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

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Mululu, I. M., [1*] Vundi, N. B., [2] & Odek, A.[3]

[1*] Master Student, St. Paul's University, [SPU], Limuru, Kenya

[2,3] Ph.D, Lecturer, St. Paul's University, [SPU], Limuru, Kenya

ABSTRACT

The study sought to investigate social and cultural determinants that affect the uptake of Universal Health Coverage (UHC) in Masinga sub-county, Machakos County. Universal Health care is a huge milestone in the attainment of not only the Millennium Development Goals (MDG) but also the Sustainable Development Goals (SGDs). 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 objective of the study was aimed at examining 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. The pilot study was done in Ndalani location, Yatta sub-county to test the validity and credibility of the study instruments before the actual research. 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. Quantitatively, the responses were fed into the SPSS program and analysed; they were presented using percentages, graphs and charts. The study established that the geographical access play an important role in either enhancing or inhibiting the utilization of UHC. It recommended that the government step up sensitization programs to get as many people as possible to utilize the program. It was expected that the study would benefit not only the policy makers, but the county government and the NGOs operating in the area as well.

Key words: Universal Health Coverage, Determinants, Distance, Utilization, Access

INTRODUCTION

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 assist 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' learning 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).

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 et al, 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 HC 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.

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. According to Obadha et al, (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. 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.

METHODOLOGY

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. The target population was 350 respondents which included; 50 respondents from each of the seven locations in Masinga sub-county. The sample size in this research constituted the households in Masinga Sub County. According to the KNBS (2019), the sub county had 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. 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 focused on households in locations within Masinga sub-county, Machakos county. The sample size was 350 households for seven locations with each location having 50 households.

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. 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.

Desk search techniques were used to collect secondary data from already existing sources and previous research studies (Mugenda, 2003). This was done through reading relevant literature available in the library, various documents publications and reports including journals, and magazines were read all alike during the study. 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.

Primary data was obtained using a developed questionnaire with both closed and open-ended questions which 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. 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. A pilot test included 10 respondents and 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.

FINDINGS

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 were presented in Figure 1 below:
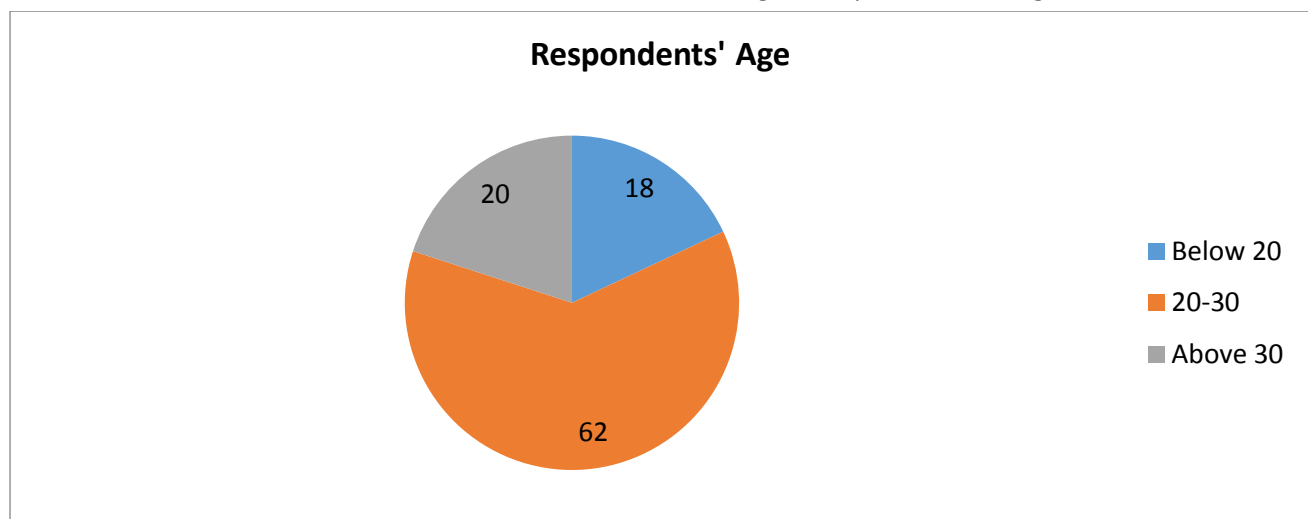

Respondents' Age

- 18 — Below 20
- 62 — 20-30
- 20 — Above 30

Figure 1: 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.

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 were presented in the figure 2 below:
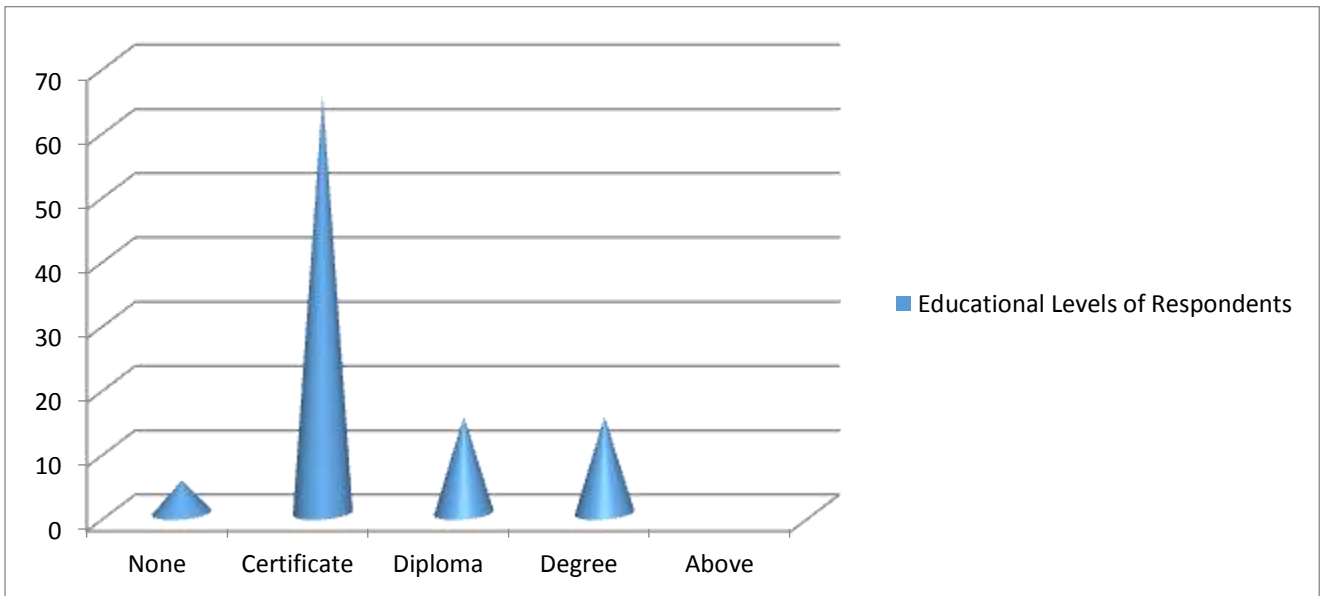

Figure 2: Education Levels

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.

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 were presented in figure 3 below:
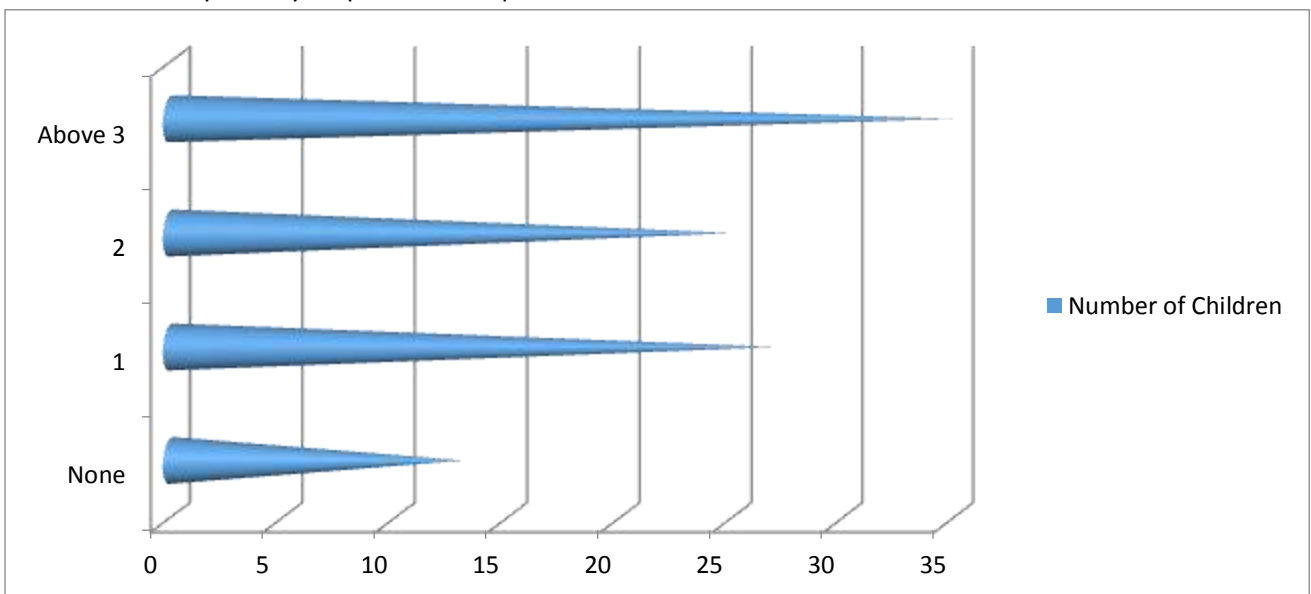

Figure 3: Number of Children

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.

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.

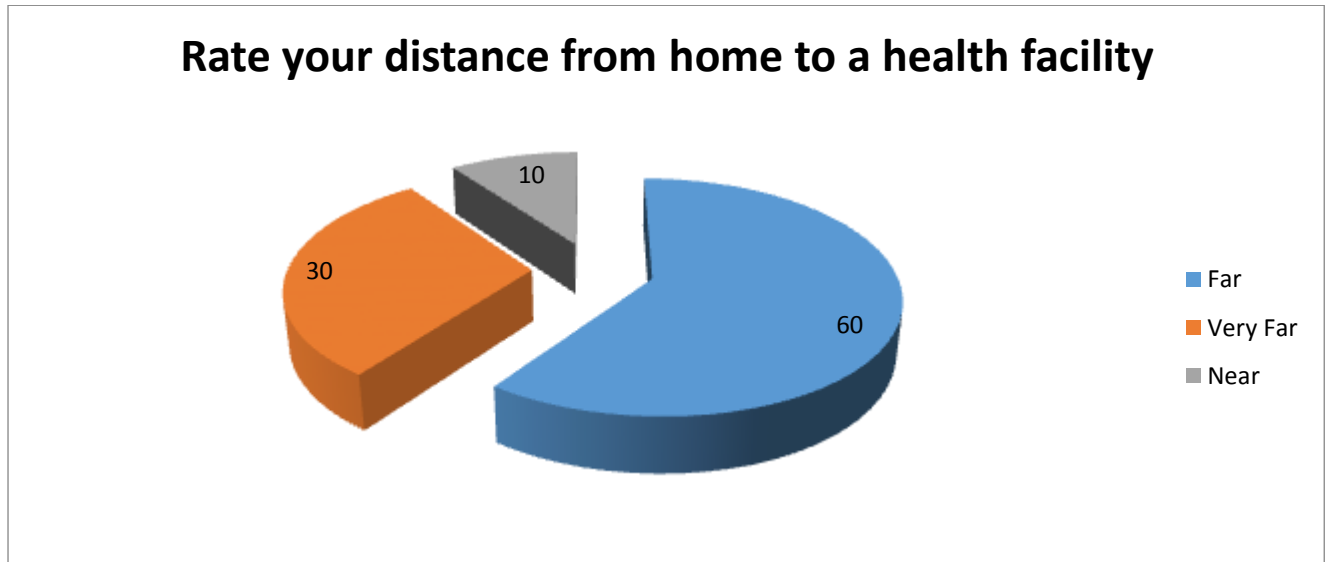## Rate your distance from home to a health facility

Figure 4: Distance to Health Facility from Correspondent's Home

From the responses above, it was apparent that distance is a constraining factor towards the access of healthcare; this was seen in the 60% of the responses that indicated that it was far and another 30% stated that it was 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 was a challenge in accessing healthcare services; they stated that it was expensive to travel to health facilities that were far and they may not have had the requisite funds to do that. This discouraged them and as such only visited these facilities when their conditions got worse. They stated that to solve this challenge, they were 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 thought 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 were 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 was less clear as women had 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 behaviors 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.

CONCLUSION AND RECOMMENDATION

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 could benefit from it.

Construction of more health facilities and improved infrastructure within the sub-county to facilitate enrolment and easy accessibility to UHC services within Masinga sub-county. Administration should be involved in door to door campaign to sensitize and mobilise the community for enrollment and accessibility to UHC services. This can be done with the collaboration with the government under the office of assistant sub-chief and chiefs.

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