

Households' utilization of Public Primary Healthcare Facilities in Nakuru Town, Kenya

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Abstract:

Background: Urban areas globally are known to offer many opportunities to urban dwellers. However, they also concentrate health risks and hazards. Primary Healthcare (PHC) is an approach used to offer the first contact healthcare services. Studies have revealed low utilization of PHC services in urban Kenya. This has led to high burden of preventable diseases. This paper set out to assess the households' utilization of PHC facilities in Nakuru town.

Materials and Methods: The study adopted mixed method research that involved quantitative and qualitative approaches. These included: a descriptive cross-sectional household survey and a health facility evaluation survey. A sample of 400 households was selected from the eleven wards in Nakuru town. Data was collected through household sample survey by use of questionnaire, healthcare facility questionnaire, interviews with key informants, interviews with patients seeking healthcare and observation.

Results: The results indicate that the level of utilization of public primary health care facilities is highest at health centres and lowest to medicine men and women. In regard to the socio-economic characteristics of the respondents, there was relationship between monthly income and level of education of households and the type of health facilities visited by households ($p=0.000$) while there was no relationship between age and gender with the type of health facility visited by the households ($p=0.478$ and $p = 0.372$).

Conclusion and Recommendation: The study finding implies that the level of utilization of public primary health care facilities is high among the population in Nakuru town. Thus this paper recommends that there is need to improve utilization of public primary health care facilities among the households of Nakuru town. This should be done through increasing the number of health personnel, establishing more public primary health care facilities, and increasing the supply of drugs.

Key Word: Households; Utilization; Public Primary Health Care; Health Care facilities.

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I. INTRODUCTION

Urban areas globally are known to offer many opportunities to urban dwellers including better employment, education, potential access to better healthcare and culture. They also concentrate health risks and hazards³³. The primary health care package guarantees universal access to all healthcare services, maternal and child health care services inclusive⁸.

There are health disparities within the urban populations within most parts of the world²⁹. Within the sub-Saharan Africa many urban dwellers live in overcrowded slums with poor sanitation and unhealthy housing³⁴. Poorly planned or unplanned urban infrastructure along with the social and lifestyle factors are drivers in the epidemic of non-communicable diseases which are linked to risks and hazards such as air pollution, poor diets and physical inactivity, traffic injuries and domestic injuries³³. This is mostly attributed to the increasing urban middle class who are eating unhealthier fast food and exercising less³⁰. The diseases that cause deaths in urban Kenya are malaria, pneumonia, HIV/AIDS, diarrheal and vomiting, road traffic accidents, bleeding in pregnancy and delivery and malnutrition¹².

The rapid urban growth sustained by Kenya in the last decades has created many difficulties that also have led to worsening inequalities in health care³³. Dramatic inequalities dominate Kenyan health today, where the conditions in which people grow, live, work and age have a powerful influence on their health¹². Some 5 million-city dwellers in Kenya lack access to primary healthcare facilities³².

Nakuru town is faced with high population growth of 7% against the country's growth of 2.9%⁹, high poverty level accompanied by poor nutrition and other related health risks and problems such as inadequate sanitation, and unsafe drinking water and high rate of environmental pollution¹. These conditions have encouraged high prevalence cases of both infant and adult diseases such as measles, diarrhoea, tuberculosis,

cardio-vascular diseases and other respiratory infections¹³. There is also growing number of child mortality age (0-4 years) and high maternal mortality.

II. MATERIAL AND METHODS

Study Area: This study was carried out in Nakuru Town, Kenya. The town is located in Nakuru County and lies 0° 15' South of the Equator and between longitudes 36° 04' East of Prime Meridian. It is the capital of Nakuru County¹⁶. Nakuru town is divided into eleven wards including Rhoda, Kaptembwo, Barut, Kapkures, Biashara, Flamingo, Nakuru East, Shabaab, London, Menengai and Kivumbini. Nakuru town had a population of 500,000 people and 30,636 households¹⁶. From Nakuru County health department's health records, the top 10 diseases in Nakuru town included: upper respiratory tract infection, other diseases of the respiratory system, diarrhoea, diseases of the skin, tonsolitis, ear infections, suspected malaria, eye infections and confirmed malaria. Nakuru Town has different categories of health institutions including a referral hospital, five private hospitals, six health centres, two private nursing homes and over 110 private health clinics Nakuru County 2019 health records.

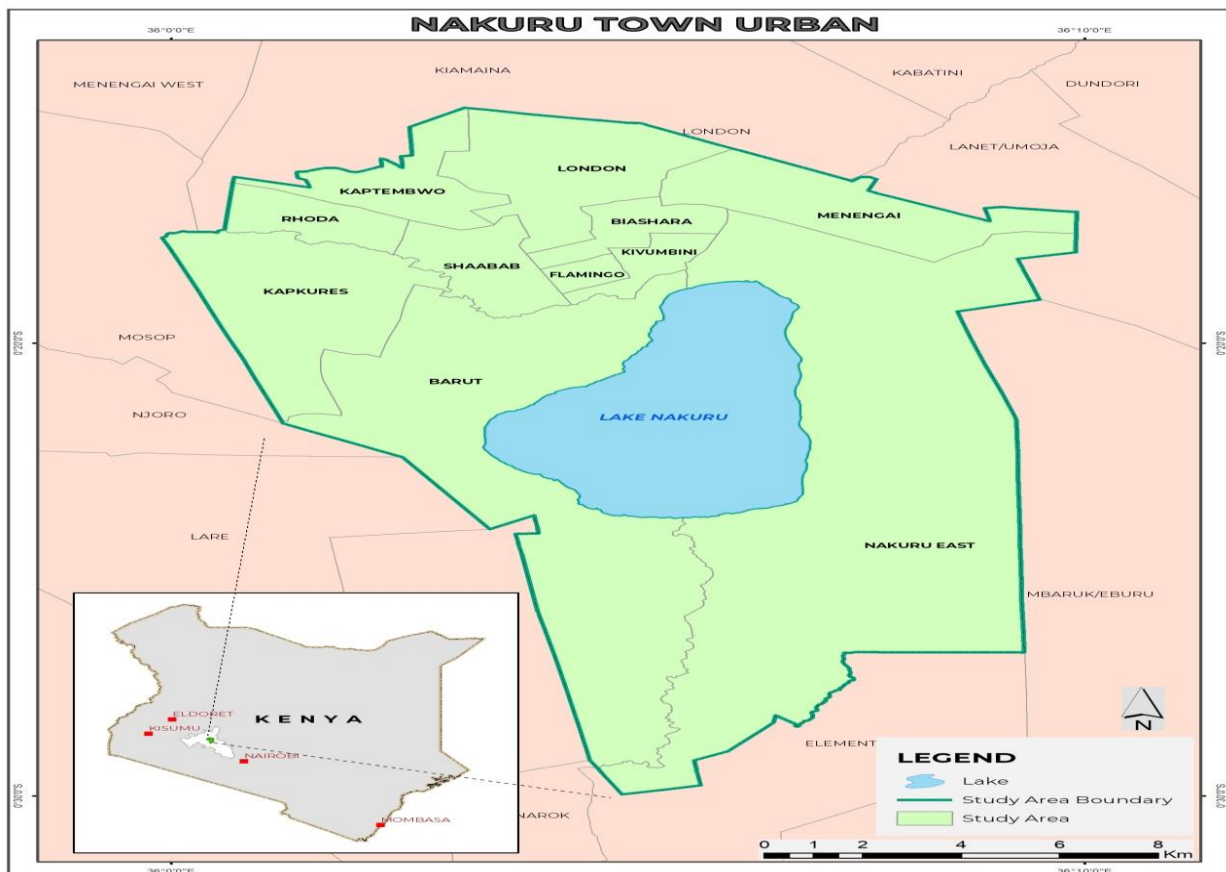


Figure 1: Map of Nakuru Urban Wards

Scale 1:50,000, using ILRI boundary shape files: GIS Archaism 10.2.

Study Design: The study adopted a mixed research design that involved quantitative and qualitative approach. It consisted of a cross-sectional descriptive household survey design and healthcare facility survey.

Study Population: The household sampling frame comprised all households (30,636) in Nakuru town which were within Rhoda, Kaptembwo, Barut, Kapkures, Biashara, Flamingo, Nakuru East, Shaabab and Kivumbini wards.

Sample size: 400 households

Sample size calculation: The sample size was obtained using the following formula (Yamane, 1967:886). A 95% confidence level and $p= 0.05$ are assumed for equation.

$$n = \frac{N}{N(e)^2}$$

Where n is the sample size, N (30,636 households) is the population size, and e ($\pm 5\%$) is the level of precision. These precision levels are predefined based on the levels of confidence used.

When this formula is applied to the above sample, we get:

$$n = \frac{N}{N(e)^2} = n = \frac{30636}{30636(0.07)^2} = 400 \text{ households}$$

Data Collection Tools

The study used different instruments to collect data for different study population. For the household survey, the household questionnaire was administered to 400 household heads. The questionnaire sought information on access and utilization of healthcare services, factors influencing household's access and utilization of healthcare facilities and perceived quality of healthcare services. The open ended questions were useful in eliciting the respondents' opinion concerning the study problem while the closed-ended questions prompted the respondents to choose from a limited number of responses predetermined by the researcher.

Validity and Reliability of the Tools

The validity of the items used was ascertained by the supervisors' advice from Egerton University and the pilot survey was expedited before the actual study. To test reliability of this research, the instrument was tested among 20 respondents from Naivasha and Gilgil towns in Nakuru County.

Statistical analysis

Data was analysed by use of both Descriptive and Inferential Statistics using SPSS version 20.0 software. Description of the study variables (tables, bar graphs), were used to analyse access and utilization of PHC facilities. The relationship between the distribution of PHC facilities and the population in Nakuru town wastested using chi-square. These tests were used to identify the significance of the relation, associations and interactions of factors, perception.

III. RESULTS AND DISCUSSION

Available Health Care Facilities Utilized by the Respondents in Nakuru Town

The results presented reveal that all respondents reported that they sought medical attention when they were sick. 52.5% of the respondents (n=400) visited a health centre to seek health care services (figure 1). 28.5% of the respondents who visited public health centre were from female - headed households while the rest were from male - headed households. Most people prefer health centres because either they are near their homes or diseases are handled better there compared to dispensaries. On the other hand, 0.5% of the responded (all of them were males) preferred seeking the services of traditional medicine man/woman. Despite the advancement in conventional medicine, traditional medicine is still in use as some people prefer (0.5% of the respondents) it more than medication from health care facilities.

The study finding on health care facilities utilized make some sense that few people within Nakuru town utilize traditional medicine men/women. This is because most of the people within the town have formal education (94.7%) to be aware of the benefits of the utilizing health facilities. The findings may imply that public healthcare facilities in Nakuru town offer cheaper health care services hence they attract more residents to visit public healthcare facilities of their own choice. A study done in Busia, Samburu and Malindi districts indicated that most of the respondents (30%) attended public health centres more than other health care facilities²⁴. The same study also showed that the least number of respondents sought the intervention of traditional medicine men/women whenever they fell sick. They noted that the preference on herbal medicine is because it is effective and has fewer side effects compared to the conventional medicine. In China, the preference for public health care to other health care facilities among the urban residents of Hokou in the 1980s was found to be as a result of the negative willingness-to-pay for private health care as well as the people's previous interactions with the health care system²⁷. Studies by Prosser and Tang and Zhang are in agreement with research finding on preference on public primary health care facilities to private facilities^{24,27}. A study on knowledge and practices on modern health care expansion in Ethiopia shows that there is inadequate information on utilization of modern primary healthcare facilities³¹. Thus, the findings from the study show that up to 80% of Ethiopians still use traditional medicine for primary health care. In addition, a study in Cambodia found that traditional herbal medicine is used as a complementary alternative medicine among patients with chronic diseases²². The study findings by Wassie, Aragie, Taye and Mekonnen and Pearson, Fleming, Chhoun, Tuot, Brody and Yi are contrary to the research finding in Nakuru town as most of the residents utilize public primary health care facilities^{22,31}.

Figure 2 shows the distribution of the respondents according to the health care facilities they access and utilize in Nakuru Town.

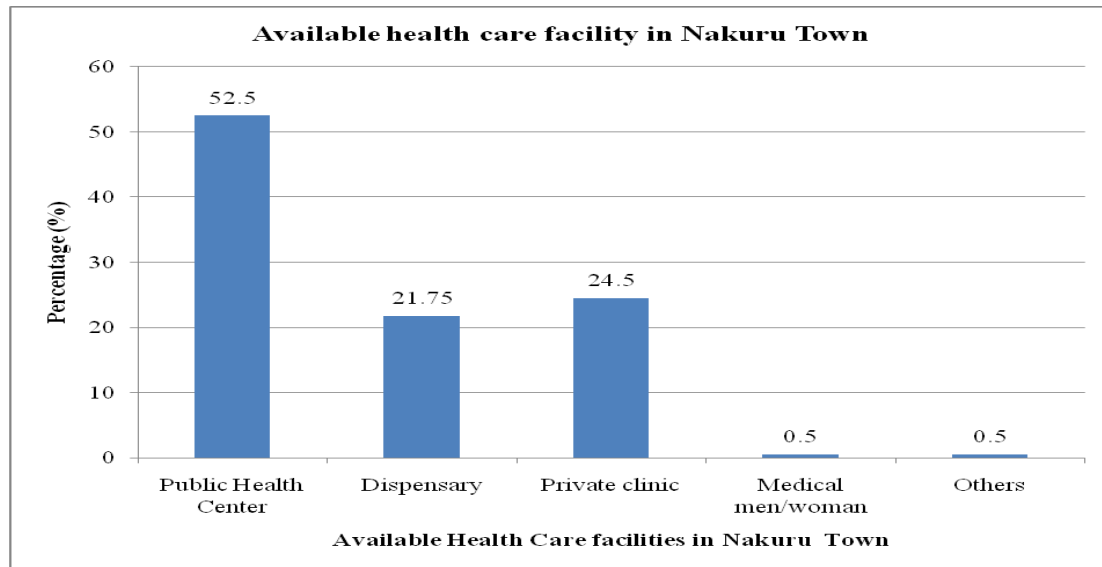


Figure 2: Available health care facilities utilized by the respondents in Nakuru town

Percentage Distribution of Respondents by Type of Health care Facility Visited by Background Characteristics

Evidence from Table 1 shows that health centres are visited by majority of the respondents of both genders, those of ages 18 years to 53 years, majority of those with no education to those with the highest level of education (university) and those with income ranging from below Kshs. 10000 to Kshs. 50000. Majority of the aged (54 years and above) and those with income of more than Kshs. 100000 prefer private clinics and dispensaries. Medicine men and women are the least visited by the respondents of both genders, of all the education levels and of different income categories. The findings are in tandem with study in Brazil that found out that family characteristic (gender, age, and income) influences access and utilization of PHC facilities²⁸.

As earlier found and discussed (table 1), age plays an important role in the access and utilization of primary health care facilities. It is perceived that as one advances in age, they are likely to have more health issues related to old age. Table 1 shows age as a factor that influences access and utilization of different health care facilities in Nakuru town. 25.25% of the respondents who were between 27-35 years old their household members sought health services from health centres. 0.25% of respondents aged 18-26 years old and 0.25% of those aged 54 years and above their household members sought services from traditional medicine man or woman. This shows that most household heads are to terms in the use of conventional medicine. Further, it was found out that, there was no relationship between age of the household heads and the type of health facility visited by their household members ($p=0.478$ which is greater than 0.05). This finding contradicts study done in Brazil which found out that age positively influences utilization health care facilities because old age is usually associated with greater confidence and experience and when combined with greater responsibilities within the household, it is not surprising that older people will seek health care more than the young one²⁸.

Utilization of health centres, dispensaries and private clinics increased as the respondents' age increased from 18 years to 35 years. The finding concurred with National Center for Health Statistics that increased functional limitations and consequent health-care utilization occurs in people as they age more so the working-age people and the older adults¹⁷.

An examination of table 2 reveals that household heads who earn an average of KShs 20,000 and below their members preferred to visit a health centre while those who earned more than KShs 20,000 their members visited private clinics. This is because as people earn more they tend to visit private clinics as they are perceived to offer better health care services than public health care centres and dispensaries. In addition, most of the respondents who earn less than Kshs. 10000 their members visit public health centres and dispensaries compared to the respondents with income of more than Kshs. 100000. On the other hand, most of the respondents who earn more than kshs. 100000 their members visited private clinics than those who earn less than Kshs. 10000. Past research have revealed that income increases the likelihood of health services used³³. For example, average monthly income also played a role in the type of health facility that one is likely to visit when sick. Income is one of the limiting factors for seeking health care services as it is related to the cost of treatment²⁰ and physically accessing treatment³. This study found out that there is a relationship between monthly income of individuals and the type of health facilities visited ($p=0.000$). This study concurs with study done in Kenya by Nyamongo and National Center for Health Statistics research findings on income trends verses health care facilities utilization^{20,17}. A study by Nyamongo found out that since 41.3% of respondents in the rural Kenya get

their income from personal business, thus influencing their ability to utilize health care facilities²⁰. National Center for Health Statistics found out that income trends of among the low income households are similar to the utilization of public primary health care facilities¹⁷. They also have greater rates of not receiving or of delayed medical care and obtaining prescription drugs because of the costs.

Income also determined the number of times one visited a healthy care facility. Generally, those who earned between Kshs. 10,000 and Kshs. 20,000 their members visited healthcare centres more often than other group of monthly income. Respondents with less than Kshs. 10,000 monthly income their members visited health care facilities more than five times compared to other groups. This study concurs with Muhofah, Atuhaire and Kaberuka that those with lower income and low socio-economic status form the bulk of people utilizing public primary health care services in solving their health problems¹⁴. The findings were in agreement with the said that very few individuals earning above Kshs. 100,000 sought treatment from public primary health care facilities including dispensaries.

Gender in this study has been categorised as males and females. More households headed by females (28.5%) indicated to have sought health care services from public primary health care facilities while more males headed households (12.75%) compared to females headed households went to private clinics (Table 1). There were more male respondents who visited private clinics and traditional medicine men or women than female respondents in Nakuru Town. This study concurred with Salganicoff *et. al.* that women overall have higher health centres and dispensaries utilization than men²⁶. This might be because of financial constrains as more males are financially empowered than the females. Gender has been reported to affect access and utilization of health care services in a study done in India²³. Even though gender has been cited to be a determining factor in utilization of primary health care services in various studies, in this study, there was no relationship between gender of households heads and the type of health facility their members visited ($p=0.372$). This study is in agreement with finding by Mbagaya *et. al.* that women in higher socio-economic group tend to exhibit patterns of more frequent use of maternal health services than women in the lower socio-economic group¹⁰. The study is also concurs with Ensor and Copper findings that utilization of health facilities is determined by gender and age⁵. Therefore, for this study, gender did not play a role as a limiting factor to accessing and utilising primary health care services. However, in a study done in Tshwane region, South Africa showed that most women had difficulties in utilizing primary health care facilities because of family responsibilities, distance to health care facilities and financial constraints¹⁹.

Table 1 shows the relationship between the respondents' education and the type of healthcare facilities visited in Nakuru town. In this study, at least 56% of the respondents had attained secondary level of education. Those with secondary level of education (24.25%) their members sought healthcare services from health care centres (table 1). Those who had attained tertiary and university levels their members tend to seek health care services from private clinics. Respondents with no formal education their households sought medication from traditional medicine man/woman more compared to others. Education background is an important factor that influences the use of formal healthcare services. For example, the level of education of an individual influences a person's decision-making in all spheres of life including utilization of health care services. Further, education allows an individual to be effective in converting healthcare and other health enhancing goods into health. The findings of this study reveals that there is significant relationship between households with various level of education and the type of health care facilities they utilized when ill ($\chi^2=60.854$, $p=0.000$). The study finding concurs with the research finding that education level in Nakuru town is high⁹. Thus, the residents of Nakuru town are well informed on health issues including the type of public primary health care facilities they visit. The study on the other hand agrees with the findings of Ensor and Copper that better education among both men and women may raise understanding and appreciation of the benefits of the primary public health care and hence demand for it⁵.

Further, table 1 most of the respondents 99.75% their members had visited a health care facility at least once in the past six months. This was regardless of their level of education. 66.7% of the respondents with secondary level of education their members had visited a health centre more than five times. In addition, 55.6% of the respondents with primary level of education their members had visited private clinics more than five times. A study done in Zambia indicated that women with low level of education were more likely to delay seeking medical attention. A person's level of education was one of the determinants in accessing and utilization of health care services. Thus from the study finding (table 1), it can be shows that education does not influence the number of times the residence of Nakuru town visited public primary health care facilities^{2,4,7}. This implies that the residence of Nakuru town access and utilize public primary health care facilities regardless of their level of education.

Table 1: Percentage Distribution of Respondents by Type of Health care Facility Visited by Background Characteristics

Characteristic		Type of facility visited					Total
		Health Centre	Dispensary	Private Clinic	Traditional practitioners	None	
Gender	Male	24%	10%	12.75%	0.5%	0.25%	47.50%
	Female	28.5%	11.75%	11.5%	0.5%	0.25%	52.50%
	Total	52.50%	21.75%	24.25%	1.00%	0.50%	100.00%
Age	18-26	11.75%	5.75%	5.25%	0.25%	0.0%	23.00%
	27-35	25.25%	8.0%	9.75%	0.0%	0.5%	43.50%
	36-44	9.0%	3.75%	5.0%	0.0%	0.0%	17.75%
	45-53	6.0%	3.25%	3.25%	0.25%	0.0%	12.75%
	>54	0.5%	1.0%	1.0%	0.5%	0.0%	3.00%
	Total	52.50%	21.75%	24.25%	1.00%	0.50%	100.00%
Income	<10,000	16.5%	7.0%	0.5%	0.25%	0.25%	24.50%
	10,001-20,000	21.75%	8.75%	7.0%	0.25%	0.25%	38.00%
	20,001-30,000	7.0%	0.75%	8.0%	0.25%	0.25%	16.25%
	30,001-40,000	4.0%	3.0%	3.25%	0.0%	0.0%	10.25%
	40,001-50,000	2.0%	1.0%	1.25%	0.0%	0.0%	4.25%
	50,000-100,000	0.75%	0.25%	2.25%	0.0%	0.0%	3.25%
	>100,000	0.5%	0.75%	2.0%	0.25%	0.0%	3.50%
Total	52.50%	21.50%	24.25%	1.00%	0.75%	100.00%	
Education	No forml Eductn	2.75%	0.75%	0.75%	0.25%	0.5%	5.00%
	Primary	5.25%	3.25%	2.0%	0.25%	0.25%	11.00%
	Secondary	24.25%	10.0%	5.5%	0.25%	0.25%	40.25%
	Tertiary	12.5%	4.5%	8.0%	0.25%	0.0%	25.25%
	University	7.75%	3.0%	7.75%	0.0%	0.0%	18.50%
	Total	52.50%	21.50%	24.00%	1.00%	1.00%	100.00%
Occupation	Business	23.5%	9.25%	8.25%	0.0%	0.0%	41.00%
	Jua Kali	10.75%	6.75%	4.5%	0.0%	0.5%	22.50%
	Farming	5.5%	3.25%	1.0%	0.5%	0.0%	10.25%
	Formal Employment	10.25%	2.5%	10.0%	0.0%	0.0%	22.75%
	Other	2.5%	0.0%	0.5%	0.5%	0.0%	3.50%
	Total	52.50%	21.75%	24.25%	1.00%	0.50%	100.00%
Household size	0-3	19.75%	13.75%	13.75%	0.0%	0.5%	36.75%
	4-7	18.0%	10.0%	12.5%	0.25%	0.5%	30.50%
	8-11	2.75%	6.25%	1.5%	0.0%	0.0%	5.00%
	11+	0.0%	0.0%	0.5%	0.0%	0.0%	0.50%
	Total	40.50%	30.00%	28.25%	0.25%	1.00%	100.00%
Religion	Protestants	18.25%	7.0%	9.5%	0.25%	0.5%	35.50%
	Catholics	24.0%	10.0%	7.0%	0.0%	0.0%	41.50%
	Muslims	6.5%	3.25%	4.5%	0.0%	0.0%	14.25%
	Others	3.75%	1.5%	2.75%	0.25%	0.0%	8.55%
	Total	52.50%	21.75%	23.75%	0.50%	0.50%	100.00%

Gender $\chi^2 = 5.377$, $p = 0.372$, Age $\chi^2 = 19.677$, $p = 0.478$, Monthly Income $\chi^2 = 155.048$, $p = 0.000$, Education $\chi^2 = 60.854$, $p = 0.000$

Frequency of Health Visits to Public Primary Health Care Facilities

Table 2 shows that most households headed by female respondents visited the preferred healthcare facility three times (19.25%) unlike most male-headed households who visited their preferred healthcare facilities twice (14.5%). This study is in agreement with study done on Kaiser Women's Health Survey which found out that most women visit health facilities than men to receive diagnostic services, screening services, diet and nutrition counselling and sexual health care²⁶. The number of visits by the female headed households of over 18 years of age and older women was found out to be as a result of reproductive health issues and cardiovascular diseases and osteoporosis cases respectively²¹. The number of visits of the male-headed households was attributed to the socio-economic factors including work related health risks, health insurance and income¹⁵. The finding on age implies that most female headed households are likely to be unwell as compared to the male counterparts in Nakuru town.

Household with the head of age between 27 – 35 years are the most who have visited their preferred healthcare facilities (15.0%). This was thrice in a year. In addition, they were leading in number of visits (1, 2, 3, 4 and more than five times) to their preferred health care facilities. Table 2 shows that there was an increasing number of visits by the respondents from once to twice in all households of all age groups. More women household heads of age between 18 years and 64 years have higher rates of disability and self-reported fair or poor health status thus visit their preferred health care facilities than their male counterparts¹⁷. A study found that there was an increasing trend in number of visits to the preferred health care facilities of the household heads of the ages over 45 years due to multiple chronic diseases affecting them⁶. The findings on age as a factor

that determine the number visits to the public primary health care facilities imply that most of those who utilize dispensaries and health centres are within the active age bracket hence prone to health issues.

The respondents with income between Kshs. 10,001 and Kshs. 20,000 were the most who's households visited their preferred health care facilities once, twice, thrice and four times while those who earn more than Kshs. 100,000 were the least who's households visited their preferred health care facilities. This implies that the low-income households in Nakuru Town are prone to health issues as compared to the high-income households. In addition, they prefer public primary health care facilities because most of the services are free. Thus, their rate of public primary healthcare utilization is high within the town.

The respondents with secondary education, their household visited health care facilities once, twice, thrice, four and more than five times more than all the respondents of other level of schooling while the respondents with no education, their households were the least to visit the health care facilities in Nakuru town. This implies that the household heads with informal education have inadequate information on the different health care facilities and services offered to take their household members unlike the respondents with high level of schooling.

Household heads who undertake businesses were the most who's households visited their preferred public health care facilities (health centers, dispensaries) once, twice, thrice and four times as compared to other respondents who are in the jua kali, farming and formal employment in Nakuru town. Occupation collate highly with health risk factors and health care facilities utilization¹⁷. People involved in industrial jobs with exposure to chemical, biological and physical risks tend to visit health care facilities more compared to those who are in other employments¹¹. National Center for Health Statistics reported that people in metropolitan areas are more likely to report having 10 or more visits to the health care facilities as a result of the high exposure to health risks¹⁷. The finding shows that business as an occupation in Nakuru town has occupational, health and safety risks as compared to farming, formal employment and jua kali.

Households with 0 – 3 members visited the preferred healthcare facilities more than households with more members in Nakuru town. In addition, they visited their preferred PHC facilities one to three times more than all other households. This study is in agreement with a study done in Rural and Urban Areas in Shiraz which found out that the utilization of healthcare facilities in both rural and urban areas of Shiraz was dependents on various factors including the low household size of 3.86¹⁸. This was attributed by the ability of the household heads to finance the costs of health consultations at the various health care facilities. The study finding on number of households shows that the smaller the household size, the more the ability to visit their preferred health care facilities within Nakuru town.

Protestants and catholic respondents were the most who visit their preferred healthcare facilities in Nakuru Town as compared to the respondents of other religions. This implies that Protestants and Catholics are the majority in Nakuru town.

Table 2: Percentage Distribution of the of the respondents by Visits to Public Primary Health Care Facilities

Characteristic	% Number of visits					Total	
	1	2	3	4	5+		
Age of Household Head	18-26	4.5	6.0	6.75	3.5	2.0	22.75
	27-35	8.5	10.5	15.0	5.25	3.5	42.75
	36-44	4.5	5.7	5.5	1.5	0.75	17.95
	45-53	3.55	5.25	3.0	1.25	0.25	13.3
	54+	0.25	1.0	0.5	0.25	0.25	2.25
	Total	22.30	28.45	30.75	11.75	6.75	100.00
Monthly Income	Less than 10,000	5.5	6.5	8.5	2.0	1.75	24.50
	10,001-20,000	9.5	9.5	13.0	4.0	1.5	38.00
	30,001-40,000	3.25	5.75	2.5	2.75	1.25	16.25
	40,001-50,000	1.5	4.5	3.0	0.75	0.5	10.25
	50,001-60,000	0.25	1.0	2.25	0.25	0.5	4.25
	60,001-100,000	0.5	0.25	0.75	1.0	0.75	3.25
	100,000+	0.25	0.5	0.75	1.0	0.5	3.50
Total	20.75	28.00	30.75	11.75	6.75	100.00	
Gender	Male	12.25	14.5	11.5	6.5	3.25	47.50
	Female	8.75	14.25	19.25	5.75	3.5	52.50
	Total	21.00	28.25	30.75	11.75	6.75	100.00
Level of Schooling	None	1.5	2.25	1.5	0.85	0.5	6.60
	Primary	1.75	1.75	4.5	1.0	1.75	10.75
	Secondary	9.25	12.35	11.0	4.5	2.75	39.85
	Tertiary	5.5	9.0	7.25	1.5	1.0	24.25
	University	3.75	3.75	6.25	3.85	0.95	18.55
Total	21.75	29.10	30.50	11.70	6.95	100.00	
Occupation	Business	8.25	11.0	9.25	3.5	10.75	42.75
	Jua Kali	4.75	3.0	3.75	3.0	4.75	19.25
	Farming	0.75	3.5	4.0	1.25	0.75	10.25
	Formal Employment	2.85	4.5	8.65	3.0	3.0	22.00

	Other	1.0	1.25	1.75	0.75	1.0	5.75
	Total	17.60	23.25	27.4	11.5	20.25	100.00
Household size	0-3	8.0	9.75	10.75	5.65	2.25	36.40
	4-7	5.5	6.5	8.5	3.75	2.0	26.25
	8-11	3.25	2.25	2.5	2.5	0.75	11.25
	11+	3.15	2.15	3.75	7.55	9.5	26.1
	Total	19.9	20.65	25.5	19.45	14.5	100.00
Religion	Protestants	10.0	9.25	9.0	4.25	2.0	34.5
	Catholics	8.0	11.5	15.0	4.25	2.25	41.00
	Muslims	1.0	4.25	4.75	2.0	2.25	14.25
	Others	2.0	4.75	2.0	1.25	0.25	10.25
	Total	21.00	29.75	30.75	11.75	6.75	100.00

IV. SUMMARY, CONCLUSION AND RECOMMENDATION

Summary of the Findings

The number of visits to the public PHC facilities was used to determine the household utilization. Most of the households in the study area utilized health centres for public primary health care services. According to the socio-economic background of the respondents, female headed households utilize health centres and dispensaries most at 28.5% and 11.75% respectively. Age group 27 – 35 years old households visited the most health centres (25.25%) and dispensaries (8%). Female-headed households visited their preferred healthcare facility at least once for the last six months. Households with heads of age 27 – 35 years are the most who have visited their preferred healthcare facilities (15.0%) thrice. However, there was no relationship between age and gender with the type of health facility visited by the households ($p=0.478$ and $p = 0.372$). Most households with low-income earning heads with monthly income of between Kshs. 10,001 – Kshs. 20,000 visited health centres (21.75%) and dispensaries (8.75%). In addition, monthly per capita of the most of the households a part from those with those with per capita income of kshs. 27,397, Kshs. 161,290, Kshs. 20,000 and Kshs. 80,000 fall below the poverty line. On education, it was found out that households with secondary level heads were the most who visited health centres (24.25%) and dispensaries (10.0%). Medicine men and women were the least visited by households of respondents with all gender, ages, education levels and income. Households with heads who undertake businesses were the most who visit their preferred public health care facilities once, twice, and thrice. On the other hand households with 0 – 3 members visited the preferred healthcare facilities more than households with more members. In addition, the findings of the study revealed that there was relationship between monthly income and level of education of households and the type of health facilities visited ($p=0.000$).

Conclusions

Since the number of visits is highest at health centres and lowest to medicine men and women in the study findings, it implies that the level of utilization of public primary health care facilities is high among the population in Nakuru town. In addition, it was found out that female-headed households accessed and utilized more primary healthcare facilities. Most households with heads having secondary and tertiary level of education utilize dispensaries and health centres compared to other calibres of education. This indicates that the more educated an individual is, the more informed he or she become aware of the importance of accessing and utilizing primary health care facility services.

Recommendations

There is need to improve utilization of public primary health care facilities among the households. This should be done through increasing the number of health personnel, establishing more public primary health care facilities, and increasing the supply of drugs.

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Abbreviations

HIV/AIDS: Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
KIPPRA: Kenya Institute for Public Policy Research and Analysis

KNBS:	Kenya National Bureau of Statistics
MoH:	Ministry of Health
MoMS :	Ministry of Medical Services
PHC:	Primary Health Care
UN:	United Nations
WHO:	World Health organization

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