using a standardized formula from Fisher et al (1991) as shown here under.

$$n = \frac{z^2\, pq}{d^2}$$

From the four Villages, a total of 113 households were selected randomly according to their households' size. Table 3.1 gives the breakdown

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Village	No. of households	Percent
Stage Two	48	42.4
Coast	40	35.8
Macedonia	8	7.2
Kabiru	16	14.6
Total	113	100

Table 3.1: Number of households Sampled

Purposive sampling was used for sampling the key informants who were composed of doctors, clinical officers and nurses heading the health care facilities in Kawangware sub-location. Purposive sampling, also known as 'judgmental or theoretical sampling', is a non-probability sampling strategy which involves the conscious selection and sampling of certain elements or subjects from a pre-specified group (Trochim, 2000) or "information-rich cases (Webb and Doman, 2008). Simply put, the researcher decides what needs to be known and sets out to find people who can and are willing to give the information by virtue of either their knowledge or experience (Lewis and Sheppard 2006).

3.6. Sample Frame and Sample Size

A sampling frame is simply a list of elements from which the sample may be drawn (Zikmund, 2010). Zikmund also calls it a working population because it provides the list that can be worked with operationally. This study's sampling frame will include household heads in Kawangware Semi-Urban Settlements.

According to Bartlett, Kotrlik, and Higgins (2001), in determining a sample size, the following key factors need to be considered: Population size, margin of error (+/-5%), and a standard of deviation of 0.5. at a confidence level that corresponds to the Z-score, a constant value which is required in calculating the needed sample size. According to Scott (2013), the z-scores for the most common confidence levels include 90% – Z score = 1.645; 95% – Z score = 1.96 and 99% – Z score = 2.576. In this study, the researcher will use the confidence level of 95% to get the minimum but a representative number of the target population.

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Kawangware Semi-Urban Settlements has more than 10,000 households (national census, 2009). When the target population is more than 10,000, Mugenda (2008) advices that the following formula by fisher et al. (1991) be applied to calculate the sample size:

$$n = \frac{z^2 pq}{d^2}$$

Where, n: is the desired sample size when the population is greater than 10,000.

z: is the standard normal deviation, set at 1.96, which corresponds to 95% confidence level

p: is the proportion in the target population estimated to have a particular characteristic (assumed to be 50% where the target population is not known in exact numbers)

$$q = 1.0 - p$$

d: is the level of statistical significance or alpha (degree of accuracy desired) set at 0.1 corresponding to the 1.96

In this study, a 95% confidence interval will be used. The calculation for the sample size, n, will be as follows:

In substitution for $n = \frac{1.96^2 \times 0.5 \times (1-0.5)}{0.1^2} = \frac{0.9604}{0.01}$

Therefore, n = 96.

According to the calculation, n was 96. However, according to USAID report, "the survey sample must also be large enough to accommodate survey attrition" (USAID, 2006, p.6). For this study, additional 17 respondents were sampled giving a total of 113 respondents in order to guard against drop out and attrition (Yaah, 2015).

3.7. Data collection Instruments

The study collected both secondary and primary data. Secondary data was collected through review of information documented in e-books and other electronic sources. Other literature used was be sourced from books on effects of poverty on health and other related human resource considerations from the University library. The Kenya National Library Services facility will

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also be of vital assistance in the affair of secondary data collection. On the other hand, primary data was collected using the methods discussed below.

3.8. Questionnaire

Questionnaires (with both open ended and closed ended questions) were used to collect primary data (Kothari 2004). Some of the issues to be captured include demographic data which includes age, sex, education level, marital status and individual respondent's observations on the subject of study. Orodho (2009) points out that a questionnaire can be used to collect a huge amount of data in relatively shorter time. Further a questionnaire reduces bias inherent in interviews leading to honest answers since no identification is needed and respondents gave answers without fear.

3.8.1. In-Depth Interview Schedules

In-depth interview schedules will be used to collect data from key informants. According to Gorman and Clayton (2005), this method is associated with a high response rate and allows the researcher to clarify ambiguous answers and where appropriate and can seek for follow-up information. Besides, this method has the benefit of getting unexpected insights which may also be relevant to the study. In total, 30 Key respondents were interviewed.

3.9. Pilot Study

The researcher used pilot study to assess the validly of research instruments. A sample of 10 people from a different location was used for this purpose. According to Mugenda and Mugenda (2003) about 1 to 10% of study sample is appropriate for pilot study. The suitability of the questionnaire for the current study was first assessed by giving out the questionnaires to 10 households which is about 10% of the 113 sampled populations. All the retuned questionnaires from the respondent were coded to assist in data entry. A coefficient of 0.74 was obtained on all the key variables. According to Zinbarg (2005). A coefficient above 0.5 indicates that the research tool is reliable. The results from the pilot phase assisted the researcher to not only ascertain the reliability of the instrument but also adjust the vague question items appropriately.

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3.10. Validity and Reliability of Data Collection Methods

Validity is generally defined as the extent to which an instrument measures what it is supposed to measure (Kimberlin and Winterstein, 2008). In other words, it answers whether the means of measurement are accurate and actually measures what they are intended to measure. To ensure validity of research instruments, the researcher consulted experts and supervisors about the research questions in relation to the set objectives and research questions.

On the other hand, reliability of data collection instruments concerns the idea of replicability or repeatability of observation or study findings. Orodho (2009) defines reliability as the extent or degree to which results are consistent over time when reproduced using the same methodology. To ensure reliability of research instruments, a test-re-test method was used.

3.11. Data analysis and Information presentation

Analysis of data employed two statistical techniques namely descriptive and inferential statistics. Inferential statistics helps in drawing conclusions on the underlying processes which generate research findings, and to extrapolate the future behaviors of the process (Welsh, 2011). Inferential statistics was most suitable for this study since it was able to account for uncertainties in the observational data, and mitigates their effects on decision making. This is a very important aspect in research since most of the data and interacting processes are contaminated with uncertainties. Hence inferential statistics enabled the researcher to come up with sound decisions irrespective of the associated uncertainties.

On the other hand, descriptive statistics is concerned with procedures and methods for interpreting and summarizing as well as presenting important characteristics of observations (Gabbay et al., 2011). Descriptive statistics such as frequency distribution, percentages, mean and mode will be calculated. Data collected was analyzed using SPSS (statistical package of social sciences). The analyzed data was presented using descriptive statistical techniques such as tables, frequencies, percentages, graphs, and charts. Cross tabulation tables of frequencies was also done to examine frequencies of observation that belong to specific categories on more than one variable. The descriptive statistics was carried out mainly to analyze demographic

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information of the respondents and health centers' data and compute scores for the various factors under consideration. Data was presented using charts, bar graphs, tables and pie-charts.

3.12. Ethical Considerations

The researcher sort permission for carrying out the study in the region from the local administration. All the participants were required to give their informed consent prior to their inclusion in the study. The researcher also sought approval from the area heath facilities and area leaders. In this process, accurate information about the research was provided. A written letter that explains the research idea was provided. The researcher obtained approval prior to any research activities at the specified locations. Participants were assured of privacy, and that their responses remained anonymous. In addition, participants were given freedom to choose whether to participate in the study or not. Accordingly, cover letters explaining the purpose of the questionnaire, and the right to accept or refuse to participate in the research activities was provided the respondents.

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CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION

4.1. Introduction

In this chapter, data analysis, interpretations and discussion of the data gathered from the sampled population is presented. The results are presented in four major sections based on the study objectives. Section 4.2 gives socio-economic and demographic profiles, section 4.3 presents information on the available health care services offered in the health care facilities in Kawangware, Section 4.4 report the commonly reported cases of ailments among Kawangware semi-urban settlement dwellers, and Section 4.5 the effect of household's income levels on use of health care facilities in Kawangware

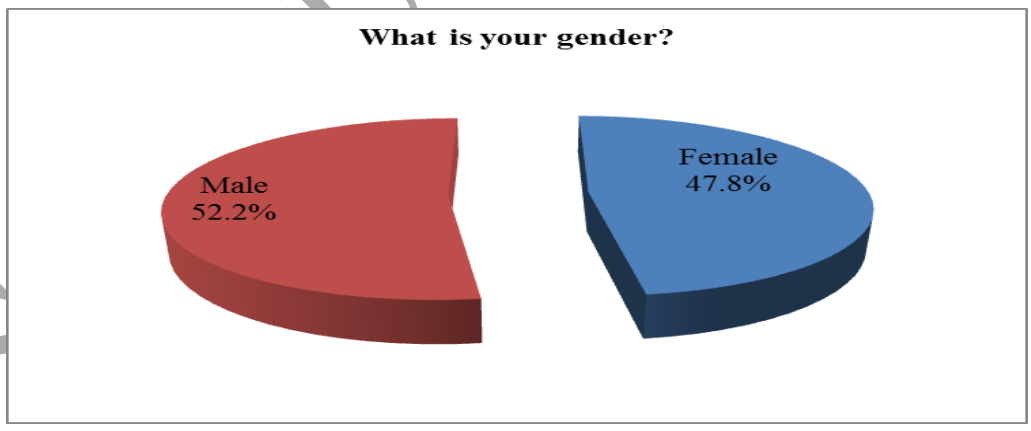
4.2. Socioeconomic and Demographic Profiles

Under this section, the following characteristics were considered. Gender; age brackets; levels of education; marital status; length of residency; village of residence; main occupation; and income

4.2.1. Gender of Respondents

From this study, it was observes that gender tended to influence the use of health care facilities. The distribution of the respondents according to their gender is presented in Figure 4.1 below.

Figure 4.1: Gender of Respondents



Source: Field Data, compiled by Million Mesfin (2016)

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As displayed in the above figure, out of 113 respondents, more than a half (52.2%) which formed the bulk of the sampled population was males. The rest of the respondents, 47.8% were females. The findings were similar to that of Prosser (2007) whose study was dominated by male respondents. The differences may be attributed to the fact that gender influences health seeking behaviour. In the present study, (Iwashyna and Christakis, 2003) Indicated males were more likely than females, to report being sick and seeking treatment.

4.2.2. Age Brackets

It was also necessary to establish the respondents' age brackets. The responses are summarized below in Table 4.1.

Table 4.1: Distribution of the Respondents according to their Age Brackets

Age Categories	Frequency	Percent
20-29 years	58	51.3
30-39 years	29	25.7
40-49 years	13	11.5
50 years and above	13	11.5
Total	113	100.0

Source: Field Data, compiled by Million Mesfin (2016)

Out of a tallied total of 113 sampled population, slightly more than half (51.3%) were aged between 20 and 29 years while 25.7% were in the 30-39 years age bracket. About 11.5% of the respondents disclosed their ages as falling between 40 and 49 years. Another 11.5% said they were 50 years and above.

These findings implied that the greatest portion of the population living in Kawangware is composed of youths. This is supported by what Mwangi (2014) found out in his research that most people in Kawangware were youths. Perhaps, this may be linked to the commonly held idea that there are more employment opportunities in the urban areas, leading people to migrate from rural areas to urban areas in search of job opportunities.

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4.2.3. Levels of Education

Education levels, particularly among adults, have a great influence on their health seeking behaviors (Prosser, 2007). In this study, education level was categorized into certificate, diploma, first degree, masters, no-formal education and others. Table 4.2 shows the distribution.

Table 4.2: Distribution of the Respondents according to their Education Levels

Education Levels	Frequency	Percent
Certificate	35	31.0
Diploma	20	17.7
Degree	27	23.9
Masters	24	21.2
No formal education	5	4.4
Others	2	1.8
Total	113	100.0

Source: Field Data, compiled by Million Mesfin (2016)

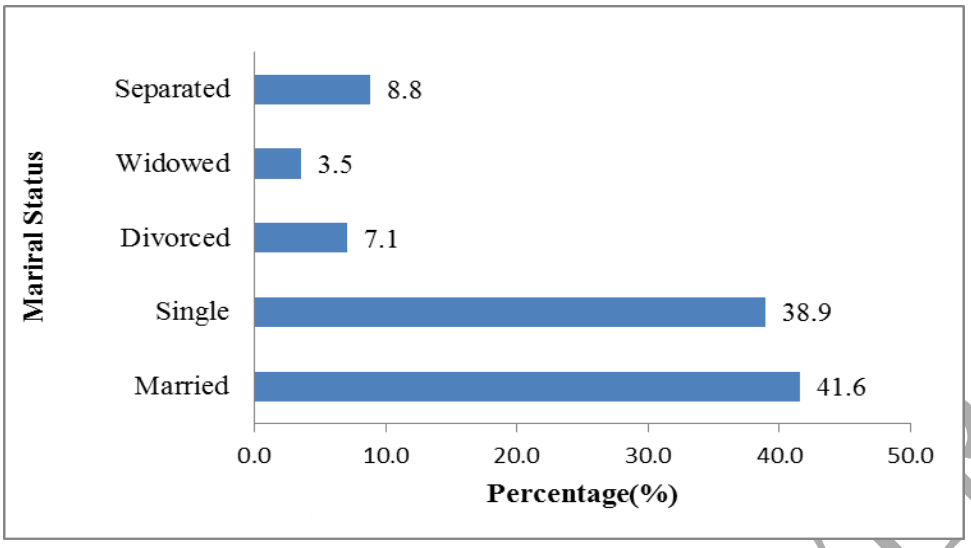
From the results, 31.0% of the respondents had certificate levels of education, 23.9% had first degree, while 21.2% revealed they had masters. Only 4.4% disclosed having received no formal education while smallest proportion of the respondent's, 1.8% indicted other levels of education such as primary and ordinary levels. This finding implies that the study was dominated by respondents who had certificates as their highest education level.

4.2.4. Marital Status

From previous studies (Iwashyna and Christakis, 2003) it has been shown that changes in marital status lead to differences in health care utilization. For instance, married individuals have lower rates of mortality, morbidity, and mental disorders in comparison to single (Iwashyna and Christakis, 2003) and as such it is an important variable. This study also sought to establish marital status of the respondents. Figure 4.2 below summarizes the results.

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Figure 4.2: Marital Status



Source: Field Data, compiled by Million Mesfin (2016)

Most of the respondents who participated in the study were married (41.6%). Sizeable fractions of the respondents (38.9%) were single while about 8.8% and 7.1% were separated and divorces respectively. The smallest proportions of the respondents, 3.5% were widowed. These findings imply that the study was dominated by the married. Possible reason for this could be due to the fact that married people are more interested in health issues. Hence, a specific marital status in a particular stage of life could be an important target group for health policy intervention.

4.2.5. Length of Residency

The respondents were asked to state how long they had been living in Kawangware Division. Their answers are as summarized Table 4.3 below.

Table 4.3: Length of Residency

Length of Residency	Frequency	Percent
Below 5 years	27	23.9
6-10 years	32	28.3
11 years and above	54	47.8
Total	113	100.0

Source: Field Data, compiled by Million Mesfin (2016)

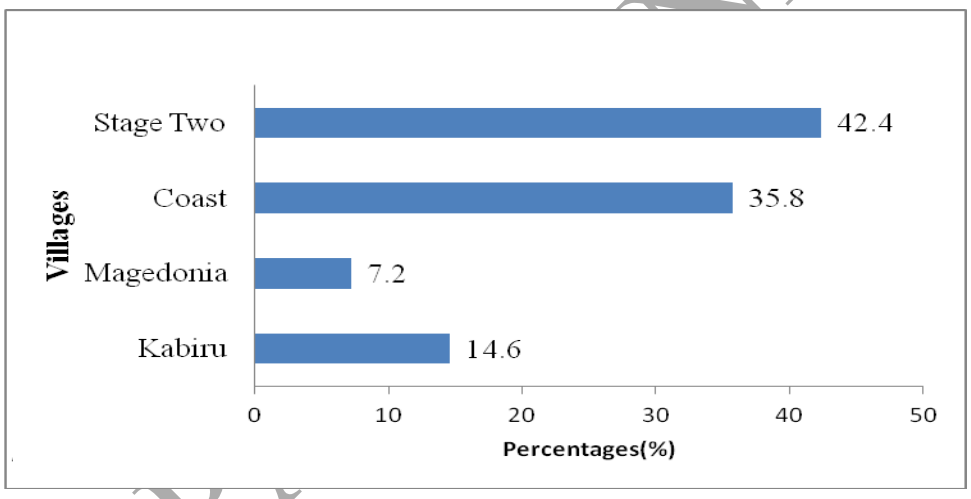
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About half (47.8%) of the sampled population had been residing in Kawangware Division for 11 years and above while slightly less than a third (28.3%) had lived in the area for 6-10 years . The smallest proportion 23.9% had been staying in Kawangware Division for not more than 5 years. It can be inferred from the study that most of the respondents had lived in the Kawangware Division long enough hence had vast knowledge about the area which, could be greatly relied upon by the researcher.

4.3. Village of Residence

Further probing revealed that majority (42.4%) of the respondents interviewed had been residing in Stage-Two Village. This was followed by 35.8 % of the respondent from Coast Village. About 14.6% and 7.2% of the respondent's specified that they had been living in Kabiru and Magedonia villages respectively (Figure 4.3 gives details).

Figure 4.3: Respondents' Villages of Residence



Source: Field Data, compiled by Million Mesfin (2016)

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4.4. Main Occupation

Table 4.4: Respondents' Main Occupations

Occupation	Frequency	Percent
Civil Servant	26	23.0
Small Business	50	44.2
Casual Worker	28	24.8
Other	7	6.2
Missing items	2	1.8
Total	113	100.0

Source: Field Data, compiled by Million Mesfin (2016)

According to Table 4.4 above, most of the respondents (44.2%) relied on small businesses as their main occupations, 24.8% indicated their main occupation as casual work while 23.0% disclosed that they were civil servants. About 6.2% mentioned other occupations which ranged from athlete, working for a company, student, to teaching in private school. Occupations of the respondents have a bearing on their health seeking behaviours especially in terms of their income and education.

4.5. Income

As displayed in Table 4.5 below, additional analysis was done to establish the monthly incomes of the respondents.

Table 4.5: Composition of the Respondents according to their Income Levels

Income Levels	Frequency	Percent
Below Kshs.4000	23	20.4
Kshs. (4000-8000)	18	15.9
Kshs. (8001-12000)	19	16.8
More than Kshs. 12000	51	45.1
Missing	2	1.8
Total	113	100.0

Source: Field Data, compiled by Million Mesfin (2016)

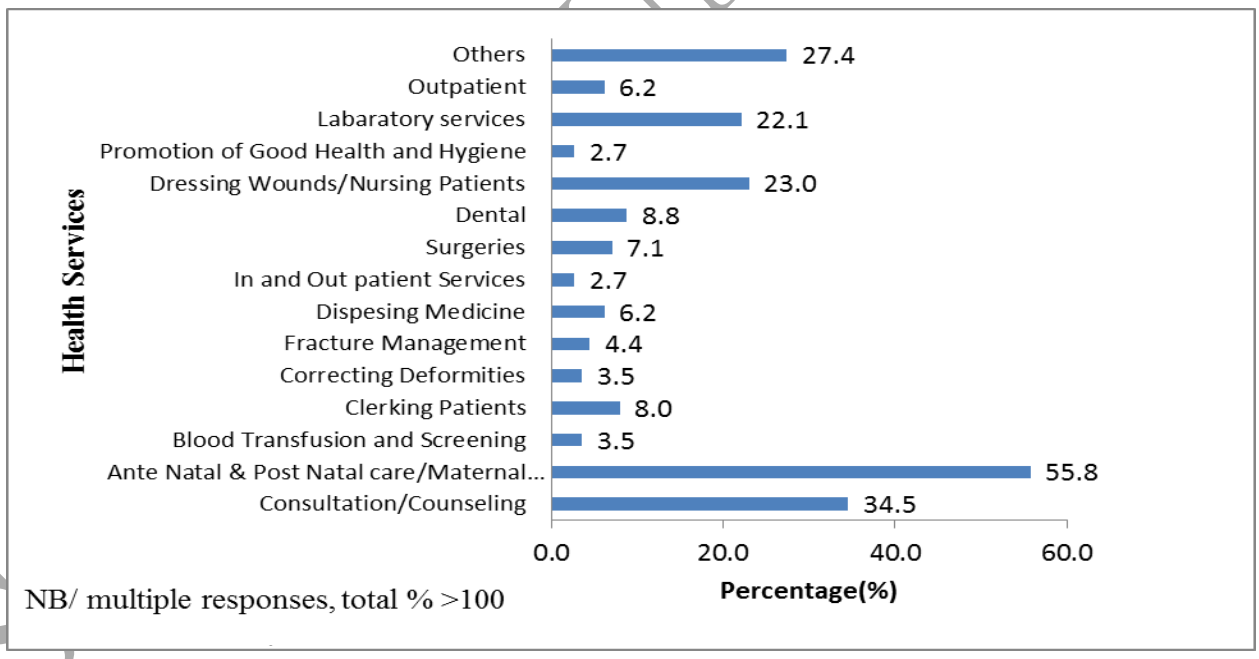
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The findings above reveal that 45.1% of the respondents earned more than Kshs. 12000 per month while 20. 4% received less than Kshs. 4000. It was evident that 15.9% and 16.8% received monthly income of Kshs. (4000-8000) and Kshs. (8001-12000) respectively.

4.6. The available Health Care Services offered in the Health Care Facilities in Kawangware

The most common health services in Kawangware Division are Ante Natal and Post Natal care, maternal care and family planning (55.8%). The second most common health service available is consultation and Counseling (34.5%). The rest of the services include dressing wounds and nursing (23.0%), laboratory services (22.1%), outpatient and inpatient (8.9%), Dental (8.8%), Clerking Patients/Recording vital signs (8.0%), Surgeries (7.1%), dispensing medicine (6.2%), fracture management (4.4%), correcting deformities (3.5%), blood transfusion and screening (3.5%) and promotion of good health and hygiene (2.7%). Figure 4.4 gives the details.

Figure 4.4: Available Health Care Services in Kawangware Division



Source: Field Data, compiled by Million Mesfin (2016)

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Some of the quotes from key respondents on the various services include the following:

"*We advice our patients on how to live positively with HIV/AIDs*" (Health Practitioner, 2016)

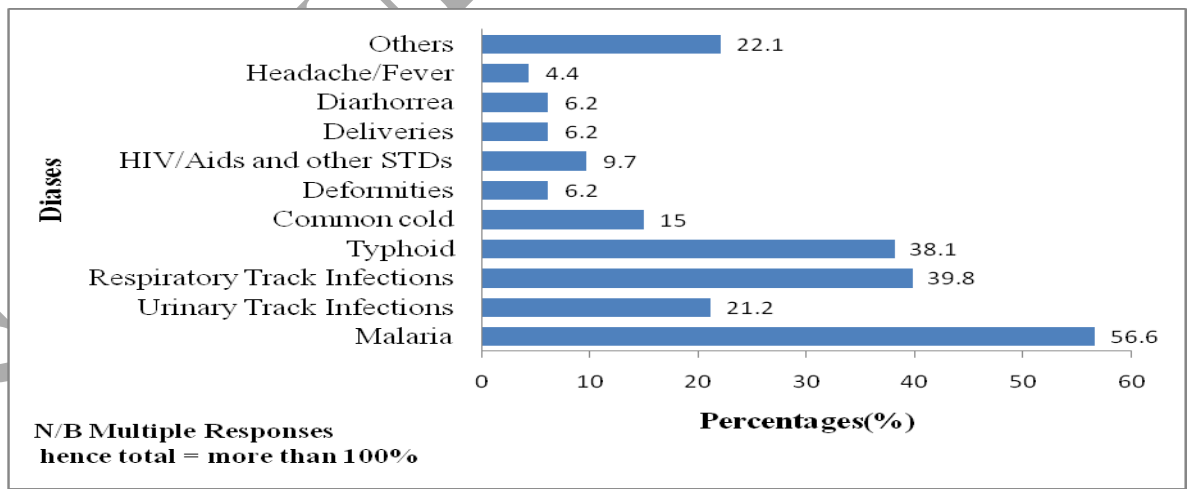
"*Sleep under a mosquito net, to prevent mosquito bites" (*Health Practitioner, 2016)

4.7. Commonly Reported Cases of Ailments among Kawangware Semi-Urban Settlement Dwellers.

In order to assess the health status of the area, key respondents were asked to state the commonly reported illness within their area of operation. Figure 4.5 presents the results.

From the figure 4.5, the most common illness is malaria (56.6%). The second most reported illness is Respiratory Tract Infections (39.8%), followed by Typhoid (38.1%). Urinary Tract Infections, Common cold, and injuries were mentioned by 21.2%, 15%, and 13.3% respectively. About 6.2% and 4.4% of all the key respondents interviewed said Deliveries and Headaches /fever were common in that order. Surprisingly, HIV/Aids and STDs were not as common as one would expect in an informal settlement like Kawangware Division as only 9.7% disclosed it was a problem. Perhaps, this may be attributed to their sensitivities. In the category of others, all illnesses with less than 2 persons were reported such as growth development and related cases, cancer, kwashiorkor, dysentery, infestation by jiggers and diabetes.

Figure 4.5: Commonly Reported Illness in the Study area



Source: Field Data, compiled by Million Mesfin (2016)

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This finding is consistent with that of Rahman, Bann and Nessa (1989) who focused on informal settlement in Dhaka. In their study, respiratory infections were reported as the most common problem. In the current study, respiratory tract infection was the second most common illness. Similarly, Marimuthu et al., (2009) reported diseases such as diarrhea, typhoid and fever as quite common in the informal settlements. They explained that hand-washing at critical times is not always practiced owing to lack of water and the linkage of hand-washing to preventing diarrhea and the transmission of infectious agents are poorly understood. In the current study the issues of hygiene may offer a good explanation for the commonly reported illnesses such as diarrhea and typhoid.

4.8. The Effect of Household's Income Levels on Use of Health Care Facilities in Kawangware

Table 4.6: Respondents' Incidents of Sickness in the last three months and their Income Levels

	Have you fallen sick in the last three months?		
Levels of Income	Yes	No	Total
Below Kshs.4000	14(60.9%)	9(39.1%)	23(100%)
Kshs.(4000-8000)	9(50.0%)	9(50.0%)	18(100%
Kshs.(8001-12000)	9(47.4%)	10(52.6%)	19(17.1%)
More than Kshs. 12000	16(31%)	35(69%)	51(45.9%)
Missing	-	-	2(100%)
Total	48(43.2%)	63(56.8%)	113(100.0%)

NB/ out of the 113 respondent, 2 were student hence their income levels have not been captured hence reflected as missing items.

Source: Field Data, compiled by Million Mesfin (2016)

From the total 23 respondents who participated in the study, those with monthly income of less than Kshs. 4000 revealed 60.9% are not fallen sick in the last three months as opposed to a mere 39.1% of those who have not fallen sick over the specified period. For people with the highest

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monthly income of more than Kshs.12000, only 31% of all the respondents had fallen sick within the last three months compared to 69% who have not fallen sick within the specified period of time.

Under the category of respondent earning monthly income of Kshs. (4000-8000), an equal proportion of respondents, 50% have either fallen sick or not fallen sick in the last three months. For people earning between Kshs. 8001 and 12000, 47.4% have fallen sick while 52.6 % have not fallen sick. From these findings, it can be inferred that vulnerability to sickness tends to diminish with increasing incomes.

In probing for the reasons for not seeking treatment one of the respondents had this to say:

> *"Lack of money, inadequate health facilities have led me not to access treatment"* (Female respondent, 2016)

Another respondent asserted that:

> "*I was unable to get money for treatment and my family could not handle*" (Female respondent, 2016)

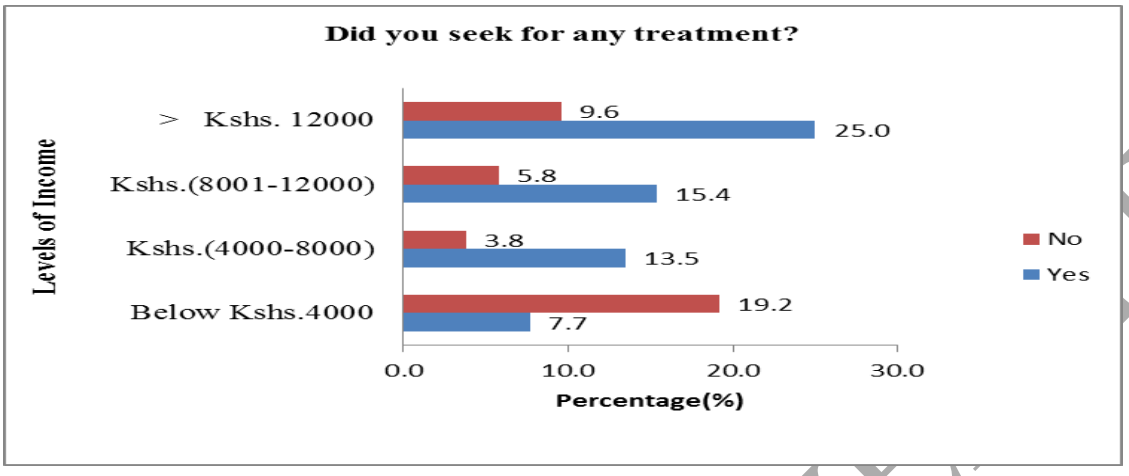
4.9. Seeking for Treatment

The researcher also enquired on whether respondents sought for treatment. Figure 4.6 summarizes the findings.

As shown in Figure 4.6, most of the respondent (25.0%) who sought for treatment had relatively high incomes of more than Kshs. 12000. Majority (19.2%) of those who did not seek for treatment were mostly person with low income (below Kshs. 4000). It therefore follows that the higher the income levels, the more chances for seeking treatment whenever one is sick.

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Figure 4.6: Whether respondent sought for treatment



Source: Field Data, compiled by Million Mesfin (2016)

4.9.1. Major Places for seeking Treatment

The researcher also requested the respondents to state where they sought for treatment in order to assess whether this was related to their income levels. Table 4.7 summarizes the findings.

Table 4.7: Places for Seeking Treatment and Levels of Income

	Whenever you are sick, where do you seek treatment?						
Levels of Income	Self-treatment	Nearest Shop	Chemist	Health Facility	Traditional Healer	Others	Total
Below Kshs.4000	1(0.9%)	1(0.9%)	5(4.5%)	8(7.2%)	7(6.3%)	1(0.9%)	23(20.7%)
Kshs.(4000-8000)	1(0.9%)	1(0.9%)	7(6.3%)	8(7.2%)	1(0.9%)	-	18(16.2%)
Kshs.(8001-12000)	3(2.7%)	2(1.8%)	3(2.7%)	10(9.0%)	1(0.9%)	-	19(17.1%)
More than Kshs. 12000	1(0.9%)	1(0.9%)	12(10.8%)	34(30.6%)	3(2.7%)	-	51(45.9%)
Total	6(5.4%)	5(4.5%)	27(24.3%)	60(54.1%)	12(10.8%)	1(0.9%)	111(100.0%)

NB/ out of the 113 respondent, 2 were student hence their income levels have not been captured leaving only 111.

Source: Field Data, compiled by Million Mesfin (2016)

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It is clear from the study findings displayed in Table 4.7 above that households with low income (below Kshs. 4000) are more likely to visit traditional healers (6.3%) whereas families with monthly incomes of more than Kshs. 12000 tend to visit health facilities (30.6%) and Chemists (10.8%). This implies that the likelihood of visiting formal health facilities and chemists increases with rise in income levels.

These findings seem to disapprove that of Schwartz *et al.* (1988) who observed that incomes to be insignificant factors of the choice of health care providers. However, the current study concurs with the previous studies as reported by Dow (1995) and Cisse (2006) who all found income levels to be key determinants for the places for seeking health services.

4.10. Discussion of the Research Findings

4.10.1. The available health care services offered in the health care facilities in Kawangware

The study revealed that the most common health services in Kawangware division are ante natal and post natal care, maternal care and family planning. This may be attributed to the fact that maternal mortality is common in informal settlements and low income areas due to a complex web of various issues including social, economic, political and cultural factors as well as gender inequity, state of physical infrastructure and the health system. Thus, in this semi urban settlement the county government and private health practitioners have tried to counter the mortality rates by ensuring that there are adequate maternal health services. The findings revealed that second most common health service available is consultation and counseling. The rest of the services include dressing wounds and nursing, laboratory services, outpatient and inpatient, dental, surgeries, dispensing medicine, fracture management, correcting deformities, blood transfusion and screening, and promotion of good health and hygiene (Figure 4.4).

Corresponding to these findings, the studies by Mehrotra and Jarrett (2002), Yamasaki-Nakagawa et al., (2001), and Taffa et al., (2005) identified maternal health services as common among their respective study areas. In the present study, more than a half (55.8%) indicated that Ante Natal and Post Natal care, maternal care and family planning services are the most

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common. However, this may not indicate the frequency of visits to these centers or clinics. The reality on the ground is that many people lack sufficient incomes to access the available maternal services due to their low earnings. This reason compels most of the poor households to choose either to ignore their health services available. In another study Muriithi (2013) argues that the past experience in Kenyan public health facilities of persistent lack of drugs and shortages of inpatient doctors and nurses could still be in the memories of the majority of the households in the slums, discouraging them from using the available health facilities. This may also hold true for residents of Kawangware semi-urban settlement. The study points to the fact that practice of the health care system in the area is like 'SHOP KEEPERS' just waiting to give the service in health centers. The focus of the health services is mainly curative as opposed to preventive which should ideally not be the case. More emphasis should be on the prevention of communicable diseases, which may include mobile services as well as health education.

4.10.2. Commonly reported cases of ailments among Kawangware semi-urban settlement dwellers.

Results of the study highlight that the most common illnesses are: malaria (56.6%), respiratory tract infections (39.8%) and typhoid (38.1%). Urinary Tract Infections, Common cold, diarrhea and injuries were mentioned by 21.2%, 15%, 14.2% and 13.3% respectively. Deliveries and headaches/fever were reported by 6.2% and 4.4% of all the key respondents respectively. Diseases such as HIV/Aids and STDs were hardly reported by the respondents. 0nly 9.7% reported having had suffered from this two conditions. This is unlike what other studies have reported, whereby the two conditions have been said to be rampant in semi urban settlements (Mnyika et al., 1994). It was therefore unclear whether in Kawangware these diseases are not common or the respondents were simply unwilling to disclose.

The common occurrence of malaria in the slums may be associated with stagnant water that provides a favorable breeding ground for mosquitoes. The respondents were well aware of malaria being the most common disease amongst them. This corresponds to the WHO (2008) claim that slum dwellers are aware of malaria as a disease. However according to WHO, the slum dwellers are handicapped due to the lack of adequate knowledge on symptoms, cause, predisposing factors and prevention and control measures. Unfortunately, this research did not

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factor in the aspect of the respondents' knowledge on signs and symptoms of the diseases that affect them. This aspect could be unveiled through another research which seeks to establish knowledge of the signs and symptoms of the diseases that affect semi urban slum dwellers.

The findings concur with those of Rossi- Espagnet (1984) who attributed incidents of diaseases such as malaria to the fact semi-urban settlement communities are at the interface between underdevelopment and industrialization and their disease patterns reflect the problems of both. The present findings were not surprising as Kawangware semi-urban settlements lacked good sanitary facilities. Sanitation was found to be generally poor. There are no well-constructed gutters or drainage systems to allow easy flow of water. This is typical of slums as was observed in other studies conducted in semi-urban settlements (Bagheri, 2012, Marimuthu et al., 2009; Viegas, 2006). Living in semi-urban settlements characterized by deprived conditions is a major cause of ill-health and the residents suffer disproportionately from ill-health throughout their life course (Viegas, 2006).

4.10.3. The ffect of houshold's income levels on use of health care facilties in Kawangware

The study reveals that income levels influence decisions on places where to seek treatment. The study has established that households with low income levels (less than Kshs 4000 per month) tend to favor services of traditional healers while households with high income (more than Kshs.12000) prefer to go to health facilities. Despite availability of enough health care services and facilities in Kawangware, they are unfortunately not well utilized by the residents of Kawangware semi urban settlements. Low income levels of most of the Kawangware semi urban settlements may explain why they have not been adequately utilizing the available health care facilities. Most of them are casual labourers who sometimes ignore the signs and symptoms of diseases even when unwell for fear of missing out an opportunity for the casual labour which would mean inability to put bread on the table for the particular day.

The findings from this study implied that lack of adequate income affected access to health services, compounded by the fact that most of the health services if not all have user charges which may not be affordable for most of the households. The finding concurs with that of

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Sverdlik (2011) who in his work about ill-health and poverty observed that many households living in semi-urban settlements have higher chances of becoming sick, suffer from injuries and premature death. Cisse (2006) also found user fees to be key in determining health seeking behavour. The findings however contradicts Akin *et al.* (1986) who found user fees to be insignificant determinants on utilization of health services implying that one's income levels had no effect on the use of health services/facilities.

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CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter brings together all that was considered in the study and the outcome of the analysis done. It summarizes the main results of the study and the methodology used. Then it derives conclusions and presents recommendations as well as giving suggestions for future research.

5.2. Summary of the Findings

This study was carried out in Kawangware Semi-Urban Settlements, Kawangware Division-Nairobi County, Kenya. The main aim of the study was to assess the effects of poverty on utilization of health care facilities.

From the findings, males outnumbered the females. The ages ranged from 20 to over 50 years however majority were youths. The youth majority in Kawangware is because of the youth migration to urban areas in search of jobs and an interest in changing their own lifestyles. Most of the respondent had certificate levels of education .The study further revealed that most of the respondents were married (Figure 4.2) and that majority had been residing in Kawangware Division for 11 years and above. The findings indicated that many households engage small scale businesses. Overall, more than half (53.1%) of the respondents earned less than Kshs. 12000 per month, implying that they are generally low income earners (Table 4.5).

Based on the findings, there were various health services in Kawangware with the most common being ante natal and post natal care, maternal care and family planning. This may be partly attributed to maternal mortality common in the semi-urban settlements and the government as well as private health practitioners working towards alleviation of the mortalities.

The study findings also revealed that malaria, respiratory tract infections and Typhoid were the most common reported cases of illnesses. The common occurrence of malaria in the slums was associated with stagnant water that provides favorable breeding grounds for mosquitoes.

The study also found that houshold's income levels played a major role in the use of health care facilties in Kawangware. It was observed that income levels influenced decisions on places

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where to seek treatment. The study findings implied that lack of adequate income affected access to health services, compounded by the fact that most of the health services if not all have user charges which may not be affordable for most of the households.

5.3. Conclusions

The study concludes that poverty affects utilization of health services and facilities. It is clear from the study that although there are a number of health services and facilities in Kawangware, they are still not being utilized adequately. This is because the resident are poor; majority are struggling to make ends meet in terms of looking for income and therefore failing to utilize the facilities.

There is relationship between poverty and health seeking behavior within Kawangware Division; such that income levels points to the vulnerability of sickness, influences household decisions on whether to seek for medical attention or not whenever they fall sick and where to seek the treatments. Therefore, health of a given population is more than physical availability of health facilities but include issues of affordability which revolves around poverty as manifested by low levels of income. This is a contradictory scenario given that some health services are free according to the Kenya health policy, but the residents still hold the notion that they are chargeable services. This burrs the residents from utilizing the services. At the same time, the residents feel that they will lose out on casual labour time and income when they attend the health facilities and opt for faster ways of addressing the illnesses, that is , seeking over the counter treatment or ignoring the illness all together unless or until it is too debilitating.

5.4. Recommendations

Based on the study findings and conclusions, the researcher offers the following recommendations:

1. From the study results and recognizing the critical role of good health of the people, it is important for the government and especially the health workers to intensify the health education on the importance of seeking medical attention whenever a person is ill or is

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exhibiting some signs and symptoms of a disease since it is only when someone is well that they can be able to adequately fed for their families.

2. As demonstrated in this study, although the government has invested in health facilities in Kawangware division, most of the population still suffers. The issue revolves around income levels. Therefore, both the national and county government needs to come up with strategies which could encourage access to health facilities by the largest proportion of the population. Some of these strategies could include setting up standard charges for specific health problems/diseases/services not included in the free medical services. There is need for programs that would encourage entrepreneurship and income generating activities with the aim of empowering the population economically.

3. There is also need for sensitization and awareness creation among the residents of Kawangware on the various ways of accessing health care. Currently the government health policies control access to health care by subsidizing health services. However, most people living in Kawangware seem to be unaware hence the need for sensitization.

4. The government needs to focus on the health care system so as to reach out to the people instead of waiting for the people to come to clinics and hospitals. The practice of the health care system in the area is like 'SHOOP KEEPERS' just waiting to give the service in health centers instead it should be prevention of communicable diseases. There is need for mobile clinics so that a wider population can have access to important health services.

5.5. Suggestions for Further Research

1. Since the study relied on a total of 113 respondents, future research could consider a larger sample size in order to come up with a clear idea of the dynamics of poverty and utilization of health facilities in the informal settlements.

2. There is also need to conduct similar study in other semi-urban settlements as comparative studies to be able to draw concrete conclusion.

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3. There is need to conduct a study on the extent to which semi urban settlement dwellers are knowledgeable about the signs and symptoms of the diseases that commonly affect them.

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Questionnaire

Dear respondent,

My name is Million Mesfin, a masters student at St. Paul's University. I am carrying out a research on the effects of poverty on health care in Kawangware Division in Nairobi County. I kindly request you to spare a few minutes and assist me fill in this questionnaire. This research will purely be for academic purposes and any information provided will be treated with at most confidentiality. Kindly do not write your name on any part of the questionnaire. Thank you for your cooperation.

PART A: Background information.

Instructions: Please tick [√] in the space provided as appropriate.

1. What is your gender?
   [ ] Male
   [ ] Female

2. Which age bracket do you belong?
   [ ] 20 – 29 years
   [ ] 30 – 39 years
   [ ] 40 – 49 years
   [ ] 50 years and above

3. Which is your highest level of education?
   [ ] Certificate
   [ ] Diploma
   [ ] Degree
   [ ] Masters

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[ ] No formal education

[ ] Others specify ……

4. What is your marital status?

[ ] Married

[ ] Single

[ ] Divorced

[ ] widowed

[ ] Separated

5. For how long have you lived in Kawangware Division? Please specify the village

_____

[ ] Below5 years

[ ] 6-10 years

[ ] 11 years and above

6. What is your occupation?

[ ] Civil Servant

[ ] Business

[ ] Casual Worker

[ ] Any others please specify …….....

……

7. What is your monthly income?

[ ] Below Kshs.4000

[ ] Between Kshs(4,000-8,000)

[ ] Between Kshs(8000-12,000)

[ ]More than Kshs.12,000

Section B: Types of ailments and Health Services.

Instructions: Please tick [√] in the space provided as apropriate and explain yoour responces where necessary in the provided space.

8. A. Have you fallen sick in the last three months?

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[ ] Yes

[ ] No

B. If Yes did you seek any treatment?

[ ] Yes

[ ] No

Please explain

……

……

……..

9. Whenever you are sick, where do you seek treatment?

[ ] Self treatment

[ ] Nearest Shop

[ ] Chemist

[ ] Health facility

[ ] Traditional Healer

[ ] Any others please specify …… ……..

……

10. Are there times that you have fallen ill but missed to seek any treatment?

[ ] Yes

[ ] No

Please explain……

…….

11. Whenever you are given a return date for review, do you always honor it?

[ ] Yes

[ ] No

Please explain ……

……

THANK YOU FOR YOUR TIMES AND RESPONSES

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Interview Schedule for Key Respondents

Dear respondent,

My name is Million Mesfin, a masters student at St. Paul's University. I am carrying out a research on the effects of poverty on health care in Kawangware Division in Nairobi County. I kindly request you to spare a few minutes and assist me fill in this questionnaire. This research will purely be for academic purposes and any information provided will be treated with at most confidentiality. Kindly do not write your name on any part of the questionnaire. Thank you for your cooperation.

A. Interview

1. What is your designation?_____
2. How long have you worked in this health care facility?_____
3. Which organization do you work for? _____
4. Which services do you give in your health facility?_____
   _____
   _____
   _____
   _____
5. What are the commonly reported illnesses with in your area of operations?_____
   _____
   _____
   _____
   _____
   _____
6. What health education services if any do you offer to your clients? _____
   _____
   _____
   _____

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7. Do you conduct mobile medical services within Kawangware Division? _____
_____

8. Which cases if any do you refer to other health care facilities? _____
_____
_____
_____
_____

9. In your opinion what percentage of clients turn up for further treatment and review when given return dates?_____

THE END

THANK YOU FOR YOUR TIME

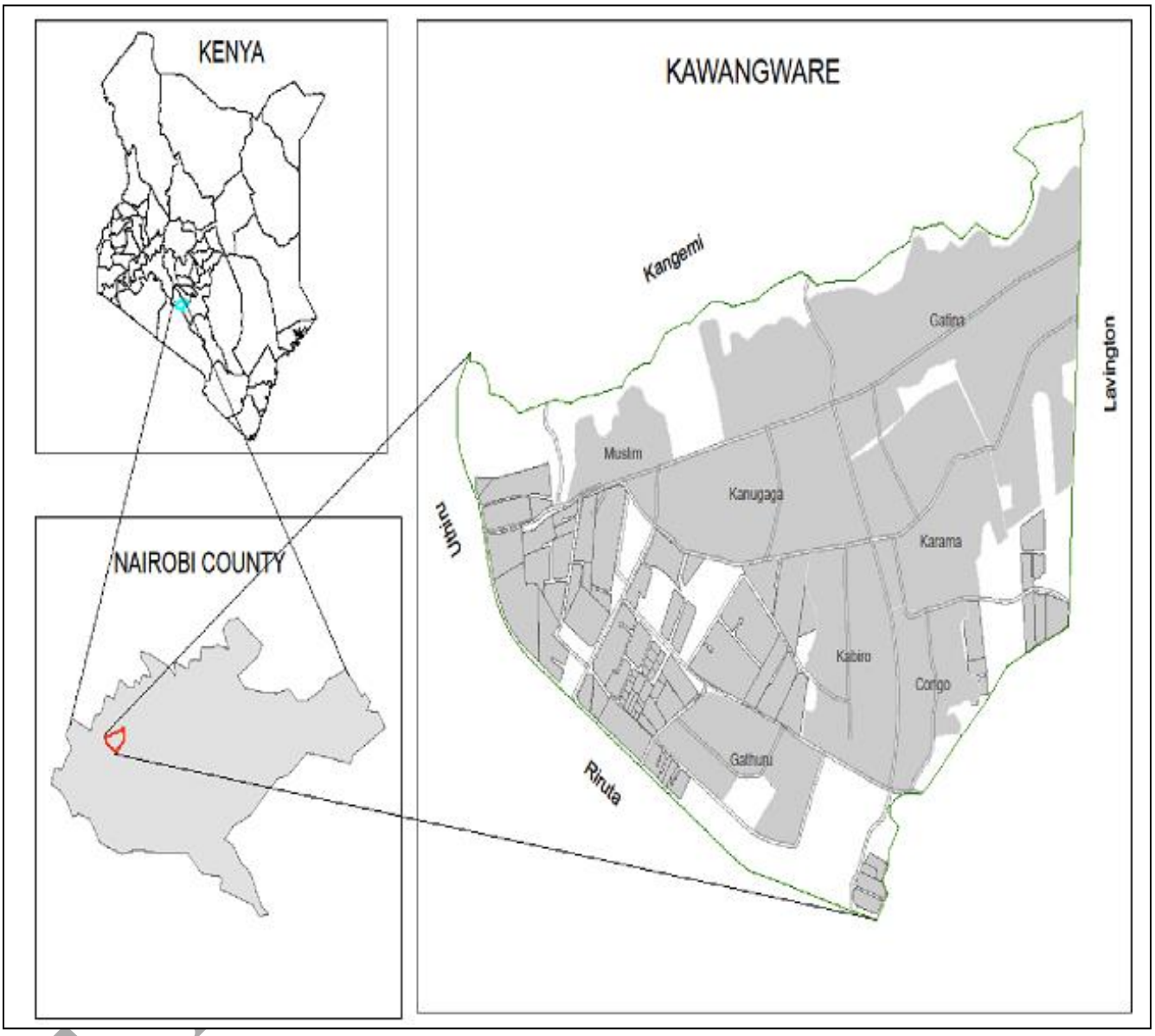
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Research Budget

Item	Cost (Ksh)	No of items/days	Total Cost (Ksh)
Research assistant allowance	5000	15	75000
Transport	1000	30 days	30000
Stationary and Printing	15000		3000
Internet	10000		10000
Accommodation	7000	1 researcher	7000
Sub-total			125000
Contingency @ 15% of the total			18750
Total			268750

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Map of the Study Area



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