SOCIAL AND CULTURAL DETERMINANTS TO THE ACCESS OF UNIVERSAL HEALTH COVERAGE: A CASE OF MASINGA SUB-COUNTY IN MACHAKOS, KENYA

NAME: ISAIAH MULULU

STUDENT NO: MDSMKS541919

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NAME: ISAIAH MULULU

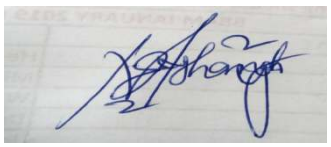
STUDENT NO: MDSMKS541919

SUPERVISORS

1. **DR. NASON VUNDI**
2. **DR. ANTONY ODEK**

DECLARATION

This thesis is my own original work and has not been submitted for another academic examination.



Signature …….. ……

Isaiah Mululu Date 16/8/2020

Adm. No: MDSMKS541919

Word Count: 19,000

APPROVAL

This thesis has been submitted for examination with our approval as the University Supervisors

…… …….. ……

Supervisor Date

Dr.Vundi Nason 17/8/2020



Supervisor Date

Dr. Antony Odek 17/08/2020



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DEDICATION

I dedicate this research to my wife Margaret Muthama; my sons Eric and Peter for standing with me throughout my studies in writing this research.

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LIST OF ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

CBHI: Community Based Health Institution

EC 2019: European Commission

EC: European Commission

ENT: Ear Nose Throat

FGM: Female Genital Mutilation

HIV: Human Immune-deficiency Virus

KNBS (2019): Kenya National Bureau of Statistics

MDGs: Millennium Development Goals.

MOH (2014): Kenya Health Policy 2014-2030

MOH: Ministry of Health

NACOSTI: National Commission for Science Technology and Innovation

NGOs: Non-Governmental Organizations

PHC: Primary Health Care

SDGs: Sustainable Development Goals

SPSS: Statistical Package for Social Sciences

SSA: Social Security Administration

TBAs: Traditional Based Assessments

UHC: Universal Health Coverage

WB: World Bank

WHO: World Health Organization

ABSTRACT

Universal Health care is a huge milestone in the attainment of the Sustainable Development Goals (SGDs). These goals put healthcare at the epicenter of development because without the latter, development may not be achieved fully. In Kenya, the government rolled out the UHC program in 2018 with four counties acting as pilot for the rest; Machakos was one of them. The study sought to investigate social and cultural determinants that affect the uptake of Universal Health Coverage. The specific objectives of the study were aimed at establishing the level of awareness on universal health coverage, examine effects of religious affiliation on universal health coverage, determine the influence of traditional beliefs on the universal health coverage and examine the effects of geographical access on universal health care in Masinga sub county. A Descriptive Research Design was adopted in which a total of 350 respondents were chosen from all the 7 locations of Masinga sub-county. The sampling was both Stratified and Systematic Random Sampling. In the actual research the respondents were issued with questionnaires that were self-administered. The questionnaires were both closed ended and open ended; the former sought to capture specific details in the respondents while the latter gave them a leeway to elaborate their answers. Analysis was both qualitative and quantitative. Quantitatively, the responses were fed into the SPSS program and analyzed; they were presented using percentages, graphs and charts. The study established that the levels of awareness on the UHC were still low in the sub county. It also established that religious persuasion, traditional beliefs and geographical access play an important role in either enhancing or inhibiting the utilization of UHC. It recommends that the government step up sensitization programs to get as many people as possible to utilize the program. At the same time, the study recommends that there should be a legislative or policy review to ensure that the role of traditional health care givers does not prejudice the access of UHC.

CHAPTER ONE

INTRODUCTION

1.1 Overview of the Chapter

This chapter basically covers the study by defining Universal Health Coverage (U.H.C) and elaborating on how the concept began and the manner in which it spread across the world including the third world nations especially Kenya. Furthermore, the chapter clarifies on the background of the study, the problem under investigation, the main objective and specific objectives, research questions, justification, scope and limitation, assumptions and definitions of the key terms.

1.2 Background

According to WHO (2019), UHC refers to all people and communities who get all the subsidized medical services. It is composed of a variety of important and quality health-based services, health-based promotion facilities, rehabilitative, preventive and palliative services. It assists people in accessing health services that look at the basic and important sources of illness and deaths, and ensuring that the service quality is adequate to improving people's health status.

Facilitating people's access to health services without incurring much financial burden is believed to reduces the likelihood of getting into poverty in the process of trying to meet medical expenses that sometimes requires one to use all his or her savings, assets hence interring with not only their own future but also of their children. The objective of UHC is part and parcel of the SDG set in 2015. Therefore, the progress of all nations is assessed in terms of whether or not they are able to meet UHC and other health based objectives. Sound health not only facilitates the learning of young people but also

adults' earning hence escaping from financial burden. It also gives the basis for long-term economic growth/development (Barasa, Rogo, Mwaura, & Chuma, 2018).

The global idea of universal health coverage (UHC) originated in Germany in the year 1883 where the sickness law was successfully legislated giving all its citizens right for the quality health services and forcing the employers in the country to give their employees' health insurance cover (Nxumalo, Tseng & Griffiths, 2018). Later the idea of UHC was introduced to Cuba in 1960s, which facilitated elimination of many diseases such as Polio, Measles, Malaria and Mother to Child Transmission of HIV leading to great heights in health security in the country. Cuba government has given all its citizens free preventive and curative health services through free Universal Health Coverage. Again the Cuban (UHC) policy is based on medical internationalism which focus on being in solidarity with world population by sending medical personnel to all other countries in America and Africa to fight outbreaks such as Ebola as witnessed 2014, in West Africa and bird flu epidemic (McCollum, Theobald, Otiso, Martineau, Karuga, Barasa, Molyneux, Taegtmeye, 2018). Universal Health Coverage is a major global idea in both millennium development goals (MDGs) and sustainable development goals (SDGs) whose ultimate objective is global health security to all individuals and communities (Mbau, Barasa, Munge, Mulupi, Nguhiu & Chuma, 2018). The other global declarations in support of Universal Health Coverage include Mexico City political declaration on Universal Health Coverage (2012); Bangkok statement on (UHC) and Tum's declaration on my money sustainability and accountability for the health sector (2012) (Nyikuri, Tsofa & Okoth, 2017).

According to WHO (2004), Germany had 77% of its citizens funded by government and the rest, 23%, funded by private sector for health care services. By 2004 Germany

ranked number thirteen worldwide in life expectancy 78yrs for adult and as low baby mortality rate as 4.7 per 1000 live births as a result of access to Universal Health Care WHO (2014). By 2000 the amount that had been saved by government for Universal Health coverage was 10.8% of gross domestic product (WHO, 2014).

The 2015 Euro consumer index placed Germany in the eighth place with the most Restructured UHC program in Europe, with patient allowed seeking any kind of health care they wanted whenever they were sick, currently the Germany government spends 18 billion dollars on Universal Health coverage ranking as one of the best in the world. By the year 2009 UHC was compulsory to all citizens in Germany (WB, 2015).

Taking Mexico as a case study which took SEGURO (a national health insurance scheme operating under the ministry of health that begun in 2003), this scheme provides access to UHC package of comprehensive health care services, with financial protection for over 50 million Mexico citizens who before were not included in the UHC (O' Conell, Rasanath, and Chopra, 2014). Registration for this program is free for the poorest citizens 20% but a small amount for voluntary enrolment for those above 20% of this economic status.

After 9 years with SEGURO popular insurance, Mexico achieved UHC in 2012 by implementing SEGURO popular among other health insurance. By 2012 Mexico had 56.6 million of its citizens registered under UHC services. Vietnam is another developing nation that is making good progress in health care services through UHC. After struggled since 1992 low on UHC was enacted in 2005, which became fully operational in 2014 insuring more than 50 million citizens with government paying for all UHC services (Barasa, Maina, & Ravishankar, 2017).

The progression towards UHC is already evident across most nations. The rate of this progression is dependent on a country's ability to speed up the progress or uphold the gains achieved. However, according to Nyikuri et al (2017), it is becoming extremely hard for countries, especially those with previous accessible services, to meet the growing health needs and associated costs due to population increase.

It is the contention of Linda, Trowman & Kearney (2018) that moving towards UHC requires strengthening health systems in all countries. Robust financing structures are very important. When people have to pay most of the cost for health services out of their own pockets, the poor are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness. Pooling funds from compulsory funding sources (such as mandatory insurance contributions) can spread the financial risks of illness across a population. Improving health service coverage and health outcomes depends on the availability, accessibility, and capacity of health workers to deliver quality people-centered integrated care. Investments in quality primary health care will be the cornerstone for achieving UHC around the world. Investing in the primary health care workforce is the most cost-effective way to ensure access to essential health care will improve. Good governance, sound systems of procurement and supply of medicines and health technologies and well-functioning health information systems are other critical elements **(**Linda et al, 2018).

In Africa, the Universal Health Coverage policy is on United Nations resolutions 2012 on (UHC) which puts health as a key factor in sustainable development (Barasa, et al 2018). The resolution encourages all the continents, Africa included, to provide access to quality and affordable health care services for the sustainable development (Obatha

& Wiley 2019). Algeria is the first country in Africa to enact the law on Universal Health Coverage (UHC) for its people in 1975. The UHC produced good indicators on maternal mortality ratio, child mortality rate and life expectancy. Both maternal, mortality and child mortality dropped drastically with (UHC) introduction while the life expectancy increased due to good health care services (Tsiachristas, Geulayov, Casey, Ness, Waters, Clements, Kapur, Daid, Brand & Hawton, 2019). South Africa is another country in Africa which joined UHC partnership in 2016 and the health system has greatly improved the health of people through quality and affordable services provision. The UHC is a major agenda for the countries Vision 2030 (Waithaka, Tsofa & Barasa, 2018). The other country in Africa which has successfully implemented the UHC agenda is Rwanda after recovering from the genocide of 1994 which had left the country in very bad health state. Tema, Vito, Zanella, Gurioli, Lanza & Sulpizio (2017) states that all the citizens are covered by UHC for their health needs, Many African nations have attempted to implement the social health insurance schemes of which majority ensure employees based in formal sector that have pooled their resources together.

A study conducted by Nxumalo et al. (2018) on health insurance systems in five countries in Africa namely Ghana, Kenya, Nigeria, Tanzania & Uganda, revealed that most of the health schemes in these nations relied on premium payments from individual memberships. In Ghana the national health insurance act was passed in 2003 which introduced UHC health framework. There are 3 types of health insurance in Ghana namely; the district wide mutual insurance scheme, the private mutual insurance scheme, the private commercial health insurance scheme, or under the umbrella of universal health coverage (Nxumalo et al, 2018). The district wide mutual insurance scheme covers the whole nation. In Nigeria the main health insurance is obtained

through (NHIS) which enrolled more than 5m people. By 2003 Nigeria UHC had only covered 6m citizens and 46 million not covered which is 33% of the total population in the country (WHO, 2018).

In Kenya, attempts have been made towards introducing UHC since 1963. A household and utilization survey; Conducted in 2007 revealed that only 10% of Kenyans had insurance cover. This involved not only those were in urban areas but also rural areas (MOH, 2019). In another demographic study done in Kenya shows that by 2008 only 9.8% Kenyans had enrolled for health insurance. KNBS (2010), by 2015 only 25% of Kenyans had been covered by UHC (Barasa et al, 2018). Mwaura, Njeri, Barasa, Ramana, Coarasa, Rogo & Khama (2017) adds that health insurance in Kenya falls under both mandatory and voluntary schemes. There are three categories of insurance companies in Kenya; General insurance firms of health care insurance on top of other things, Insurance medical Schemes & health care practitioners doing private clinics, Health management organization used by employers, or under supervision of ministry of health. In Kenya there are two types of public insurance; The National Hospital Insurance Funds (NHIF) and the Community Base Health Institution (CBHI). Membership in NHIF is compulsory for those in formal employment (between Kshs.500-2000 monthly subscription and voluntary Kshs.500 monthly for the voluntary membership (Barasa et al., 2018).

According to Obadha and Wiley (2019), poverty in Kenya has achieved great heights; preventing many poor Kenyan citizens from access to health services when they are sick. In 2010, the Kenyan Government come up with health policy in its new Constitution which gave all citizens a right to access quality and affordable medical care. Furthermore, in a sessional paper no of 2012 the Kenyan government enacted a policy of universal health coverage (UHC) for all Kenyan citizens regardless of their

social and economic state. After the general elections of 2017, Kenya's president outlined in his four agenda development agenda. This was derived from the Millennium Development Goals (MDGs) which put universal health coverage on his priorities with a vision that by 2022 all the Kenyan citizens will be covered by UHC. This is in line with Sustainable Development Goals (SDGS) and Millennium Development Goals (MDGs) envisioned in the Vision 2030. To realize the universal health coverage agenda, the government of Kenya selected four pilot counties namely: Kisumu, Nyeri, Isiolo and Machakos for the UHC study. The results were to be used in implementing the UHC services in the other counties and the whole country (Kamau, 2018). In spite of these efforts however, access to universal coverage still remains a mirage to many people across the country, particularly in rural areas. It is against this background that this research chose to do an evaluation of the household factors hindering access to universal health coverage, a case of Masinga Sub-County in Machakos County.

1.3 Statement of the Problem

According to Linda et al. (2018), there is a close affinity between health and development; health precedes development because when people are healthy, that is when they can engage themselves in meaningful activity. Therefore, sustainable development in any Country hinges itself to quality health care. Linda et al. (2018) states that for this to happen, there should be well structured health policies that enable to all people in a society to access quality health services through universal health coverage (UHC).

A robust health system is essential in order to reverse the declining trends in health. Improved health systems lead to increased productivity and it increases life expectancy, decreases health expenditure, and reduces infant mortalities. Improved health is a key factor for development. However, the current efforts to improve health systems are not

satisfactory. The efforts have not been able to promote healthcare for all. At the global level, advances have been made to improve health systems (WHO, 2002). Health infrastructure has been expanded and socioeconomic opportunities have improved as well. These interventions have reduced mortality rates and raised life expectancy. However, despite the advances, gaps still exist (Tong, Schirnding, & Prapamontol, 2000). Disparities have increased and the majority continues to live in poverty; more than 100 million children die every year due to health inequalities worldwide (Gwatkin, 2000).

Most Social Security Administration (SSA) countries are constrained by resource scarcity. Most SSA countries still finance their healthcare far below the Abuja Declaration of 15%. Their average health expenditure rarely exceeds 5% of their GDP. They spend less than 10% per person per year on healthcare compared to US $ 27 needed. More than 50% of SSA countries have no access to modern facilities; 40% have no access to clean water, high levels of maternal, child and infant mortalities. Immunization is at low rates especially in the rural areas (WB, 2006).

Universal Health Coverage was established so that it ensures that the access to quality healthcare by all citizens is guaranteed. This is so because, a majority of Kenyans are poor and hence accessing healthcare is a herculean challenge to meet. The roadmap for attaining UHC for nations entail three things; first, prioritization of the health services; second, expand its base to cover more clients and significantly lower the money people pay to access medical care. As much as this program is good, there are several challenges that it faces; these entail not only poverty, but also illiteracy and above all lack of political backup. For example, some of challenges towards UHC in Asian countries include cultural factors and lack of good-will among the politicians. Another

barrier is the fact that most people cannot afford the services due to their poverty (Linda et al, 2018).

On the Kenyan context, before the rolling out of the UHC program, KEMRI (2019) states that 6 out of 10 Kenyans could not have access to essential healthcare services in 2014 and 4 out 10 Kenyans were at risk of getting into financial hardship or poverty because of out of pocket healthcare payments in 2014. Furthermore, the Universal Health Coverage index for Kenya was 52% in 2014. This meant that only slightly more than half of Kenyans had coverage with both essential healthcare services and mechanisms to protect them from financial hardship or poverty because of out of pocket healthcare payments and a majority of them, 48% could not access healthcare. Following this, the government originated an ambitious plan that was aimed at ensuring that health care is accessed by all in 2018 (Waithaka et al, 2018). This plan came to be known as the Universal Health Care. In doing so, the government had come to the realization that in every year, one million Kenyans were driven below the poverty line by healthcare-related expenditures and that poverty predisposes vulnerable Kenyans to disease and slows all aspects of growth in the economy (Mulupis, Kirigia, & Chuma, 2018).

According to the Machakos County Government (2018), the UHC package was to include all the services accessible in public health facilities; among them being provision of door-to-door screening for non-communicable diseases, immunization, antenatal care, outpatient services and inpatient services, issuance of mosquito nets, drainage of stagnant water and inspection of eating places, abattoirs and health facilities (Mulupis et al, 2018). In fact, in 2019, the County government gazetted additional level

4 hospitals in Masinga, Ndithini, Kalama, Matungulu, Athi River and Mutituni to make sure each sub-county has a Level 4 hospital so for advanced medical care.

However, despite the government of Kenya and Machakos County government having spent a lot of money for the UHC program to succeed, evidence still shows that the enrolment to the program by the community is still very low. By 2019, there were only 290,000 households that had registered for the program out of a total of 402,466 (KNBS, 2019). This means that close to 28% of the households are yet to benefit from the program which is free. Therefore, this study therefore sought to establish social and cultural hindrances to access to Universal Health coverage in Masinga Sub-County in Machakos County.

1.4 Research Objectives

1.4.1 General Objective

The general objective of the study was to investigate the Social and Cultural Hindrances to Access to Universal Health Coverage in Masinga Sub County in Machakos County.

1.4.2 Specific objectives

This study was guided by the following specific objectives, to;

a) Establish the level of awareness on universal health coverage in Masinga Sub County
b) Examine effects of religious affiliation on universal health coverage in Masinga Sub County
c) Determine the influence of traditional beliefs on the universal health coverage in Masinga Sub County

d) Examine the effects of geographical access on universal health care in Masinga sub county

1.5 Research questions

a) What is the level of awareness on universal health coverage in Masinga Sub County?
b) In which ways does religious affiliation affect universal health coverage in Masinga Sub County?
c) What is the influence of traditional beliefs on the universal health coverage in Masinga Sub County?
d) What are the effects of geographical access on universal health care in Masinga Sub County?

1.6 Significance and Justification of the Study

The findings of this study were significant at theoretical, empirical and policy making level. The study was important since the investigation into social and cultural determinants the access of UHC and how it can help to predict whether or not the country will realize both millennium development goals and sustainable development goals (SDGs). The study is also important in that it documents the challenges that hinder full access of the UHC. This information will be of benefit to policy makers, county government and the NGOs that deal with health issues; the policy makers, notable, the ministry of health, will be able to take note of these challenges that prevent full uptake of the services; in so doing, they will come up with more policies that will address these issues and in turn enhance more people to access the services. On the other hand, the county government will be able to take stock of what has been attained since the program was rolled out and as such put in place practical measures that will enhance access. Lastly, the NGOs which complement the government's efforts in health

provision will also be able to discern the driving factors towards full access of UHC; this discernment will enable them to help the government in achieving full uptake of the UHC services.

1.7 Scope and limitations

The study was carried in Masinga Sub County in Machakos County. Masinga Sub County has a population of 125,943 as per censures data 2017 (KNBS). The data was collected from the target population and a sample was taken from the total population and a study which was used as a representative of the total population. The results from the study were used to represent all the other sub-counties in Machakos County in general. The limitations included: Geographical terrain; the sub county is vast with poor roads that impeded the successful coverage by the researcher. Furthermore, the issue of information volunteering was a challenge; given that health information is confidential, it was anticipated that the respondents would be reserved in disclosing their information. To counter this challenge, the researcher explained to the respondents that the information sought was to be used for research purposes only and would in no way prejudice their confidentiality. In general, care was taken to ensure that these limitations do not adversely affect the outcome of the findings.

1.8 Assumptions

The study was premised on the following assumptions:

- That there are social and cultural factors that hinder the full access of UHC
- That the respondents will cooperate when it comes to volunteering information
- The government agencies will provide requisite information.

1.9 Definition of Key Terms

Maternal mortality rate: This refers to the deaths of pregnant mothers associated with complications from pregnancy or during childbirth.

Maternal mortality ratio: This refers to the risk associated with each individual pregnancy in pregnant women.

UHC program awareness: it is the program with an objective of building awareness on the core concepts of UHC, including its scope and contents among different levels of stakeholders in the supply side.

UHC needs: there those healthcare services whose cost is supposed to be met by universal healthcare coverage.

Cultural effects: there are those cultural beliefs and practices that would hinder the society from enrolment and accessibility to the UHC services.

Social effects: it how interaction among different groups hinder enrollment and accessibility of UHC services.

Geographical effects: this refers to how distance between people and health facilities would affect the enrollment and accessibility of UHC services in the community.

Religious affiliation: this refers how different religious beliefs, practices and teachings influence the enrollment and accessibility to UHC services.

Primary health care: is systematically addressing the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviors) through evidence-informed public policies and actions across all sectors**.**

Child mortality rate: This refers to the death of children under the age of five years or the possibility of dying between birth and exactly five years of age. It is expressed per 1000 live births.

Non communicable diseases: These are diseases that are not transmitted directly from one person to another e.g. high blood pressure, diabetes, etc.

Communicable diseases: These are infectious diseases that are shared from one person through a variety of ways that include: body fluid contact, coughing and sneezing (airborne) or by insect bites.

Episiotomy: This term ass used in this study refers to one of the procedures done surgically to expand the birth canal's opening to allow a baby's safe delivery.

Perineum: This refers to the area between the anus and the reproductive organs which contains the structures that support the urogenital and gastrointestinal systems and gives support during childbirth.

Female Genital Mutilation: Ritual cutting or removal of some or all the external female genatilia in some African and Asian cultures to control women's sexuality.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter begins by reviewing theoretical framework that the study utilized in articulation of the research; it then proceeds to review the literature related to the issue of Universal Health Coverage from a global, regional and local perspectives. It then presents the conceptual framework that was used in the study. Lastly, the chapter reveals the gap in literature that the study intended to fill.

2.2 Theoretical framework

According to Simon (2006) many theoretical models have been used to explain health related-behaviour and to establish the salient parables in health performance behaviours. Several theories and models were employed in understanding the issue of the determinants of the uptake of UHC. These include: Healthcare Utilization Model; The Health Belief Model; The Behavioural Model on Healthcare Utilization; Andersen-Newman Utilization Model and the Cultural Context of home care approach (Kimani, Ettarh, Kyobutun, Mberu, & Kanyiva, 2012)

The determinants of the uptake of Universal Health Services include but not limited to attitudes, personal agency and perceived norms (institute of medicine 2002) however as Simon (2002) suggest these very determinants s hare historical criticism from where they are derived. The criticism is based on the contribution of logical and critical thinking in health behaviour and lack of attention to social cultural factors of health behaviour. Hence the tradition explanatory model compliments the more cultural model and explains the social cultural determinants affecting the preventive health behaviours in general. Stemming from traditional beliefs and values are very dynamic and constantly changing. This model explains that the heath care provider and the clients

may have different traditional understanding of health and illness. Simon, (2006) To determine the extent to which traditional beliefs are shared, the cultural consensus model was developed Smith (2012) this model was statistically made to measure the extent of agreement among the individuals and weight the individuals understanding based on how they respond to the overall group. Unlike the medical understanding which measures the biomedical correctness, traditional correct answer. Despite cultural consensus and model having been criticized as idealistic concept to studying the frequency of the cultural beliefs and aspects of agreement without reliability and meaning of interpretation the model still remains useful in research (Smith, 2012).

2.2.1 Andersen-Newman Utilization Model

Health care utilization is determined by several individual and contextual factors: hence a good starting point for analysing health care utilization and cost to define theoretical framework. Heider, Matschinger, Muller, Saum, Quinzler, Haefeli., Wild, Hsiao, & Shaw (2014) many explanatory frameworks come up with predictors of health care utilization as it was done before. Heider et al (2014) behavioural is one of the most comprehensive and widely used model, developed by Ronard Andersen in year (1968) and which was later revised by John Newman, and John Andersen (1973). Philiphs, Morrison, Andersen & Aday (1998) points out that Heider realized that the model and refined over the following years where it assumed. Individual utilization of services is a function of predisposition to make use of services (predisposing factors) factors which support or impede use (enabling factors), and as well as their need for health care (illness level) predisposing variables have to do with social- demographic, (e.g. education, and marital status) and also belief characteristics (e.g. values to do with health and illness measurable associated with behaviour such as smoking behaviour, alcohol consumption or body-mass index) enabling factors are those which support or

impede health care services, utilization income and type of insurance (Keonig, Dana, & Carson, 2012).

The Andersen-Newman theoretical model on health demonstrates the patients' illness level (representing the need factor), which is understood to be the main determinant of health care utilization (Kiss, Pim, Hemmelgarn, & Quan, 2013). The illness level as considered by an individual or a group is based on cultural aspects or focused on ones beliefs or health seeking behaviours are used to Heider et al (2014) also since behavioural model was developed in the year 1968 it has received many criticism however its use for examining the utilization in health has not been revised to change its application.

The variables proposed by Philips et al (1998) in behavioural model find a lot of utilization in the health care services. Again, the model and the frame work used as analysing tool for utilization of health care services, finds a lot of use in the universal health coverage where the patient would use the model to access and utilize the (UHC) Services.

The model would also be used to analyse patient utilization to know how useful the UHC program and show what adjustments can be done to improve the program. The model however has been criticized by many scholars as having been outdated and not applicable with the present technology (Nandi, Galea, Lopez, Strongarone & Ompand. 2008).

The model was criticized for not paying enough attention to culture and social interaction and also the overemphasis of need and at the cost of health beliefs and social structure (Petrovic & Blank, 2015).

2.2.2 The Behavioural Model on Healthcare Utilization

This was also another model that the study utilized; the sole premise of the model lies in its reliance on those factors that can be categorized as non-cognitive. According to Philips et al (1998), behavioural model is motivated by the circumstantial dictates that either hinder of promote healthcare utilization. One of these dictates is the economic and social background that can make a person seek the healthcare or shun it altogether. Socially, factors such as the age of the person, gender, profession and education levels can enhance or reduce usage of healthcare services.

According to Petronic et al. (2015) this model is based on determinants that affect decision-making and take into account economic circumstance, distances to travel, level of education, individual satisfaction based on previous services utilized and perceived quality of services.

On the other hand, Nandi et al. (2008) recognizes other cultural, social, organizational, environmental, geographic and economic aspects that appear to affect peoples' health and at times are seen as the prerogative of the studies. Consideration is given to individual level, household level and health systems level characteristics (Tema et al. 2017). According to Waithaka et al. (2018), prompts for health seeking and health service use are determined by social, cultural, political and economic factors as seen by the individual and as defined by the community. In this case free maternal health care services in relation to utilization by pregnant women involve a kind of analysis of health care use leading to recognition of the importance of the social determinants of health. Note that social capital has of lately become increasingly important to the general population welfare because it dictates their behaviour and actions towards health issues, and particularly maternal health issues (Kazungu, Barasa, Obadha & Chuma, 2018).

The model would be useful in UHC access which provides affordable and quality healthcare services to all people.

2.2.3. Explanatory Theory

Philips et al (1998) was a psychiatrist and an anthropologist who came up with explanatory model. The model consists of a set of questions which are based on patient's health, sickness and health care. The health care providers ask their patient these questions to understand the patients' world view cultural issues, social life and spiritual elements: Siroud (2008) the health care giver can ask the client, when the sickness started, when is it very severe, what the patient thinks may be the cause, how has it affected the clients social, economic, family life and work. Lastly the health work may need to know if the patient has any insurance cover that he uses to cater for the medical bills for quality health care, services (Barasa, et al, 2017).

The model will help in the planning and evaluate the nature of the existing patients' problem and its characteristics (Simon, 2006). Through getting the answers to the questions from the client, the health care giver will gain insight of the problem, and advise the patients on they can get quality and affordable healthcare services through accessing the universal healthcare services, the knowledge of the later would improve their health status, which would lead to sustainable development (Mbau et al, 2018). However this model faces critic because sometimes plays a less central role in science than causal theories(Baskerville & Pries-Heje, 2010).

The health worker would use that information to evaluate the patient's problem and plan the right action. In access to UHC the theory would be used to evaluate and plan how the patient would access the UHC services (Mbau et al, 2018).

2.2.4 The Health Belief Model

This model has its origin in the works of various scientists who operated in the 1950's. They include Kergeles, Stock and Baum. The main argument of this model is actually to foretell a nexus that exists between health and a combination of attitudes and beliefs. Wafula & Snipes (2014) avers that this model rests on the premise that the perception of people is a key determinant to seeking healthcare. The model operates within the following points of action: The first one is the extent to which the health problem is severe; here, people's action or inaction is dictated by the ramifications of the people's health. If people perceive a health issue as serious, they are more likely to come up with mitigation actions towards alleviating it; a case in point is when the parents know that failure to vaccinate a child against polio can occasion a disability; they are more likely to engage in actions that will ensure the child gets the vaccine in order to prevent an impending disability. This principle argues that individuals perceived in a serious health problem are likely to engage in behaviour to reduce its severity of polio which would lead to disability (McCollum et al., 2018).

The next issue revolves around being susceptible to health problems; here the model argues that when people are aware that there is a correlation between their risky behaviour and possibility of getting a certain disease, then they are more likely to engage in activities that will reduce this possibility of getting the disease. In contrast, the individuals who perceive that they are at a risk of developing health problems e.g. people living next to a lake will use mosquitoes nets to reduce malaria risk unlike those who live far from water bodies (Irimu, Greene, Gathara,, Kihara, Maina & Mbori-Gacha, 2018)

The next principle is the benefits of good health behaviour; here, people see the essence of being engaged in those behaviours that will minimize the disease and its occurrence

typical example would be for those individuals engaging in behaviours that they believe will prevent the disease like wearing sunscreens to reduce cancer or avoiding smoking (Tsiachristas et al, 2019).

The last tenet of the model is that of barriers to good health behaviour. Here, the avoidance is driven by the prevention of any action that can lead to health risks. Because of this, individuals focus on ensuring that the right decision is taken with regards to health problems. A balancing act is weighed and it tilts towards the benefits that will accrue through the taking of medicine and the pain incurred in the beneficial medical process. According to Irimu et al (2018), it is driven by the advantages of preventing the condition from happening and as such; the advantage must outmaneuver the disadvantage. This model if applied would be a paradigm shift in altering the perception of people towards the health sector. At the same time, this model can catalyze the change of attitude in people in the health matters. Nyikuri et al (2017) posits that through this model, people's attitudes will significantly change and this will enable them to freely acquire medical services.

Through the application of the model, people will be convinced to take Tuberculosis and Human Immune deficiency Virus testing in hospitals because of the perceived risk of not taking these tests. Furthermore, there will be accessibility of free maternal and renal, not to mention dialysis free of charge. Nyikuri et al (2017) therefore avers that in essence, this model has the potency of significantly changing people's perception with regards to health risks without fears of costs to be incurred.

The model would help to predict individual's future health challenges hence encourage people's registration to UHC which would cater for the health care expenses. However Health Belief Model faces critic because it only predicts health related behaviors for

individual beliefs and attitude but doesn't consider other factors that affect other health behaviors such as smoking and environmental factors (Jones, Smith, & Llewellyn, 2014).

2.2.5 Healthcare Utilization Model

According to this model, what influences the utilization of healthcare range from both individual to circumstantial factors? Heider et al (2014) avers that the definition of cost is the surest way to the analysis of the utilization of healthcare. This approach was conceived by Andersen (1973) alongside other researchers such as Newman and Morrison. According to Heider et al (2004), this approach has been a subject of discussion and alterations over the years. The assumption of the model is that people use their predisposition to utilize health services. Besides their predisposition, the model also assumes that there are enabling factors which promote their need for healthcare.

The factors that are considered as predisposing entail the level of education, their marital status and occupation. At the same time, people's beliefs and values including their behaviours matter. These also include things such as taking alcohol, smoking and others. According to this model, the level of a patient's sickness does determine healthcare utilization. Heider et al (2014), states that according to this model, a culture dictates a person who is seeking healthcare. This model has been instrumental since its inception in the late 60's and ever since, its intention of the examination of health seeking behaviour remains as it was articulated first. It even got support from scholars such as Anderson and Aday (1998). The model and most frequently used framework for analysing patient utilization of healthcare services is the behavioural model developed by Andersen, Aday, and others. Since the time that the behavioural model

was first developed in 1968, it has been extensively critiqued and revised. However, its use for examining the context within which utilization occurs has not been reviewed (Wamai, 2009).

This model was criticized for being associated with higher subsequent utilization of visits related to both the psychosocial/somatic and biomedical domains. In addition the model faces perceived criticism on psychosocial/somatic and biomedical utilization which was mediated through self-rated mental health and physical function, respectively (Fiscella, Franks & Shields, 1997).

According to this model the predisposing factors such the level of education, marital status, occupation, people's beliefs and values encourage people to enroll to UHC, which would meet their future healthcare needs expenses.

2.2.6 The Cultural Context of Home Care Model

Culture being a way of life that typifies how humans behave on a day to day basis, it does affect people's healthcare utilization. This model therefore advocates for the collaboration between families and health care providers. This collaboration heavily relies on home care agencies. Edwards (2017) states that this happens where medical agencies respect and acknowledge the ability of people to manage diseases within families with the assistance of the medical personnel.

However, the family may get involved in this care only if the provider is perceived positively as a member of the family. Edwards (2017) posits that how the family perceives the relationship is what matters. It can either help or destroy. Closely related to this is the issue of tele health or simply seeking medical services through the telephone. Furthermore, this depends on the need for the families to seek hospice at the end of their life.

How do people identify these cultural expectations, and how might they be relevant for decisions about home care? One productive approach is Bottom of Form to elicit concepts using techniques from cognitive anthropology. Essentially, this approach extends investigation of folk taxonomies (e.g. colours, plants, pottery, kinship, and emotions), the stock-in-trade of cognitive anthropology, into broader domains (Setharaman & Canagarajah, 2001). Early on, in such an investigation conducted for caregiver tasks, it was determined that caregivers distinguished among emotional, cognitive, and physical disability support (Simon, 2006). More recently, the same technique has been used to elicit expectations regarding more abstract cultural domains, such as what makes success in life, leisure activity, social support, and family relationships (Kenneth, 2013).

Some of the issues that arise when conducting investigations into the viability of home care health services. These entail issues such as the modifications that may be needed in order to take care of a sick member; the alterations the family ought to do in order ensure that there is the provision of quality care to the member. Another issue will revolve around how the home can be able to accommodate the health care provided and ensure that there is a conducive working environment. Yule (2006) contends that those families that have experience in taking care of the sick acknowledge that certain things such as hospice services, infusion technologies, a hospital bed, a commode, smart home tele monitoring, more reliable telephone or utility service, modifications to the home to increase access, a place to store medical supplies, a separate place for visitors or other family members, and perhaps others are prerequisites for effective home based care.

Some caregivers would produce shorter lists, some longer, but it is likely that a single cultural consensus would emerge. This elicitation would allow a first look at the cultural domain of home care. A reasonable hypothesis would involve less efficient decision making (and perhaps poorer outcomes for patients) by caregivers who do not express the consensus view (Cooper& Findley, 2013).

This approach to culture does not involve differences among ethnicities or people who speak different languages but rather the operation of culture in Bottom of Form a population. Family caregivers and health care professionals in a single culture may differ in expectations for care or home accommodation, but these differences may be less salient than cross-cultural differences associated with ethnicity, race, country, or language. A growing body of research suggests that expectations regarding care differ across cultures (Morrall, 2009). For example, cultures differ in the degree to which pain, limitation in activity, or cognitive impairment is considered an appropriate cause for medical intervention.

In the United States, minorities are less likely to use skilled nursing facilities and perhaps more likely to tolerate dementia and old-age disability at home (Guldenmund, 2003). The elicitation of home care culture described above can be used to identify subcultures and also differences across cultures.

This model had criticism of cultural diversity in which negative viewpoint of the community and their distrust towards healthcare givers affects the homecare service utilization (Morrall, 2009). Cultural patterns determine what changes should be done at home to support a sick family member who needs home-based health services. Cultural home-based healthcare practices may hinder UHC access where many people prefer to manage their patients at home and not in hospitals.

2.3 Empirical Review

2.3.1 Overview of Universal Health Care

Globally, countries have committed to ensuring that the UHC is enhanced in the various countries. In 2018, Leaders met in Kazakhstan in Asia in which they made declarations regarding their commitment towards meeting UHC. These declarations were made at Astana and they came to be referred to as the Astana Declaration (WHO, 2019). In this declaration, countries committed to build sustainable primary health care PHC will be implemented in accordance with national legislation, contexts and priorities. We will strengthen health systems by investing in PHC. We will enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions (Deloitte, 2011). We will prioritize disease prevention and health promotion and will aim to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care.

PHC will provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of non-communicable and communicable diseases; care and services that promote, maintain and improve maternal, new-born, child and adolescent health; and mental health and sexual and reproductive health. PHC will also be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive (WHO, 2019). We will strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. We will benefit from sustainable PHC that enhances health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks (WHO, 2019).

Regarding knowledge and capacity-building; the countries committed to apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy. This was to be done by the continued research and sharing knowledge and experience, building capacity and improving the delivery of health services and care (WHO, 2019).

In recognition of the immense role played by health workers, the countries committed to creating a decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context (Mbau et al., 2018). Furthermore, they were to continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. Similarly, they committed to strive for the retention and availability of the PHC workforce in rural, remote and less developed areas. They asserted that that the international migration of health personnel should not undermine countries', particularly developing countries', ability to meet the health needs of their populations. WHO (2019) the current movement to promote UHC has been encouraged by other key actors in the field of global health such as the World Bank, the United Nations Children's Fund (UNICEF), the United States Agency for International Development, the Inter-American Development Bank, the Rockefeller Foundation, and the Bill and Melinda Gates Foundation (Linda et al, 2018).

Benefits of UHC should closely be linked to target population's needs. Policy makers with a definite budget have to manage the trade-offs between what and how much is covered. In doing so, they should carefully examine the target population's needs by looking at indicators such as population 14 epidemiological profile, major barriers to access, unsatisfied demand and major sources of financial hardship (Tsiachristas, 2019).

2.3.2 Program Awareness and its Influence

Globally, previous studies have shown that many people who fail to enroll in various health insurance schemes are associated with lack of awareness due to poor information flow from the facilitators' negative attitudes, low technological education levels, lack of public participation on government policy, illiteracy, and ignorance (Tema, 2017). Linda (2018) points out that in the social study conducted in the cities of Beijin, Ninabo, Harbin, and Chonguing in China in 2015, universal health Coverage (UHC) showed that, out of the total targeted population 90% enrolled for UHC and the remaining 10% failed to register as a result of lack of awareness. The associates represented by 10% got poor information flow from the program facilitators (Kumar, 2019). According to another study conducted in China rural areas to enroll older people, (Above 36 years) for health insurance scheme, showed poor turn out to the registration that was attributed by lack of awareness and low funding from the government (Webar, 1990).

According to the WHO global report 2019 on pandemics and UHC role, the surest way to fight and eradicate any pandemic is to create awareness to all people in that they can take all the necessary precautions. Through awareness, people will know how the disease occurs and spreads and take preventive measures such as maintaining health standards. An example is in the prevention of cholera, people are urged to use toilets, washing of hands before handling of food and draining of sewage waters where the

causative bacteria *Vibriocholera* might be present (Obatha, 2019). With disease awareness many people will register for UHC.

The WHO report (2018) from Germany on the role of UHC on the world pandemic Spanish Flu of 1918 which claimed more than 50 million lives globally was controlled through creation of awareness on the disease and UHC. People were advised to practice social distancing at all times, to wash hands and avoid handshakes, wearing of facial masks was made compulsory as the virus was airborne and people were advised to avoid social gatherings. Through creating awareness by use of media, curfews controlled the spread of the disease and people were eventually able to go back to their normal lives but under a new normal that called for maintaining health standards. Many people registered for UHC and benefitted (WHO, 2020).

According to the World Health Organization (WHO) report on December 2019, a case of the Severe Acute Respiratory Syndrome (SARS) occurred in Wuhan China. It was later confirmed as a case of Coronavirus (Covid19). The spread was exponential and a month later, on January 20th 2020, WHO declared the outbreak a public health emergency of an international scale Reynolds Matt (4th March 2020). It was declared a pandemic after 4.8 million cases are reported worldwide (WHO, 2020).

UHC has been very instrumental to the fight against the Covid19 globally and it has been demonstrated as countries that have UHC were able to control the spread of and mortality from the disease as people can access quality health care services and many have recovered from the Corona Virus (Barasa et al, 2018).

A study conducted on UHC performance in the Indian slums, indicated that poor performance in on the UHC programs was associated with poor funding and lack of awareness to the programs as the two major reasons (Nxumalo et al, 2018). A research conducted in America (2008) on the socialized medicine, (one of the health insurance schemes) showed that among the many reasons why the scheme was not doing well was due to low public awareness associated by lack of public participation and poor government health policies.

In the year 2009, a group of medical researchers found that, American doctors supported UHC and other natural insurances but faced a great challenge with poor patients' turn out to the health centres associated with low awareness of the health insurance as most of them were imposed by the government not people. A different study in 2008 showed that in 2008, in Cuba which has one of the best Universal Health Coverage (UHC), resulted from good public awareness through public education and participation financed by the government (Barasa et al, 2018).

According to the United Kingdom Prime Minister, Theresa (2018), statement in South Africa conference, Nigeria had overtaken India to become the country with the highest level of poverty globally. This reflected that many of the citizens could not achieve their own medication support and hence chose UHC program. Studies conducted to determine household dynamics influenced the decision for the health scheme enrolment. Maliandano Mutual health scheme revealed that, large households were unlikely to enrol in health schemes due to low income in the families (Criel & Van Dormael, 1999). Another study conducted in Nigeria found that individuals with large families were likely to enrol in a (CHBI) Community Health Based Institutions (Barasa, 2017).

A study conducted in Uganda and Rwanda by Havalts and Levine (2015) on UHC accessibility and on the war against HIV/AIDS, they determined that the only way to win the war against HIV/AIDS, it was by creating awareness around the disease at all levels (Barasa et al, 2018). People should be made aware through serious campaigns and it affects everybody. Behavioral change and attitudes embraced should also be emphasized among people to prevent the spread. Voluntary testing should be encouraged for people to know their status in that necessary actions can be taken depending on the status. Good support should also be availed to prevent stigmatization among the affected and the infected. With full awareness people will register to UHC for quality services.

A study conducted by Mutei et al. (2012) in (2011) showed that Algeria is one of the developing country that has a free UHC and that offers quality health services globally where the government funds all the healthcare services (Word Bank, 2018).According to the Ministry of Health, on 13th March, the first corona virus case was reported in Kenya and from then, the Ministry of Health and the Cabinet Secretary for Health, Mutahi have created a lot of Covid19 awareness to the people. Through the Ministry of Health, churches, media houses and social media, awareness has been created to prevent the spread of the disease. Preventive measures such as washing of hands, maintaining social distancing, wearing of face masks have been shared to the public to curb the spread. The government has enforced a nationwide curfew and a lock down on select counties that pose a risk, businesses have encouraged their employees to continue working from home, public gatherings of all forms and manners have been banned to reduce the spread of the virus. These are all measures that have been deemed uncomfortable by a few, but they are necessary. To echo the words of Cabinet Secretary

Mutahi Kagwe, “if we continue to treat this disease normally, it will treat us abnormally” Mutahi Kagwe (22nd March 2020).

In Kenya, a study done by Kenya Medical Research Institute (KEMRI) in 2003 to introduce UHC in Kenya between 2003 and 2014 showed that by the year 2014 concluded that only 52% of the Kenyan population has medical cover where 48% still have no health care coverage (Barasa et al, 2018). According to Waithaka et al (2018) Kenyan government has come up with many health policies since 1963 including Kenya Health Policy Framework (KHPF) (1994-2010), Health Sector Strategic Plan (2008-2012), the constitution 2010 and lastly the health bill of 2015.

According to Barasa et al (2017), the Kenyan government recognized key pillars to development in the health sector in the year 2017 where President Kenyatta chose UHC as one of his four development agenda for sustainable health development by the year 2030. The government chose four counties namely Kisumu, Isiolo, Machakos, and Nyeri as pilot study for the UHC. Despite both central government and Machakos County government having used a lot of money for the UHC program success the enrolment and turnout still remains low; a research will be conducted in for UHC Masinga sub- County to establish the UHC access hindrances.

2.3.3Effects of Religious Beliefs and Affiliation on Access to Healthcare

Koenig et al. (2012) suggests that the world over, health is influenced by religion in four major ways; the first one relates to health behaviours; this occurs when religious practises impose on the adherences what to eat and not to eat, what to drink and avoid, general exercise, emotional stability; all these have a tendency of encouraging healthy lifestyles which lead to avoidance of disease (Koenig et al, 2012).

Koenig et al (2012) further observes that since religion influences health through these pathways, they act in an indirect way on health. There is increasing recognition within contemporary western medicine of the significant links between spirituality/religion and health, and the need for health professionals to understand their patients' spiritual/religious beliefs and practices. Religion is usually seen as the institutionalization of shared beliefs and customary practices. It is often integrated into a community's cultural life. Most religions have traditional beliefs and practices relating to healthy living, illness and death.

According to Wafula et al. (2014) religion differs from spirituality because spirituality is generally perceived as more fluid, eclectic and individualized. Spirituality and religion are not necessarily mutually exclusive because a significant proportion of the population identified as being spiritual but not be religious (Mbiti, 1969). In identifying 'spiritual or religious needs' in the hospital context, health professionals are attempting to gain an understanding of two broad issues. Firstly, beliefs or practices which are significant to the patient's health that can affect decision-making, coping, support networks, commitment to treatment regimens, use of complementary health practices and general wellbeing. Secondly, patients' wishes about the way their beliefs and practices are acknowledged and supported while they are in hospital. Health Personnel's inquiry about the spiritual beliefs and practices of patients should not offend those without such beliefs if inquiry is done in a sensitive and respectful manner (Koenig et al., 2012).

If patients indicate that religious or spiritual beliefs are not important in their lives, then the spiritual history should end and the Health Practitioner should explore what factors provide meaning, purpose, and support for the particular patient. Religion is certainly not the only source of fulfilment for basic existential and psychological needs during

illness. Such a transition from a religious focus to a nonreligious one should be done so smoothly and seamlessly that the nonreligious patient hardly notices it. If there is indication that the patient has religious conflicts or struggles, however, then these need to be brought out into the open, because they may worsen the course of the illness and adversely affect medical outcomes, because the focus is always on maintaining and maximizing the health of the patient (Koenig et al 2012).

A study done in the USA showed that although the doctrines of Christian churches vary greatly both within and between countries, there are four features of Christianity that are nearly universal: initiation (baptism), worship, ministry and 'good works'. The sacred writings of Christian religion are in the Bible. A Christian's individual faith and religious practice will be influenced by the tradition of the church to which they belong as well as their own personal relationship with God. There are no general dietary requirements. Some Christians observe Friday as a day when they do not eat meat. Some Christians may wish to abstain from food (fast) before receiving Holy Communion. Some abstain from alcohol (Oman, 2018).

Koenig et al (2012) study in Italy and Turkey observes that family Planning varies from Religion to Religion. No religious objections about blood transfusion and organ transplantation. Routine last rites are appropriate for all Christians after death. There is no age limit for baptism. When babies or children are very ill, baptism should be offered. Roman Catholics – Baptism – A lay person may perform this ceremony if death is imminent. In the absence of a Minister of Religion, anyone may perform a baptism. This is done by making the sign of the cross on a person's forehead. A little water is poured on the forehead (or another accessible part of the body), with the words, "… (Name of the person)…" I baptise you in the name of the Father, and of the Son, and of the Holy Spirit. Amen". A Catholic patient will probably wish to be visited by a

Catholic Priest and to receive Holy Communion and the “Sacrament of the Sick”. This is not only for the dying, but also for the sick, especially before an operation. The Sacraments are very important. The Catholic Priest must be called to the dying patient and if the death is sudden, immediately afterwards. The chaplain should be informed as soon as possible. If a child dies unbaptized the Chaplain will offer a Blessing and Naming service and a certificate to commemorate this will be given to the parents. This is particularly appropriate following a miscarriage or stillbirth. Christmas and Easter are the most important festivals/celebrations. Christians will usually wish to receive Holy Communion at these times. There is no religious objection about post mortem (Koenig et al, 2012).

A study conducted in India and Asia showed religious and spiritual beliefs have a big influence on attitudes towards health among the ethnic people in remote regions; in fact, they prevent the groups from using maternal services. In most cases, the people consult both spiritual leaders for information on care. The solution lies in collaborations between traditional and religious leaders and health ministry clinicians which can improve outcomes for everyone. This is because some ritualized practices can be harmful and costs of services constrain such arrangements. According to Koenig (2012) religion is defined as set of unified beliefs values and practices concerning a super natural being who is believed to have created the whole universe and all its contents and is in control of everything the main religion in the world include Christianity, Muslim Hindu, Buddhism, Judaism and traditional religion. Religion is a global thing and occupies the whole world. Every religion has its own beliefs, Values and praises different from others.

According to the study conducted on UHC by Oman (2018) in San Diego on Somali women receiving prenatal care services, the respondent observed that pregnancy as per

Islamic teaching is a blessing from Allah and use of contraceptives and any other family planning methods contravenes on Allah's will for humanity. In another study conducted on UHC access and registration in Michigan on cervical cancer screening revealed that Muslim faithful perceive gynecology services as a threat and an abuse to virginity of unmarried women and exposure of their privacy. This may influence the health care seeking behavior which is a big challenge and this explains the poor UHC registration (Oman, 2018).

In south Asia, a study revealed that women with breast cancer perceive it as a disease of fate where God can allow suffering as punishment and removes it at his will after prayers and sacrifice. This connection limits the hospital services compliance and UHC services acceptance Koenig et al., (2012). In North America, Muslims believe that they identify values, beliefs and practices that are different from what other non-Muslims groups align themselves with. When it comes to health care services, this contributes to inequalities on a global level.

According to a study done by Tsiachristas et al., (2019) in Italy and Turkey on UHC registration revealed that the Catholic faithful do not believe in hospital based family planning methods, use of condoms and abortion but would advocate natural family planning which involve counting safe days of a woman's menstrual cycle using special beads on a string. This explained the poor registration to UHC. According to a study conducted in Nigeria by Oman (2018), both Muslim men and women would prefer being attended to by health care workers of the same sex when they visit hospitals and if possible, they should be of the same age. This poses a great challenge to achieve the above.

A study conducted in Kenya on access to UHC services revealed that on hospitalization Muslim patients would prefer being brought food from home as opposed to food being served in the hospital particularly meat as it should be prepared according to Islamic law as otherwise would compromise their faith and offend their God. This limits the healthcare giver choice on patient (Koenig et al. 2012). The study continues to observe that many Muslim women continue to fast while they are still pregnant during the month of Ramadan which is against medical principles at it would harm the mother's health as well as that of the unborn baby (Oman, 2018).

Protestants in some churches in Kenya do not believe in services offered by hospitals such as blood transfusion in the case of anemia or laboratory tests as they believe prayers and healing and as a result did not heed to UHC services (Wafula et al., 2014). Therefore, incorporating spirituality or religion into health care requires the same skills that competent practitioners already use in the delivery of person-centred care (Koenig, 2012). These skills are underpinned by the principles of respect and collaboration. Besides the many positive effects that religion or spirituality may have on health, they can also have negative effects. Believers (and nonbelievers) may experience subtle psychological, social, and spiritual strains related to religious beliefs that distress them, their family, and their support network.

According to Oman (2018) Religious beliefs cause patients to forego needed medical care, refuse life-saving procedures, and stop necessary medication, choosing faith instead of medicine. Health Practitioners need to learn to respect the decisions that patients make based on their religious beliefs and not become offended or feel rejected. Instead, they should try to enter into a patient's religious worldview in order to better understand the logic of the decision. Only in this way can the door of communication be kept open between Health Practitioners and the religious patient. Health Practitioners

should obtain training in understanding the religious or spiritual issues concerning patient's health in order to address such areas that may be of vital importance to many patients' psychological, social, and physical health (Koenig, 2018). This understanding of one's religious beliefs will encourage people to accept hospital services and registration for UHC uptake.

2.3.4 Effects of Traditional Beliefs on access to UHC

According to Mbiti (1969), traditional and spiritual beliefs have a big influence on attitudes towards health among the ethnic people in remote regions; in fact, they prevent the groups from using maternal services. In most cases, the people consult both spiritual leaders for information on care. The solution lies in collaborations between traditional and religious leaders and health ministry clinicians which can improve outcomes for everyone. This is because some ritualized practices can be harmful and costs of services constrain such arrangements (Koeng et al., 2012).

The World Health Organization (2003) defines traditional medicine as health practices, approaches, and knowledge and beliefs incorporating animal and mineral based medicines, spiritual therapies, manual techniques and exercise singularly or in combination to treat diagnose and prevent illness or maintain wellbeing. Culture and society shape traditional medical beliefs and practices. Traditional Medicine is often used when the economic, social and cultural cost of using public health services are perceived as too high. In Africa up to 80% of the populations utilize traditional medicine for health care (WHO, 2003).

A study conducted by WHO (2003) in Minnesota University on the impact of traditions on healthcare revealed that the difference in beliefs and traditional values that exist between the patient and the healthcare giver may either encourage the patient to

continue to open up for diagnosis and treatment or to avoid the clinician and health facilities. The study suggested that it is important for the healthcare giver to try and understand the different traditions and beliefs and to respect and accommodate them as it would encourage them to come to the hospital to access UHC services for example the patient may not be aware of germ theory but may believe in witchcraft and evil spirits as it is believed in rural Afghanistan that convulsions in children is as a result of demons. Depression and mental illness are seen as resulting from misfortune and seeing a psychiatrist is seen as being crazy (Koenig et al, 2012). This was seen to affect patients' UHC uptake. Another study conducted in Canada revealed that what Canadians would call overweight in some African traditions would be referred to as being strong and having energy for future use in case of famine or as a woman, it is seen as being attractive and healthy (WHO, 2003). This difference in cultural beliefs affects UHC access as many people would not go to hospital.

According to Oman (2018) study in Rwanda, the African Traditional Religion does not believe in preventive measures such as cancer screening, HIV/AIDS testing, prenatal care and use of vaccines for prevention and giving birth in hospitals. This limits their use of hospital services and UHC access. A study done in Ghana and Nigeria on UHC uptake revealed that African Traditional Religion faithful believe in the experience and expertise of traditional healers, herbalists and ancestral intervention hence going to hospital is seen as not being beneficial to them which may lead to worsening of conditions. It is also believed that a sick person might die and should not die away from home where some death rituals are performed immediately that includes washing the body and placing it facing the right direction hence their UHC use is not very high (Wafula et al., 2014).

According to Mufaka (2013), “Culture includes a particular people’s beliefs, value orientations and value systems, which give meaning, logic, worth and significance to their existence and experience in relation to both the universe and other human beings”. Culture determines both who you are and what you are, and critically is the determiner of gender roles and identity. Each culture has a distinctive moral code. FGM was traditionally associated with rites of passage ceremonies. Demographic and Health Despite the increased awareness of the dangers of FGM on the girl child, particularly on her educational development and empowerment, FGM has persisted in practice by both the elites and the less educated worldwide, especially in Africa (Mbiti, 1969).

According to Wafula et al. (2014), many people in Kenya and many African countries would prefer to use herbal medicine as opposed to conventional medicine as it is cheap and readily available. This is because of the availability of traditional practitioners in every market and village. This would lead to low UHC compliance. According to Tema et al (2017), in Kenya, the difference in age between the health care provider and the patient will determine the patient’s willingness to co-operate. If the clinician is too young, the patient might be unwilling to discuss their health issues. Many patients would also prefer same sex clinicians especially women who believe that a male clinician should not see their nakedness as it is taboo in their culture.

According to Barasa et al. (2018), many patients in remote areas of Kenya experience a language barrier and lack a trusted interpreter to communicate with the clinician and this discourages many from going to healthcare facilities. Patients should be made to understand why they should use both complementary and alternative medicine at the same time as lack of this information might complicate the treatment. In Western Kenya and Nyanza areas, birth rituals are performed at home where a child is born at home. Going to hospital to give birth is seen as going against their cultural practices. They do

not believe in vaccines as they believe vaccines will cause sickness in their young children (Wafula et al., 2014).

A study conducted by Barasa et al (2018) on UHC uptake revealed that many people in Kenya practicing the African Traditional Religion avoid hospitals for the fear of being discouraged from using herbal medicine and traditional methods. They also believe that many sicknesses are associated with witchcraft, bad weather, bad omens and evil spirits and only traditional healers and practices can be used for healing to occur. This explains the negative attitude to UHC.

According to Mufaka (2013) study in Kenya, an example of the relationship between culture and health care can be seen in Narok and Isiolo; in these counties, female genital mutilation (FGM) continues to affect women during childbirth as well as service provision. According to one midwife in Narok "we are yet to see a change in the numbers of FGM". And in Isiolo, a midwife explained that "the majority of Borana and Somalis even with the third baby they will get an episiotomy even sometimes the fourth. This is because when you suture an episiotomy you suture what you cut, so you leave behind again the very small hole that you met. Sometimes you give bilateral episiotomies and she will still tear however much you support that perineum, even if they are birthing a child of two kilograms" (GoK, 2019).

There are deep cultural biases that influence the uptake of maternity services. For example, "Maasai generally birth at home, we don't often go to maternities"; "I didn't go or even consider going to the hospital as Maasai women do not like to go to hospitals as they believe that God will help them"; "we Turkana's just have our babies at home"; and "the Turkana like to give birth at home". The perception of pregnancy and birthing being a very normal function and part of the cycle of life is very strong among these

communities. A Maasai woman shared that "even now there are still many who birth at home. People have always been birthing at home throughout our history (Pureyio 2018). People are yet to get confidence/trust in hospitals. Some people have, some people haven't." And a mother in Isiolo confidently said that "we don't go to hospital because we are used to birth at home. In 12 African countries which include; Ghana, Mali, Nigeria and Zambia, 60% of children with Malaria are treated with local herbal medicines (WHO, 2013). Traditional birth attendants are also considered a part of traditional medicine. According to Mufaka (2013) women are often more comfortable with traditional practice and the individual performing these services, which in turn alleviates the stress of using unfamiliar western style medical services at health care facilities. Scientific evidence for the efficiency and safety and of traditional medicine is ambiguous.

Also, the lack of coordination between traditional medicine and western medicine creates problems of competition, communication and safety. Overdoses of some traditional medicines can have negative health effects. In China, the Herb Ma Huan or Ephedra is traditionally used to treat upper respiratory tract infections however; overdoses have caused heart attacks and strokes in the United States (WHO, 2003). In South Africa, the medical research council is studying the efficiency of traditional medicine for treating of pregnant women.

According to Hunt (2005), Socio-cultural practices and factors that influence access to health deaths in Ghana have been identified to include low socio-economic status, early marriage and childbearing, poor dietary practices and taboos surrounding sickness, use of trained and untrained Traditional Medicine men/women. In fact, access to health can be best understood with the application of medical anthropology that explains how

people of different cultures and social status view and perceive illnesses and their cure. In Ghana for example, local contextual issues influence the paradigm to disease causation and the health-seeking behaviour of Ghanaians. Thus, to understand why many rural folks patronize the services of TBAs, interpretive approach to research may be the best way to go (Hsiao & Shaw, 2014).

WHO (2013) reports that in rural Ghana; just like Nigeria and Ethiopia, individuals prefer to be attended to by Traditional Medicine men. This really poses risk to such people because these individuals lack the technical ware withal to competently administer the correct medicine and treatment. The question to ask whether these rural folks know the risk that these socio-cultural practices and critical decisions they take at the time they are critically ill?

The question as to what then prevents inhabitants from using health facilities can be found in their social and cultural factors (Oman, 2018). These factors have therefore been identified as having significant influence on health outcomes. Several people lose their lives due to factors such as poverty, ineffective health systems and gender inequalities which make them unable to take pragmatic measures and independent critical decisions concerning their health. Health decisions in this study refer to those actions taken by the community members in compliance with religious beliefs and practices, taboos related to herbal medications and the choice of use of orthodox health facilities and medications during illness (Koenig, 2012).

According to Pureyio (2018), various studies have been conducted on the socio-cultural drivers of mortality in Africa and elsewhere, and some interventions which are mostly determined by 'the experts' from outside the affected community have been put in place to address some of these factors. It is reasonable to assume that if people are aware of

the socio-cultural factors and practices that increase the risk of people's health; they will take proactive steps to curb its occurrence. This study was therefore aimed at finding out the knowledge on socio-cultural factors associated with access to health and how this knowledge affects health decisions; based on this, suggest practical ways of improving upon the current mortality ratio in the country from the perspectives of rural communities in the African countries.

2.3.5 The Effects of Geographical factors on Utilization of Health Services.

According to Nxumalo et al. (2018) Geographic health care access refers to diversity and distribution to health care services and physical accessibility. Globally the research has revealed that health care access is critical to improve physical, and mental health, prevention of the disease extending life expectancy access to health care services can be defined based on geographical, economic or on cultural considerations (Kamuzora, 2007).

According to Irimu et al. (2018) distribution of the health facilities and their accessibility may globally be defined by geographical terminal, reworking up to do framework and include recent global innovation and interventions on the health sector. Studies done in Germany, Fin land, Israel, Spain, England, Canada shows that there is big health care services variation globally associated with geographical distribution of the health care facilities among other reasons. Studies also show that the probability to receive a diagnosis or be done on the geographical procedure would depend on the geographical location of the facility from the urban area and the development levels. For example, in Germany and Belgium people living in towns were likely to get a knee replacement then the people living in the rural areas. This might be attributed to the economic levels and proximity to the facilities (Irimu et al., 2018).

According to research done on UHC access and geographical effects in the Czech Republic by Tsiachristas et al., (2019), the existence of geographical differences determines the equality and accessibility of the health facilities at a global scale. In public financed health institutions, equality in accessibility should be the major objective of the global health policy. This will warrant equal geographical distribution of healthcare resources to benefit the people through UHC services (WHO, 2019).

Inequalities in distribution of healthcare facilities has been mainly associated with the distance between the health facility and the location of the households especially in rural areas. Geographic effects determine UHC accessibility to the public. Equal distribution of healthcare resources involve both equality and efficiency within the targeted population (Tsiachristas et al., 2019). Tsiachristas et al (2019) points out that in low-income countries, the distance that persons travel to health facilities has been reported to be a determinant of health-seeking behaviour. For example, recent studies on health services utilisation in Pakistan and Zambia respectively, observe that physical distance to the health facility influences health seeking-behaviour and use of UHC services. Some of the women chose to travel from their rural homes to residences of their relatives who lived closer to the health facilities in order to report to the clinic on time. Similar observations were made in Tanzania regarding distance, indirect costs, and use of public transport.

According to Koenig et al (2012) the findings on the complications that distance adds to accessing formal health services in the foregoing studies are consistent with some recent studies in India on geographical distance from place of residence to a health facility as a factor for consideration in the choice and use of health services. Distance influences frequency of clinic attendance and the overall management and treatment of disease. The debilitating nature of some health conditions potentially results in long-

term damage, malfunction, and eventual failure of different body organs. This requires the women to attend diabetes clinics at designated intervals for screening and monitoring diabetes control, blood pressure, weight, etc. Uptake of health services, based on the level of illness, is dependent on predisposing, enabling, and need-for care factors. The need to cover varying distances by the respondents and accompanying costs influenced the follow-up protocol at the health facility. Challenges of geographical accessibility to health facilities cause patients to use different modes of transport to access biomedical treatment.

A study in rural parts of Kiambu revealed that people walked, used public and private means of transport, and, in a few cases hired vehicles in order to reach health facilities. (Tsiachristas et al., 2019). Use of transport has an impact on healthcare expenditure. When they were accompanied to and from health facilities, the cost of transport increased. In some cases, depending on their general health status, two adults accompanied them. Accompanying an ill person to a health facility constitutes indirect costs of illness, which is an increase in the burden on the household budget Ekman, B (2004). At the same time, limited access to transportation and costly public transport are among the challenges facing women while seeking treatment, particularly in resource-poor settings. A study by Koenig et al. (2012) in China revealed that distance from place of residence to the health facility invariably influences the frequency of clinic attendance, mode of transport, and cost of transport for persons suffering from diabetes.

A study conducted in France, Portugal, Swaziland and Spain also suggested that people living in urban areas would easily go for Caesarean section compared to people living from urban areas. This might have been associated with social-economic, cultural and geographical location of health facility. Other studies suggest that variation on

Caesarean section may not be explained on clinical issues but also demand and other related determinants, such as availability of physicians (Hammer et al., 1995).

According to Setharaman et al. (2007) analysis study in China on quality and distribution of Health workers, using provincial health data from Chinese ministry of health, ministry of education, census data and population survey data there is a big difference in distribution of health workers in both rural and urban areas: where the health workers are more in urban health facilities and very few rural areas (UNPD 2009). In a different study by Musgrove (1996) in China, suggested that low income people be it in rural or urban cannot access quality health care services. A study conducted by McCollum et al (2018) in Canada, Australia and United states on their metropolitans ratio found that nurses see many patients without doctors and physicians input.

A study conducted by Kamuzora (2007) on detailed GIS and analysis of car travel time and accessibility to facility using a bus in rural area (East Anglia) found that people using cars would reach a health practitioner faster than those using a bus who would take the whole day, hence distance to health facility was a big challenge. Hunt (2005) in his study on accessibility of health facility to asthma patients in Norway and England concluded that the asthmatic patients living in rural are poorly managed compare to those living in urban areas and near health facilities (Hunt, 2005).

According to many health studies conducted by OECD in many African countries OECD report (2014), geographical factors are the major cause of healthcare being inaccessible to many. The OECD recommends that with equal geographical distribution of healthcare facilities and resources, the global healthcare accessibility would improve greatly. It observed five dimensions to access healthcare equally, availability,

approachability, accomodatability, acceptability and appropriatability. All of them are possible through UHC services (WHO, 2019).

According to research conducted by Barasa et al (2018) in South Africa and Algeria on UHC services resource accessibility and utilization in different urban areas and their metropolitan areas have good access to health resources through UHC as compared to those who live in suburbs who were observed as having more chronic diseases and disabilities. The study further revealed that people in urban areas had good access to physicians as compared to those in rural areas. This was associated with the distance from health facilities and underdevelopment in rural areas (Linda et al, 2018).

According to WHO report (2015) in West Africa both Nigeria and Algeria have Universal health coverage, which has facilitated access quality health care services. A World Bank report suggests that the level in poverty in Nigeria is high and the UHC service reach only few individuals who stay in towns. The geographical position of the health facility hinders the citizen's access to UHC services. In Algeria the (WB) report suggest that the UHC has succeeded because the government pays all UHC services and the health facilities are well distributed in the country (WHO and WB 2015).

According to World Bank report (2015), Kenya health system falls under levels of the hierarchy that include level 1, community services, level 2, dispensaries and clinics level 3, health contras and maternity and nursing homes, level 4, sub county hospitals and medium sized hospitals level 5, county referral hospital and large private hospitals and level 6 national referral hospitals and large private teaching hospitals (WB, 2015).

According to Kenya health policy (2014-2030) leading cause of death include HIV related disease (29%), Malaria 50% cardiovascular diseases (3%) respiratory infections (8%) diarrhoeal diseases (6%). The policy gives everyone right for a quality health care

service through universal health coverage (UHC). Further the policy defines how distribution of health care facilities should be done in that the health care services are available in every region of the country regardless of geographical location. The 2014 health policy also points a specific concern on reducing maternal mortality rate, child mortality rate, and lastly increasing life expectancy (WB, 2015).

According to WHO 2015 in Kenya a health section has influenced great increment in the number of health workers in the last five years, though there has been problem in documentation to show the inventory of health personnel in the facilities and their geographical locations despite the efforts in 2003 to come up with debates of health workers and facilities, nothing much was accomplished. This lead to another study conducted in 2008 for a new database for the health providers which shows that there was increase of health facilities and health workers by 34%. Recent construction of the new health centres has revealed in improved geographic access to the health facilities and 71% access to health care services within the national population focused with a distance of 5km radius where the health centre is located (Barasa et al., 2018).

Despite improved health care services and location, the sparsely populated pastoralized still stay away from geographical access to health services. Between 100,000 - 500,000 in Kenya stay on a sized geographical access, which is 5km from home stead to health facility. The Nairobi and central have the 97% of their population within 5km and coast and the five kilometres and 50% of their populations within the geographical access to the facility. North eastern access to geographical access to health facilities associated with distance between the health care facilities (Irimu et al., 2018). According to Obatha et al. (2019) monitoring geographical distribution of health facilities has been great essence to make sure that health care services are available and accessible to all.

A study conducted in Kenya by Barasa et al (2017) on location of healthcare facilities revealed that their decentralization of the health facilities in counties and sub-counties would greatly help in accessibility of healthcare facilities in rural areas leading to a decrease in maternal mortality rates and child mortality rates and increasing life expectancy through management of communicable and non-communicable diseases in the community.

To achieve the main goal of Kenya health policy 2014-2030, health bill 2016 and constitution of Kenya act 2010 on universal health coverage, the government of Kenya through president Uhuru Kenyatta has come up with four development goals of which universal health coverage is one of them UHC. The government chooses four pilot countries for pilot study namely Machakos (road accidents), Isiolo (high maternal mortality rate), Nyeri (non-communicable diseases) and Kisumu (communicable diseases). Despite the county government of Machakos and national government having spent a lot of money for the success of the households seems to be still very lowObatha (2019), as a result research would be carried in Masinga sub-county in Machakos to determine if geographical location of the health facility can be a cause.

2.3.6 General Global Institutional Health Barriers

Lack of support or absence of health personnel at health care facility is reported to be constrains in scheme implementation, negatively influence enrolment. Conversely, the availability of health care providers at health facility was reported to increase utilization and enrollee satisfaction with CBHI schemes (Onwujekwe, 2009). In fact, Lack of awareness by communities about the vital role played by health care services is one of

the determinants of utilization of UHC; this is so since some members of the community only see the importance of health services when obstetric complications occur.

Traditional birth attendants are mostly used, and their services are perceived to be more vital in maternal health care. Visiting home about health care is essential in the provision of health care services for people who have not gone to any hospitals or health centres. A study by Raphael et al. (1994) established that traditional medicine men/women have an essential role during and after illness. In some rural communities, services of traditional birth attendants are considered vital. Other studies also report that marketing and promotion strategies influence implementation and uptake of a CBHI scheme. Limited information on the availability of scheme and poor sensitization on the core principles of CBHI negatively affected consumer awareness of scheme, enrolment rates, utilization and satisfaction with services (Barasa et al., 2017).

Infrastructure determines the accessibility to the nearby health facility. Here, accessibility refers to the distance the patient lives from a health care facility, transportation and total travel time, wait time and available services, (Raphael et al, 1994). In Andean, Bolivia where travel times are greater than one hour by walking, limited physical access to care is a major obstacle in improved health (WB, 2015). Limited access is especially important in rural areas where there are fewer healthcare facilities and villages may be physically isolated. In Zambia, 56% of surveyed rural household perceived distance as an obstacle WHO (2013) in the same study, only 17% of individual living more than 40 kilometres from a facility sought care when sick compared to 50% of individuals living less than five kilometres away. Another barrier in the rural areas is that travel time takes longer per kilometre than in urban areas due to poor quality of roads and the burden of having to use several modes of transportation.

Climate is also a factor especially during the rainy season when heavy rains and flooding create even worse road conditions.

Advanced transportation is often non-existent in developing nations and healthcare may be unattainable if the means of transportation are in adequate or time consuming such as walking, bicycling or using the bus (Tschanz, 2003). These longer travel times deter individuals from travelling particularly to access advanced technology that may only be available in large health facility located in the cities. These sometimes overwhelming obstacles may also encourage women in developing countries to turn to traditional medical practices. Mulupis et al (2018) found that maternity referral system in Mali, that attempts to remove geographic and financial barriers, that ensured basic and comprehensive emergency obstetric care, transportation to obstetric health services and community cost-sharing schemes, has produced a substantial reduction in maternal mortality rates (EC, 2010).

2.3.7 Challenges in provision of Universal Health Care (UHC)

Countries in Africa (and in most other parts of the world) face an array of health care financing problems that leave their health systems far from achieving the objectives of good health status, equity, efficiency, acceptability, and sustainability. The main problem is simply a shortage of government budgetary resources for health care relative to increasing demand and need for care. One manifestation of the budgetary shortfall is deterioration in the quality and effectiveness of publicly provided health services (Wamai, 2009). In a macroeconomic climate that has been characterized by slow or no growth in national income or government budgets, and often a per capita decline in real terms, governments are seeking ways to limit their financial responsibilities for health services (GoK, 2019). The reforms being considered or implemented constitute

strategies to improve the use of existing resources and/or mobilize additional nongovernmental resources for health.

In addition to an absolute shortage of resources going into the health sector, patterns of spending in most countries cause or reflect an inequitable and inefficient allocation of inputs and services. The clearest example of this is the concentration of government resources in large, urban hospitals. On average, people who live in urban areas have higher incomes than those in rural areas, yet the urban bias in government health spending means that the costs of gaining access to good quality care are highest for the most remote, and usually poorest, groups of the population.

Moreover, evidence from several countries, for instance, Kenya, and Tanzania Griffin and Shaw (1995), indicates that non poor people tend to consume more publicly financed hospital care per capita than poor people, which implies that they receive a disproportionate share of government subsidies. This pattern of government resource allocation may also be inefficient because the most cost-effective clinical interventions that health systems can provide are those that are most appropriately delivered in a health centre or other nonhospital setting. Hammer et al (1995), argue that the challenge in many developing countries is exacerbated by a host of additional obstacles including inadequate tax collection system, corruption, weak management and oversight, insufficient skilled personnel and difficulties in identifying and reaching the most vulnerable citizens. High levels of waste and other forms of technical inefficiency also plague health systems in these countries. These problems are a threat to any gains that reforms to improve cost-effectiveness.

2.4 Research Gap

There has not yet been a scholarly investigation done about the social and cultural hindrances to access to universal health coverage in Masinga Sub-County in Machakos County. This chapter has unveiled the studies that exist on the issue of UHC accessibility. These studies have demonstrated the seriousness that countries are attaching to this concept. However, most of the studies examine the issues related to full uptake of health care services from a general perspective. This is a gap that this research intends to fill, particularly in Masinga Sub County of Machakos County.

2.5 Conceptual framework

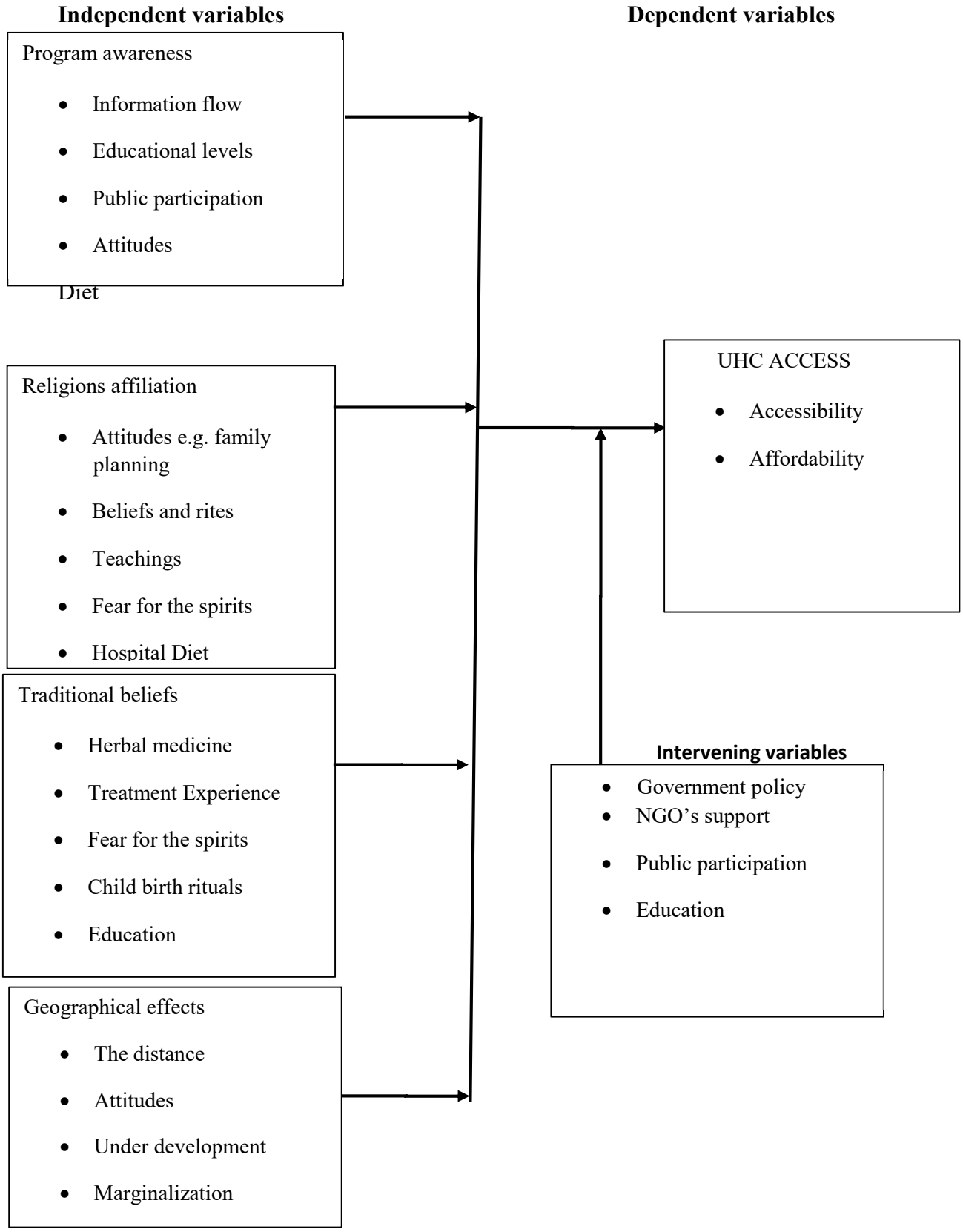


Figure 1: Conceptual Framework

From the conceptual framework outlined above, the independent variables entailed those actors that shape the nature of the program in terms of its availability and uptake. These include household factors, social factors and program acceptability. These factors can either lead to acceptance or rejection of the program. The dependent variable is the government's policy of Universal Health Care. This policy is solely dependent of those social and cultural factors that have been outlined. If these factors are moderated through such interventions as political willingness, public participation and partnership support, then the program of UHC will succeed; hence these become the intervening variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the methods that were used to collect data in the field and thereafter how these methods were analyzed. Specifically, the chapter outlines the study site, Research Design, target population, sample size, sample size determination, Sampling procedures, Data collection, piloting, reliability and validity, data analysis and finally the ethical considerations.

3.2 Study Site

This study was done in Masinga sub-county which has a population of 148,522 and is in Machakos county (KNBS, 2019). It is one among other seven sub-counties in Machakos county, namely; Machakos sub-county, Yatta Sub-county, Kangundo sub-county, Mwala sub-county, Mavoko sub-county, Kathiani sub-county and Matungulu sub-county. The research site is important for the study, because from the UHC enrollment's records 2018 in Machakos county indicated low levels of UHC registration in Masinga sub-county (GoK, 2019).

3.3 Research design

This study adopted a descriptive survey design to collect and analyze data. This design is usually appropriate for studies that intend to collect both qualitative and quantitative data. According to Mugenda (2003), this method is appropriate because it eliminates researcher's manipulation of the variables and enables the researcher to describe the state of affairs of the problem under investigation and the relationship between the variables. It also suits research types that require detailed explanation of phenomena. In this case, the design suited the research because it seeks to describe in detail the social and cultural factors that hinder the UHC program in Masinga Sub County.

3.4 Target population

The target population of the study or the sample frame is a group of individuals, cases or objects with some familiar characteristics to which the researcher wants to generalize results of the study. The idea of sampling a target population arises from the inability to carry out interview and test all the target population hence a representative is drawn in a good size that warrants statistical analysis. The target population was 350 respondents which included 50 respondents from each of the seven locations in Masinga sub-county.

3.5 Sample size

The sample size in this research constituted the households in Masinga Sub County. According to the KNBS (2019), the sub county has a total of 36,251 households. These households were picked from all the 7 locations of the sub county namely: Kivaa, Masinga, Muthesya, Ndithini, Kithyoko, Kangonde and Ekalakala.

3.6 Sample size determination

A sample is a sub-set of the population that can be analyzed at reasonable cost and used to make generalizations concerning the population parameters easily (Mugenda, 2003). The sample size was determined by use of stratified sampling technique because the study site had seven locations which acted as stratums. Basically, the study focused on households within Masinga sub-county, Machakos county. The sample size was 350 households for seven locations with each location having 50 households. To determine the sample size for the study the formular of Krejcie and Morgan, (1970) was used.

3.7 Sampling technique

Sampling is the process of picking a sample out of a particular population. In other terms it stands for the entire population, helping the researcher to draw some conclusion concerning the population (Mugenda, 2003).

Systematic random and stratified random sampling technique was used to select the sample where 350 households were selected and each location had the following sample; Kivaa 50, Masinga 50, Muthesya 50, Ndithini 50, Kithyoko 50, Kangonde 50 and Ekalakala 50. Stratified random sampling was used to select the respondents from their respective strata where the sample size was derived randomly where the respondents were first grouped into strata of 50 per ward and then selection was done through random systematic technique in which after every five homesteads/respondent were picked until they reach the total of 50 per ward. The seven locations made a target population of 350 respondents.

The researcher read relevant literature from journals, books and other scholarly documents about the effects that hinders the enrollment and accessibility to UHC. Some of the effects that the researcher found from the already existing reading materials were the social effects, religious affiliation effects, traditional and geographical effects.

The researcher developed the questionnaire which were used by the respondents for the study. The study also undertook interviews of the nurses, sub chiefs and chiefs. These interviews were undertaken through the use of a structured questionnaires and interview guide for the study.

3.8 Data collection method

Quantitative primary data was obtained using a developed questionnaire with both closed and open-ended questions which the researcher and research assistants administered to the households and key informants at convenient time of early hours in the morning, in the evening and over the weekends. The primary data that was collected in the field were both subjective and objective data in a large sample of the study population in order to obtain results that were statistically significant.

Secondary data was sought through desktop search techniques from the existing material sources and from previous research studies through reading relevant literature available in the library, various documents publications and reports including, journals, and magazines; where all the relevant information on previous UHC studies were reviewed. Some of the secondary data that were the hindrances that affect the enrollment and accessibility of UHC services.

3.9 Piloting of the study

A pilot test included 10 respondents and it was done in Ndalani location in Yatta sub-county to evaluate the completeness, precision, accuracy and clarity of the questions to the respondents. This piloting was done in Ndalani location because it borders Masinga sub-county and has similar demographic characteristics with Masinga sub-county. Out of the 10 respondents 5 were households, 2 sub-chiefs, 1 chief and 2 nurses. This was done to ensure the reliability of data collection tools that were used in this study. The questionnaires were administered to the respondents and the whole exercise was conducted within three weeks. To increase the reliability and validity of the research instruments, the researcher engaged test-retest technique in which the tools was administered twice to the same subject.

3.10 The Reliability and Validity of the Instruments

3.10.1 The Reliability of the Instruments

The questionnaire instrument is a trusted source of information collection for it collects both subjective and objective information particularly to a large sample of respondents and will surely provide statistical reliability (Mugenda, 2003). It prevents the privacy of the respondents as well as an available instrument. The instrument can be used to measure both qualitative and quantitative information. To increase the reliability of the data collected, the researcher engaged test-retest technique in which the tools was administered twice to the same subject. The pilot test of the tools was done in Masinga

sub-county on six respondents to make sure that intended data or results are acquired. The instruments of the study were found to be reliable for the study.

3.10.2 The Validity of the Instruments

Validity can be defined as the degree to which a research tool measures what it is supposed to measure (Mugenda, 2003). In order to ascertain face validity; the tools made were given to the senior researchers at the St' Paul's University for constructive criticisms. Thereafter, they were revised according to their comments. Moreover, content validity was sought from requesting for experts in the field of study to provide their comments on the relevance of every item on the instrument. The data for piloting was collected from six respondents from Masinga sub-county with similar characteristics as the study sample even though was not to be included in the final sample. The result of the piloting study was used to improve the instrument as well as the effectiveness and competence of the researcher in asking questions. Pro-testing is done to test for validity and reliability of the tools.

3.11 Data Analysis and Presentation

The data collected was subjected into analysis including interpretation of findings against the research questions. The information gathered was coded and entered into the Statistical Package for Social Sciences for analysis (SPSS) which helped in organizing and summarizing the data by the use of descriptive statistics such as measures of central tendency (mode and median). Frequency tables were used to present the data collected for ease of understanding.

3.12 Ethical consideration

The researcher and assistants ensured that got an informed consent from the respondents, the ministry of Education National Commission for Science Technology and Innovation (NACOSTI) and from St. Paul's post graduate Board. High degree of

anonymity was assured because data was coded to protect respondents' identity. Objectivity and subjectivity in the study was put into consideration.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.0 Introduction

This chapter presents the findings which were derived from the questionnaires and the interviews that were conducted in the field. A total of 350 respondents, who constituted household heads in the 7 locations of the sub county namely: Kivaa, Masinga, Muthesya, Ndithini, Kithyoko, Kangonde and Ekalakala. The first part presents the demographic data then followed by the findings which were themed according to the objectives namely; To establish the level of awareness on universal health coverage; to examine effects of religious affiliation on universal health coverage; to determine the influence of traditional beliefs on the universal health coverage and to examine the effects of geographical access on universal health care in Masinga sub county. Out of a total of the 350 questionnaires that were administered, 348 of them were returned back; this was a response rate of 99.3%.

4.1 Demography of the respondents

4.1.1 Age

The age of the respondents was considered as an important element of the research because well distribution of age brackets would be representative of the entire population. The findings are presented in Figure 2 below:

Figure 2: Respondents Age

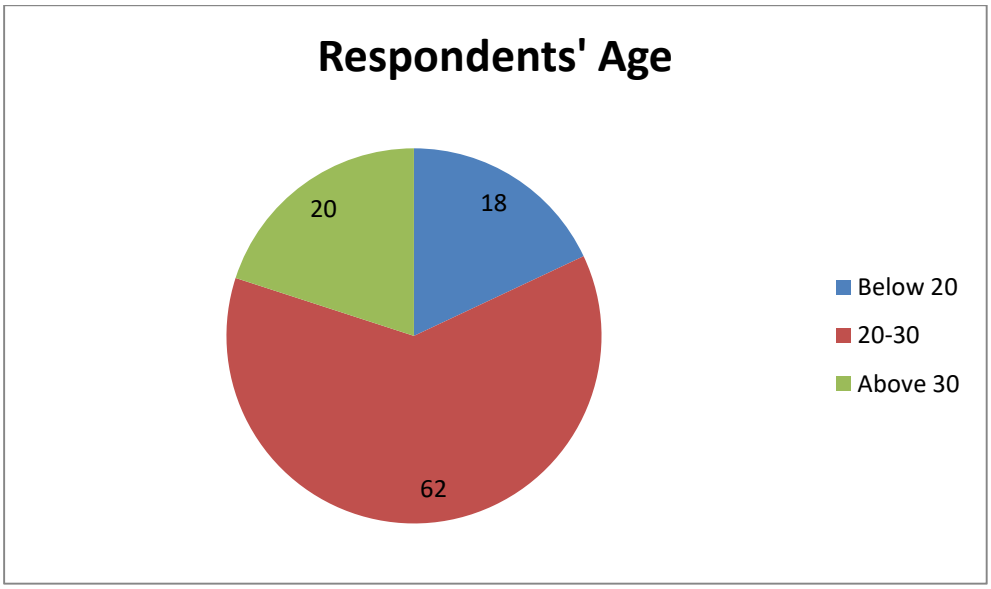


Figure 2: Respondent's Age

The age of the respondents, as indicated in the figure above, was distributed with a majority of them, 62 being between 20 to 30 years and another 20% were above the age of 30. The rest, 18% were aged below 20 years. This was considered as an appropriate representative sample to generate anticipated responses because they were well distributed and as such representative of all age brackets.

4.1.2 Education Levels

Education levels play an important role in as far as moderating socio-cultural practices and beliefs. Therefore, this study sought to establish the educational levels off the respondents in a bid to understand their views on the matter under investigation. The results are presented in the figure 3 below:

Figure 3: Educational Levels

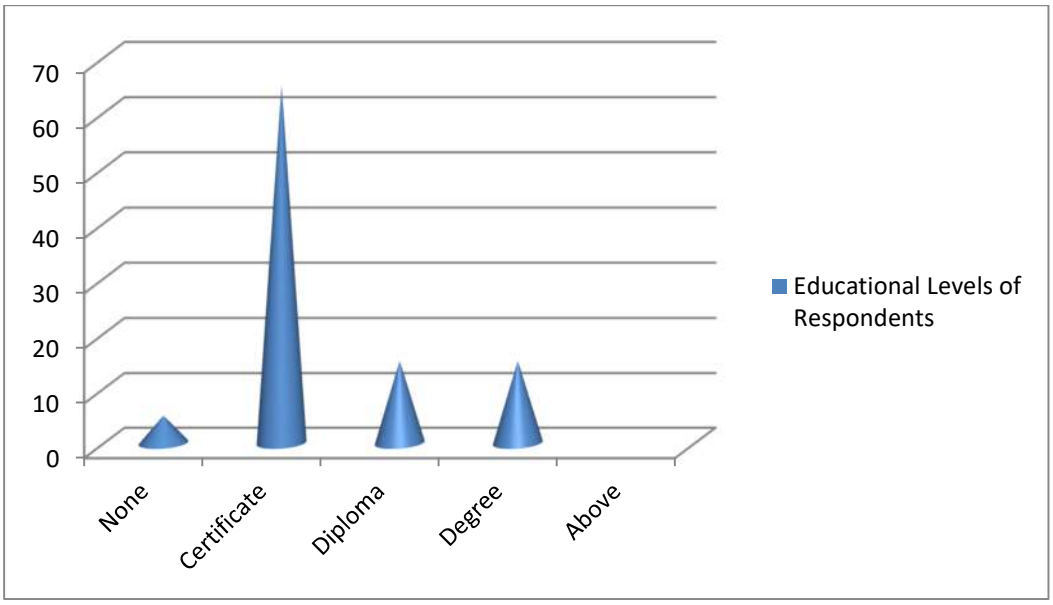


Figure 3: Education Levels

A majority of the respondents, 65% indicated having certificate level qualification, another 15% had diploma and 15% more had degree. A paltry 5% indicated having no academic qualification. This representation was considered largely literate and thus able to competently respond to the questions.

4.1.3 Number of Children

Since the study targeted households, it was important to know the number of children in the households because healthcare cuts across all ages in the households. The responses are presented in figure 4 below:

Figure 4: Number of Children in the household

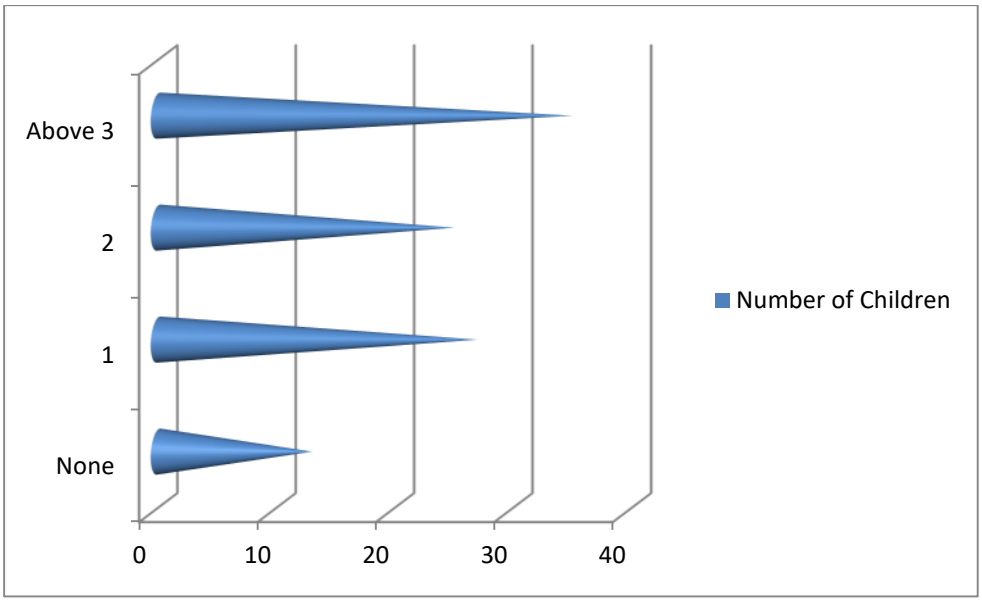


Figure 4: Number of Children

A majority of the respondents, 35%, indicated that they had more than three children in their households; another 27% had 1 and 25% had 2 children. At the same time, 13% also indicated that they had no children in their households. This representation was appropriate as it was representative of the scenarios listed above.

4.2 Level of Awareness on health Coverage in Masinga Sub County

The success of the Universal Health Care is mainly hinged on the levels of awareness of the program. In most cases, people, especially those living in the rural areas, fail to enjoy the benefits of the program because they lack awareness of the program. This is usually complicated by the inadequate sensitization measures that can enable them to discern the program and how it works. To find out the level of awareness among the respondents on the Universal health coverage, several questions were asked and the responses are as follows:

4.2.1 What are the common Illnesses among people in Masinga Sub County?

Condition	Percentage
Heart Disease	30
Diabetes	15
Asthma	15
Skin Disease	5
Joint/Bone	5
Neurological	3
Cancer	3
Liver Disease	4
Mental Illness	20
Tuberculosis	10

Figure 5: Common Illnesses in Masinga sub-County

From the table above, the conditions that affect the people in Masinga Sub County were established by asking the respondents the cases that have made them to seek medical healthcare in hospitals. 30% of them indicated heart disease, 15% diabetes, another 15% asthma, 5% skin disease, 5% joint and bone, 3% neurological, 4% cancer, 4% mental illness and 10% tuberculosis. This was an indication that the respondents sought medical healthcare in hospitals where they were diagnosed and told their conditions. It also implies that they are aware of the various ailments that they suffer from. Asked to state the source of income that they use in accessing these facilities for treatment, they indicated current income, past savings, sale of assets and donations from friends. Very few of them did indicate that they had health insurance premiums that cushioned them from spending on health such as National Hospital Insurance Fund (NHIF). This

suggests that the respondent's conception of the government initiatives was not fully comprehended.

4.2.2 Ever been targeted for Universal Health Coverage?

Figure 6

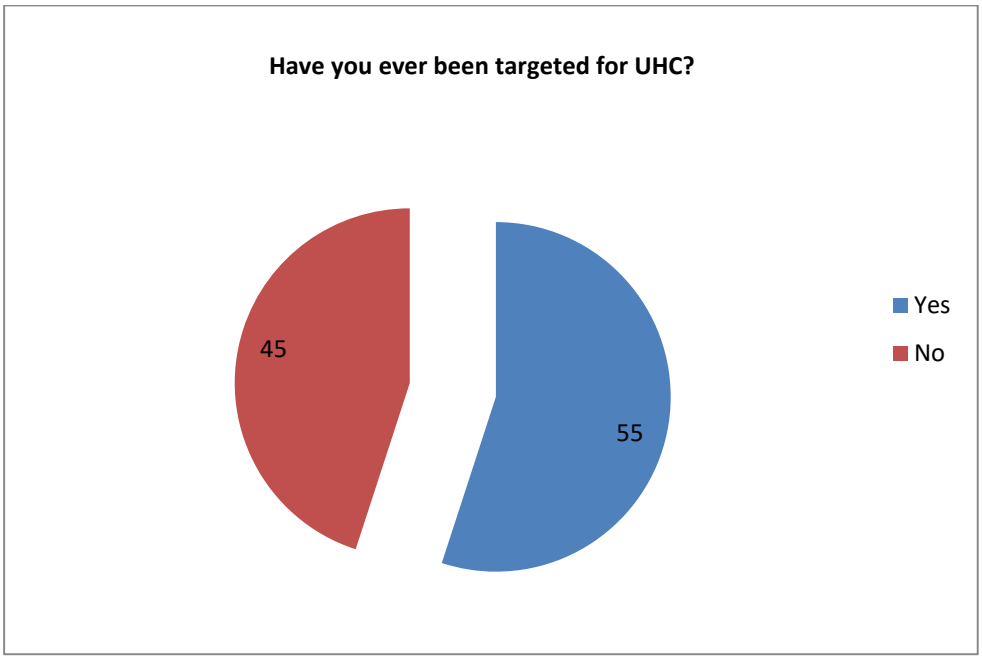


Figure 6: Correspondents targeted for UHC in Masinga sub-County

The respondents were required to indicate whether they have ever been targeted for Universal Health Coverage. From figure 6 above, a slight majority, 55% indicated that they have ever been targeted while the remaining 45% answered in the negative. The deduction from these findings is that although the program is in existence in the sub county, a good number of people are yet to benefit from it. They were asked to indicate the services that they seek in medical centres; their answers ranged from counselling to medical check-up and referrals. All these services are covered by the UHC.

An interview with a key informant; a locational chief revealed the following;

> *In my location public meetings and door to door campaigns to pass an information about UHC registration in my location proved to be very effective*

in sensitization and mobilization of people towards UHC enrollment. (KIS 001).

4.3 Effects of Religious affiliation on Health coverage

Religion plays a critical role in shaping the world view of people. This is because it determines the values, preferences, and ethics and as such, plays a significant role in determining the health preferences people make. That being the case, the respondents were asked different questions and their responses are as follows:

4.3.1 What religion do you subscribe to?

Figure 7

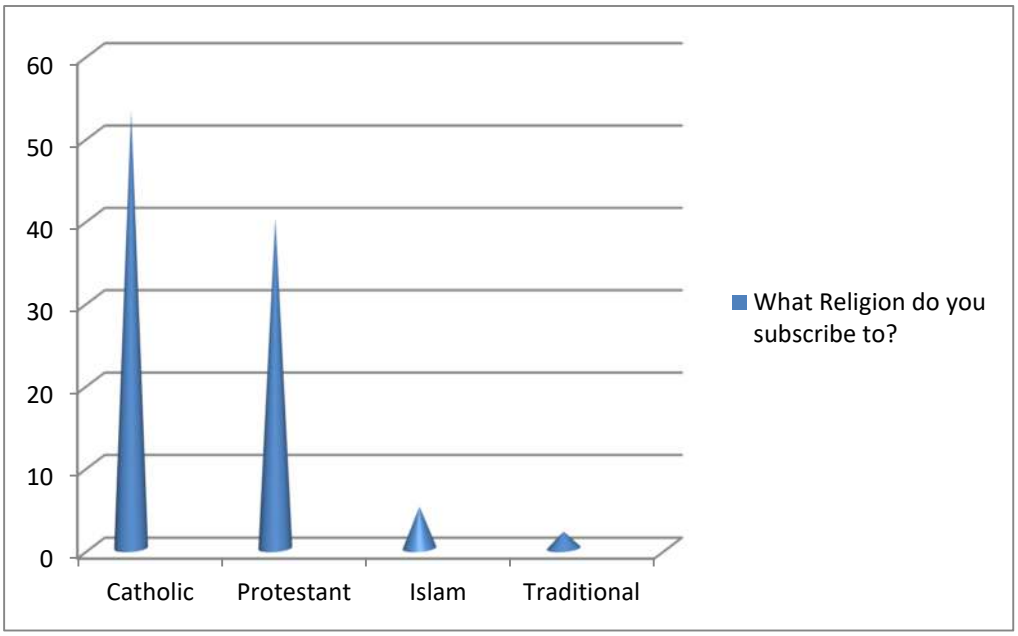


Figure 7: Religious Subscriptions in Masinga sub-county

From the figure above, it can be seen that a majority of the respondents are Christians with 53% of them being Catholics and 40% of them being Protestants. The rest

subscribe to Islam and Traditional African religion at 5% and 2% respectively. They were further queried about their views with regards to healthcare, particularly lab tests, hospital treatment and general healthcare. Most of them indicated that being Christians, their religion allowed the use and access to medical healthcare in hospitals and they are very comfortable with the medical procedures that are usually undertaken in hospitals. The few who were subscribers of the Traditional religion stated that they believe in traditional herbal medicine as it works and cures diseases that conventional medicine does not cure. They also indicated that the traditional medicine men and women were well respected in the community and were sought by people even when they consult professional healthcare.

Since the vast majority of Masinga Sub County is situated in the rural areas, the researcher wanted to find out how the community members help those who are sick. They indicated that depending on the condition of the person, they preferred taking him/her to either Masinga Health Centre or Machakos Level 5 hospital; besides, they indicated that they usually pray for the person, contribute or the family and pay visitations in the hospital that the person is admitted. The unity that brings them together is catalysed by their religious views of compassion and care for the sick members of the community.

4.3.2 Do your religious views discourage you from seeking healthcare in hospitals?

Figure 8

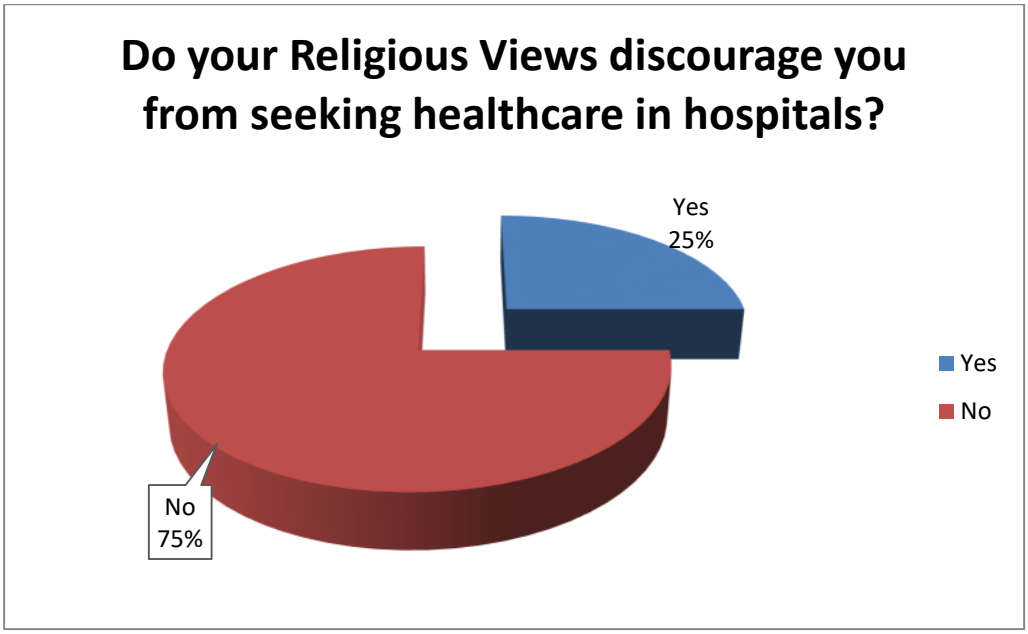


Figure 8: Religious Views and seeking Healthcare

A majority of the respondents, 75% indicated that religious views do not in any way discourage them from seeking healthcare in hospitals. They indicated that on the contrary, their religious persuasions favour the utilization of healthcare in hospitals. To this end, they stated that some missionary organizations have even invested in the establishment of hospitals and medical centres.

According to them, their religion promoted pro-life approach to healthcare in the sense that anything that can be done to restore life is considered morally correct and that's why they encourage members to visit hospital for medical attention. A paltry 25% indicated that religious views discourage them from visiting healthcare facilities. They stated that according to their religious persuasion, it is discouraged to use herbal medicine and at the same time conventional medicine as it can lead to death. Therefore, when they fall ill, they visit the traditional medicine person and he/she dispenses the

herbal medicine until the person recovers. However, this argument was largely found in those who stated that they believe in traditional religion. Asked whether they thought that religion can be used to mobilize people about healthcare,76% off the respondents answered in the affirmative; they explained that religion is the single most important tool for mass sensitization and information spread through religious communities is bound to reach out many people and hence make positive change regarding healthcare decisions.

4.4 Effects of Traditional Beliefs on healthcare coverage

Being in the rural areas, traditional beliefs still shape people's thinking; especially among the illiterate and semi illiterate communities of people. In order to ascertain whether traditional beliefs have an impact on people's decisions, the respondents were asked a wide array of questions whose responses are presented below:

4.4.1 What causes diseases according to your traditions?

Figure 9

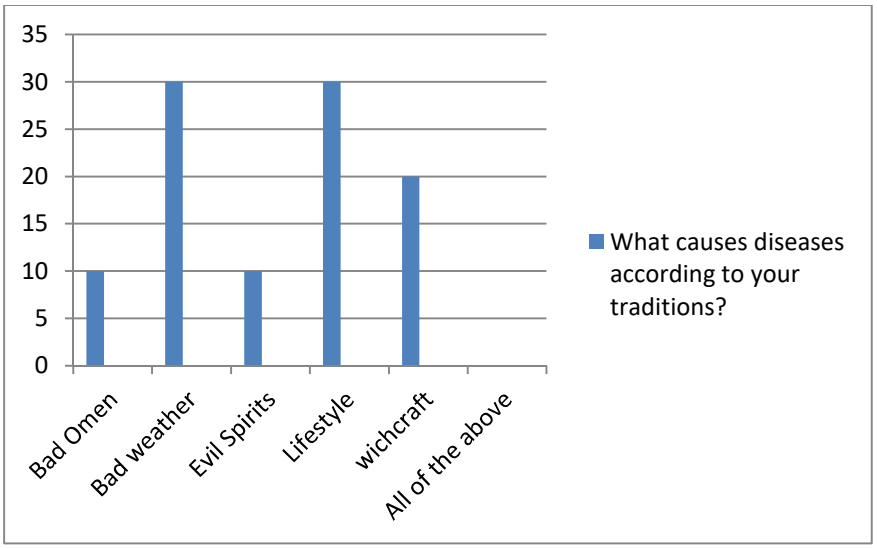


Figure 9: Belief in Causes of disease

From figure 9 above, it can be deduced that a majority of the respondents do not attribute causes of sickness to superstition but on medically ascertained causes as seen

in the 30% who attributed it to bad weather and another 30% who attributed it to lifestyle. However, there were also a sizeable proportion of people who attributed causes of disease to traditional beliefs such as bad omen, 10%, evil spirits, 10% and witchcraft, 20%. These responses go a long way in showing that traditional beliefs are still a determining factor in healthcare access. It also means that if disease is attributable to superstition, it is very difficult to seek the attention of conventional and professional healthcare. Asked to indicate if there are traditional healers in the community, the respondents indicated in the affirmative and went further to enumerate their roles as diviners, circumcisers, those who perform brain surgery, exorcists and midwives.

These categories of people were consulted depending on the religious persuasion or the condition of the sickness. Others, such as midwives, helped mothers deliver at home in cases where it happened as an emergency. They were also quizzed on the advice they would give to sick members in the community. A majority of the respondents indicated that they will advise these members to seek medication from hospital as that is the surest way to discern their ailment. Others also indicated that they would advise them to enroll for UHC so that they can benefit and minimize costs that they incur on medications which discourage them from visiting hospitals. A few of them, however, indicated that they would advise the members to consult a traditional healer and find out exactly what could be troubling them; in their defense, they stated that some ailments are not usually detected in health facilities and hence the importance of these people.

In an interview with one of the traditional herbalists (informant), he stated the following:

> *To be honest, as much as modern medicine has come and is embraced all over, we still cling to traditional beliefs about health. Some diseases are seen to have other external causes*

*and as such, we usually seek traditional medicine's interventions. (*KI 002)

4.5 Effects of Geographical Access on Healthcare coverage

As much as the government may have opened up opportunities for free medical healthcare, one impending challenge is that of accessibility. To this end, the respondents were asked several questions aimed at determining the effects of geographical access on healthcare coverage.

Figure 10

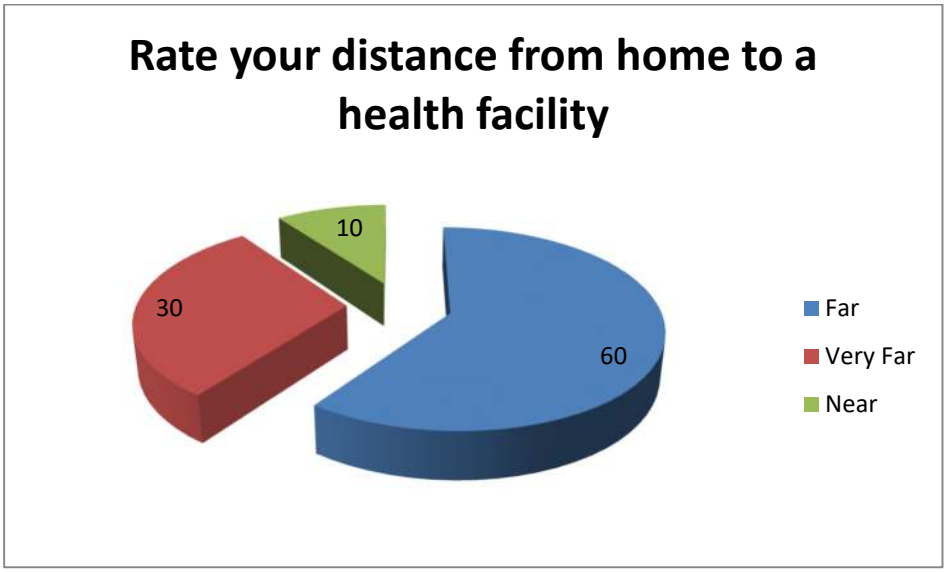


Figure 10: Distance to Health Facility from Correspondent's Home

From the responses above, it is apparent that distance is a constraining factor towards the access of healthcare; this is seen in the 60% of the responses that indicated that it is far and another 30% stated that it is very far. Only 10% indicated that it was near; this was because they resided near Masinga town. Asked further the specific distance, 10% indicated that it was 1 Kilometre away, 60% stated it was up to three Kilometres away while another 30% indicated that it was more than 5 Kilometres away from their home. They were further asked to state how distance is a challenge in accessing healthcare

services; they stated that it is expensive to travel to health facilities that are far and they may not have the requisite funds to do that. This discourages them and as such only visits these facilities when their conditions get worse. They stated that to solve this challenge, they are forced to hire motorbikes to take them faster to healthcare facilities and this was risky and at the same time more expensive.

When asked to state what they think ought to be done in order to solve the problem of distance; the respondents stated that the government ought to build more health facilities closer so that those who reside in far flung areas are not disadvantaged by distance. Others stated that the government ought to employ mobile clinics that rotate in the various parts of the sub county regularly in designated places so that more people can be covered. These findings are in tandem with those of Anand (2008) analysis study in China which established that the geographical factors were inhibiting factors towards access to medical healthcare; those who resided in the rural areas hardly frequented hospitals because of the logistical nightmare that it brought in terms of transportation costs and other related costs. It was found out that because of this, there was a huge disparity in mortality rates when rural areas are compared with urban areas because in the latter, geographical factors played a central stage in discouraging or inhibiting their uptake of medical services.

An interview with a Key respondent, a nurse, revealed the following:

> *As much as the UHC program is in progress, it is challenging for medical workers to reach out to people who are in far flung areas……just as it is difficult for them to visit the health facilities, so it is also challenging for us to reach them.* (KIS 003).

The relationship between distance and facility selection in urban settings is less clear as women have more health service options within reasonable travel distance. Factors

such as market or employment location may also influence health facility selection. In a dense urban setting in Senegal, women were willing to travel further to obtain family planning services from higher quality facilities. In urban Sierra Leone, few women cited facility distance compared to reputation or cost as a primary consideration when selecting health providers for their children. The study took place in adjacent neighborhoods with multiple clinics and hospitals within a 1 km radius, potentially attenuating the role of distance. The relationship between distance and facility selection for delivery in urban settings is also complex.

Health service availability and access does not ensure use. While urban women are more likely than rural women to deliver in facilities, the percentage of urban women delivering outside of a facility remains high. A Nigeria DHS study found that nearly half of all urban women sought health services of a facility. In an urban settlement in Lagos, Nigeria, women had multiple facility options within the city, but over half (51.4%) delivered outside of facilities.

According to Winston et al (2016), poverty further complicates the relationship between health service access and bypassing behaviours in urban environments. Urban poor often live on city outskirts and must travel further for health services. Inability to pay service fees or the cost of consumables poses a challenge for many women who would prefer to seek another provider if cost was not an issue. Further, insufficient funds to cover fees often result in women choosing to treat a sick child at home rather than visit a health facility. Urban poor living in informal settlements face added challenges of insufficient quality health care options. Studies from two informal settlements in Nairobi, Kenya, found that women did not consider distance or transport a hindrance to visiting the nearest facility within the settlement. However, facilities

within informal settlements are often private making cost a challenge for obtaining care and are often poorly equipped to provide adequate services. Focus groups from an informal settlement in Nairobi, Kenya, found that poor women recognize the safety of hospital services but prefer home due to challenges with traveling outside the settlement to reach the main road for transport, transport costs and facility-related costs, and perceived negative provider treatment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECCOMENDATIONS

5.1 Introduction

This study sought to establish the socio and cultural determinants to the access of Universal Health Coverage in Masinga Sub County, Machakos County. The study was guided by the following specific objectives: To establish the level of awareness on universal health coverage; to examine effects of religious affiliation on universal health coverage; to determine the influence of traditional beliefs on the universal health coverage and to examine the effects of geographical access on universal health coverage in Masinga sub county. A total of 350 respondents were sampled by the study. These were mainly household heads and those residing in their respective homes.

5.2 Summary

5.2.1 Findings on the level of awareness on Universal Health Coverage

It was established that the level of awareness on universal health coverage in Masinga Sub County was average. Close to half of the people (45% as indicated in figure 6) who were sampled indicated having not been covered by the program which was an indication of the fact that the level of awareness was low. The success of the Universal Healthcare Coverage solely depends on the reception of the people, especially in the rural areas. This is because if they are not well versed with the program, they may not be able to sufficiently take advantage and utilize these programs. Therefore, the people of Masinga demonstrated below average level of awareness and this was an indictment to health department about the measures they have undertaken to sensitize the public on this program. It was also established that the people in this Sub-County are well aware of the various ailments that afflict them ranging from lifestyle diseases to those

that are caused by weather and those that are inherited. Therefore, this brings to the fore the role of mass mobilization on the successful implementation of the programs.

5.2.2 Findings on the Effects on the role of Religious Affiliation on access on Universal Coverage

On the role of religious affiliation as a determinant to Universal Health Coverage, it was established that religion played a significant role in the access to Universal Health Coverage. By and large, it was established from the majority of the respondents who were Christians (53% Catholics and 40% protestants) that their religious persuasion favors the access to healthcare. In fact, many of the religious bodies have gone a long way in complimenting the government through the establishment of mission health centres and even training colleges run by the religious organizations. Therefore, rather than being a hindrance, religious affiliation was seen as a great catalyst towards the access to Universal Health Coverage. However, it was only on a very small scale that religion was found to be a hindrance to access to UHC; this was with both muslims (5%) and the traditional religious beliefs who had 2%. Those who adhere to the tenets of this religious persuasion were found to be intolerant to the utilization of conventional medicine because they perceive it as an anti-thesis to their traditional healthcare.

In two separate interviews with both a chief and an assistant chief revealed that they used both public meetings and door to door campaigns to sensitize and mobilize people to UHC enrollment within their locations. Thus, encouraged registration and accessibility to UHC enrollment.

5.2.3 Findings on the Effects of Traditional Beliefs on Access to Universal Health Care

The study was able to establish that, though there was minimal percentage of people who subscribed to traditional beliefs (2%); these beliefs negatively affected the

utilization of healthcare services. The presence of a wide array of traditional medical attendants sought to reinforce the finding that those who visit them shunned healthcare offered in medical facilities and thus limited its access. The traditional health attendants were seen to be attending to virtually all the medical cases that arose within the community. It was also found out that they were used as a measure of last resort, especially when a person's condition seems to deteriorate and yet he/she has been in hospital.

However, as earlier noted, majorities of the people do not subscribe to these views and as such are not influenced by them when it comes to accessing the conventional Medicare found in hospitals and other health care centres.

An interview with a traditional herbalist (informant) revealed that as much as modern medicine is so much in use there are some illnesses and conditions that would require traditional medicine interventions. Thus, creating a negative effects on UHC enrollment and accessibility.

5.2.4 Findings on the Effects of geographical Access on Universal Healthcare

Being in the rural areas, it was established that Masinga Sub-County is vast and its geographical terrain is a limiting factor in movement. At the same time, it was found out that means of transport from the far flung areas was a challenge. To complicate the equation, it was established that there are few health centres and they are far from a majority of the people (60% according to figure 10) in the Sub County. Therefore, geographical access was found to have a direct consequence on the access to healthcare; many of the people in the sub county prefer visiting health centres only when their health conditions are serious and because of the distance. This was found to be having a negative effect on the utilization of the Universal Health Care program. It was

suggested by the respondents that apart from building more health facilities in the area, the government ought to use mobile clinics in order to minimize the challenge of access to these facilities which are far from them.

As revealed through interview with a health nurse distance was found to be a big challenge to UHC registration as many people lived far in rural areas from the health facilities; it was difficult for the information to reach them on UHC enrollment and accessibility to the services.

5.3 Conclusion

The purpose of this study was to investigate the socio and cultural hindrances to access to Universal Health Coverage in Masinga Sub County in Machakos County. The target population of the study was 350 respondents. The researcher grouped the respondents into strata of 50 per location and then selection was done through random systematic technique in which after every five homesteads, respondents were picked until they reach the total of 50 per location. The findings of the study informed the specific objectives and answered the study questions.

The study found out that socio-cultural factors can either positively or negatively influence the uptake of Universal Health Care program. It was also established that as much as the program is well intentioned; it still needs a lot of sensitization in order to foster full acceptance by the vast majority of people. At the same time, the determinants such as religion, traditional beliefs and geographical factors ought to be mitigated by the county and national government so that more people can benefit from it.

5.4 Recommendations

Based on the study findings, the following recommendations are made:

The government ought to prioritize mass sensitization of the Universal Health Access program to the rural areas through information flow in which people are educated on the importance of UHC enrollment which would help people to access health care services.

Religious institutions should be used as a platform of encouraging people to utilize these programs. Religion should be used to inform and sensitize people on the benefits of the UHC in healthcare services accessibility. The religious teachings should be used to change people's primitive beliefs which hinder them from UHC registration and hospital services accessibility.

Door to door recruitment be organized by health workers in order to recruit as many people as possible in the enrollment of UHC. This can be done with the collaboration with the government under the office of assistant sub-chief and chiefs.

There should be policies that regulate the activities of traditional health attendants to ensure that they do not reverse the gains made by the government. These policies should be implemented to discourage people from seeking health services from traditional health attendants. Thus UHC's enrollment will be encouraged.

Partnership between NGOs and the government be stepped up to ensure that superstitions that are contrary to Universal Access to Health care are diluted and challenged. This can be done through educating people the dangers of not registering with UHC.

5.5 Further Study Recommendations

- There is need for further studies to be conducted to determine other factors hindering accessibility of Universal Health Coverage uptake in other counties.
- Since this study was conducted in a government institution there is need for a similar study to be done in a private sector to determine if the same factors would hinder the Universal Health Coverage accessibility in a private sector.

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APPENDIX 1: NACOSTI

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National Commission for Science, Technology and Innovation
off Waiyaki Way, Upper Kabete,
P. O. Box 30623, 00100 Nairobi, KENYA
Land line: 020 4007000, 020 2241349, 020 3310571, 020 8001077
Mobile: 0713 788 787 / 0735 404 245
E-mail: dg@nacosti.go.ke / registry@nacosti.go.ke
Website: www.nacosti.go.ke

APPENDIX II: QUESTIONNAIRE

My name is Isaiah Mululu, a student at St. Paul's University Pursuing a Master's Degree in Development Studies. I am writing a research on *'Social and Cultural Hindrances to access Universal Health Coverage: A case of Masinga sub – county in Machakos, Kenya'*. Your responses will be treated with outmost confidentiality and anonymity. The responses will be used for research purposes only.

PERSONAL INFORMATION (use a tick ( ) for your answers)

1a) Kindly Indicate your sex

Male ☐ Female ☐ Others ☐

b) How old are you?

Below 20 ☐
20-30 ☐
Above 30 ☐

c) What is your level of education?

Certificate ☐
Diploma ☐
Degree ☐
Above ☐

d) How many children do you have?

One ☐
Two ☐
Above 3 ☐

2. Level of awareness on Universal Health Coverage in Masinga Sub County

a**) What are the common illnesses in Masinga sub county?**

i. Heart disease ☐
ii. Diabetes mellitus ☐
iii. Airway disease & asthma ☐
iv. Hypertension ☐
v. Bone/joint disease ☐
vi. Skin diseases ☐
vii. Gastric/peptic ulcer/ GI tract ☐
viii. Neurological ☐
ix. Cancers/tumour ☐
x. Liver disease ☐
xi. Mental illness ☐
xii. Tuberculosis ☐
xiii. Ocular/ENT ☐

b) What are the sources of money that you use for treatment?

i. Current income ☐
ii. Past savings ☐

iii. Sale of assets ☐

iv. Donation by friends & relatives ☐
v. Borrowings through mortgage/ loans ☐

vi. Re-imbursements (insurance/ employer/ government scheme) ☐
vii. Other sources…….

c) What areas do you spend money on during healthcare services?

i. Consultation/ Service fee ☐
ii. Diagnostic tests (lab & radiology) ☐
iii. Medicines and consumables ☐
iv. Transportation ☐

v. Informal payments ☐

d**) Have you ever been targeted for the Universal Healthcare Coverage?** Yes ☐ No ☐

e) **Which of these services do you access in hospitals?**

- Counselling ☐
- Health Education ☐
- Exclusive Breastfeeding ☐
- Thermal Care Practices ☐
- Dispensing ☐
- Assessment ☐
- Case-Management ☐
- Referral ☐

f) **How often do you access these services?** Frequently ☐ Rarely ☐

- Counselling ☐ ☐
- Health Education ☐ ☐
- Exclusive Breastfeeding ☐ ☐
- Thermal Care Practices ☐ ☐
- Dispensing ☐ ☐
- Assessment ☐ ☐
- Case-Management ☐ ☐
- Referral ☐ ☐

3. <u>The effects of religious affiliation on universal health coverage in Masinga Sub County</u>

a) **Which religious affiliation do you subscribe to?** Protestant ☐ Catholic ☐ Islam ☐ Traditional ☐ Any other ☐

i. What are your religious views about?

Lab Tests
……
……
……..
Hospital Treatment
……
……
……..
Health Care
……
……
……

ii. According to you, what causes illnesses?

……
……
…….

iii. What are the effects of illnesses in the family community?

……
……
……

iv. As a religious group how do you help a sick member or his/her family?

……
……
…….

v. Which hospitals do you go to in Masinga sub county when you are sick?

……
……
……..

vi. What services do you get from these hospitals?

……
……
……..

vii. If you don't go to hospital when you are sick what do you do?

……
……...

b) Do your religious views discourage you from seeking Healthcare? Yes ☐ No ☐

c) If yes, state how ……..
……
……
…….
d) Do you think religion can be used to mobilize people to seek healthcare? Yes No ☐
☐
e) If yes, state how……
……
……
……..

4. Effects of traditional beliefs on Universal Health Coverage (UHC) access in Masinga Sub County

a) Kindly tell me according to your traditional beliefs what causes sickness

- Witchcraft
- Evil spirits
- Bad omens
- Bad weather
- All the above

i) What is your understanding on the following?

1) Hospital lab testes
   ……
   ……
   ……....
2) Hospital treatment
   ……
   ……
   ……....
3) Hospital care services

……
……
……....

ii) According to you how would illness affect your family, community etc.?

……
……
……

iii) As a traditional group how do you help the sick members in your family, community, etc?.

……
……
……
……

iv) Do you go to the hospitals? If yes name the hospitals. If no move to the next question…….

v) If yes what services do you receive from the hospitals

……
……
……
……

vi) If no what do you when you are sick?

……
……
……
……..…..

b) Kindly tell me do your traditional beliefs discourage you from going to the hospital when unwell? Yes ☐ No ☐

c) If yes explain how

……
……
……..……
……

d) Do you think your traditional beliefs can hinder people from seeking health services when sick? Yes ☐ ☐

If yes explain your answer

……...……
……..……
……
……..

e) Kindly tell me are there herbalist/ traditional healers etc. in your community? Yes ☐ No ☐

If yes state their role

……
……
……
……

f) In your own words how would you encourage people to seek health services from the hospitals?

……
……
……
……

5. <u>The effects of geographical access on universal health care in Masinga sub county</u>

i. What means do you use to get into the hospital? …….
……..
ii. How far is your distance to the hospital? Near Far ☐ Very Far ☐
iii. How far are you from the nearest health centre? Below 1 Km ☐ Between 2-5 Km ☐ More than 5 Km ☐
iv. How is distance a challenge when it comes to accessing healthcare?
……
……
……
……
v. How do you solve the challenge of distance to access health centres?
……
……
……
vi. In your view what should be done to ensure that distance does not affect your need for medical services? ……..
……
……
……

THANK YOU

KEY INFORMANT INTERVIEW SCHEDULE

1. How have you been creating awareness about UHC in your location?
2. How does the hospitals in the Masinga sub county offer Universal Health coverage?
3. How does distance affect your uptake of UHC?
4. What services does the scheme entitle you to at the facility?
5. How does your religion influence your decision to seek healthcare?
6. Where do you at times seek traditional remedies when sick?
7. How can traditional beliefs hinder you from seeking universal health coverage?
8. How does distance to the medical facility affect your access to Universal Healthcare?
9. What do you think should be done to ensure that all people have access to universal healthcare?