healthcare facilities increases more you increase level of education as revealed by variation odds of the usage. Our results regarding relationship between education attainment and accessibility to healthcare services were consistent with other studies that examined the relationship with between education attainment and healthcare utilization and Self-Care Behavior by Individuals with Diabetes. Individuals with high educational attainment were more likely to have had an ophthalmologic examination, were more likely to report having a specialist or other paramedical professional than those with high educational attainment.(Alguwaihes & Shah, 2009). General the respondents' marital were highly reported of being married with 76.3% married couples and we noticed 72.9% of family size with 3 to 6 members in a family, this implies that people from urban settlement understand and comply with family plan and requested by government of Rwanda. As the study was conducted in Kicukiro district and as it one of Kigali city district, our respondents were more allocated in urban settlement of 95.1% this is seen as good social determinant of health, as this has been proved that the place of residence are all closely linked to people's access to, experiences of, and benefits from healthcare(Andersen et al., 2002). Concerning occupation 74% live with informal source of income while only 26% of respondent are formal-salaried workers. Research finding from occupation status of respondents has been proved statistically significant either from crude or adjusted analysis whereby for respondents with formal-Salaried workers the odds were 17.341 times (AOR=17.341 95%CI [9.509-31.641]) at $p<0.001$ to access easily healthcare facility than those with informal source of income. The results from this study has been consistent with others studies revealed that most of the informal workers suffer from certain challenges (such as unaffordable out-of-pocket payments, time spent traveling to the health facility and long waiting time before they are attended to by health service providers) in using the needed health services(Akazili et al., 2018). 76.8% of our respondents were categorized in Low middle income (C) of Wealth index [Ubudehe] even those this type of indicator of life was not prove significant associated with inequality in healthcare facilities accessibility from crude analysis but was proven strongly significant associated from adjusted analysis whereby the odds of accessing healthcare services increased by wealth indexing scale. And this implied that healthcare can be accrued from people high income than those from low income. Study on inequality in access to healthcare proved that several population groups have significant difficulties in accessing healthcare. The lowest income quintiles are among the most disadvantaged groups in terms of effective access to healthcare(Akazili et al.,

2018). The study had found that 53.1% of monthly family income ranged between 100,000 to 250,000Rwf followed by 26.6% ranged between 250,000 to 450,000Rwf. Even if our research findings, in crude analysis, did not find family income as predictor on healthcare facility inaccessibility but was found significantly associated from adjusted study analysis. This tells that, as per odds from adjusted analysis, more the family earn more it's easily access healthcare facilities. Meaning for services not covered by insurance policy are being paid under out pocket money. This evidence was observed similar as a qualitative study in São Paulo, Brazil proved that there is strong proof linking social inequality in terms of income, and ethnicity to health inequalities(Bloom & Mahal, 1997). A key Health objective of insurance policy is to achieve adequate access to healthcare by all people on the basis of need even from the start of our study we believed this to be predictor of resolution of healthcare facilities inequality but still in our research findings we observed different as the respondents who are using almost private insurances are those from formal-salaried workers and found more advantaged in access to healthcare facilities than those using Community health insurance(CHI). This was quite similar with study result conducted from underdeveloped in Chine, where healthcare utilization and cost were varying significantly by different insurance schemes(Xian et al., 2019).

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5.0 Conclusion

This cross-sectional study was aimed to evaluate the effect of socioeconomic inequality in access to healthcare facilities in Kicukiro district. Even though Rwanda has made exceptional progress to improve equal access to medical service to the majority of people include vulnerable ones, the existence significant healthcare service use inequality at sub-national level exists still. The findings from this study indicated that time waiting for medical service is remarkably high for the majority and again accessibility was accrued for some advantaged people due to health insurance scheme and family income. The rate of healthcare facilities time visit a year decreases due to socioeconomically characteristic for each individual.

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