SOCIAL CLASS AND ACCESS TO PUBLIC HEALHCARE IN KENYA: A CASE STUDY OF NAIROBI CITY COUNTY

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

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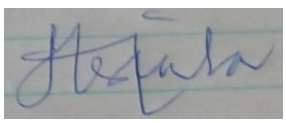
Signature  **Date 18/11/2021**

DEDICATION

This work is dedicated to my parents, Luka Kitio Mukuta and Beatrice Mukuta, for having been my inspirations. I extent my thanks to all my children for constantly inspiring hope, and my wife Mary C. Chelogoi for being a firm and reliable anchor.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
APHRC	-	African Population and Health Research Centre
ASAL	-	Arid and Semi-Arid Land
CA	-	Capability Approach
CBOs	-	Community Based Organizations
CHI	-	Commission for Health Improvement
DV	-	Dependent Variable
FBOs	-	Faith Based Organizations
GDP	-	Gross Domestic Product
GNP	-	Gross National Product
GOK	-	Government of Kenya
HISP	-	Health Insurance Subsidy Programme
HIV	-	Human Immune Virus
HRIO	-	Health Records and Information Officer
HSSPIP	-	Health Sector Strategic Plan and Investment Plan

IV	-	Independent Variable
IPRSP	-	Interim Poverty Reduction Strategic Paper
KHHEUS	-	Kenya Household Health Expenditure Utilization Service
KHSA	-	Kenya Health System Assessment
KII	-	Key Informant Interviews
KNASCOP	-	Kenya National Aids Country Programme
KNH	-	Kenyatta National Hospital
KNHA	-	Kenya National Health Accounts
KRA	-	Kenya Revenue Authority
LMICs	-	Low Middle Income Countries
MD	-	Medical Doctors
MTEF	-	Medium Term Expenditure Framework
MDGs	-	Millennium Development Goals
MFL	-	Master Facility List
MMR	-	Maternal Mortality Rates
MOH.	-	Ministry of Health

MTRH	-	Moi Teaching and Referral Hospital
NCSS	-	National Cross- sectional Slum Survey
NPRP	-	National Poverty Reduction Policy
NHIF	-	National Health Insurance Fund
NHS	-	National Health Sector
NHSSPII	-	National Health Sector Strategic Plan II.
NICE	-	National Institute for Clinical Excellence
NGOs	-	Non- Governmental Organizations
NRTH	-	National, Referral and Teaching Hospitals
OOP-	-	Out of Pocket
OP & PWSD	-	Older Persons and Persons with Severe Disabilities
PHC	-	Primary Health Care
PPPs	-	Public Private Partnerships
SES	-	Social Economic Status
SDG	-	Sustainable Development Goals
SPSS	-	Statistical Package for the Social Sciences

THE	-	Total Health Expenditure
UHC	-	Universal Health Coverage
UK	-	United Kingdom
UNDP	-	United Nations Development Programme
USAID	-	United States of Agency for International Development
WB	-	World Bank

ABSTRACT

Access to public healthcare is necessary because it improves the general well-being and productivity of a people, and is good for sustainable development. However, despite the fact that access to public healthcare is arguably cheaper compared to private facilities and allows for early diagnosis and management of physical, psychological, and societal illnesses, and is thus critical for people's overall health, its access has been worrying especially in Kenya. This study is an inquiry into the influence of social class on access to public healthcare in Kenya, a case study of Nairobi City County. To support this inquiry, intervening variables (demographic, socio-cultural and institutional) were used to investigate the relationships between social class and access to public healthcare. The study was based on households in were used to explain causal links between the two variables (independent variable-Social Class and Dependent variable-Access to Public Healthcare. The study employed descriptive and longitudinal research design. A multistage random sampling technique was employed to arrive at a sample size of 1066. The study employed both primary and secondary data sources. Semi-structured questionnaire and an interview guide were used to collect data. The study employed drop and pick later method for the questionnaire data collection while face-to-face interview was used to respond to interview guide questions. Cross tabulation analysis was done between each independent variable indicator and dependent variable, access to public healthcare. The results were presented in frequency distribution tables and correlation results for each item in the questionnaire. With regards to the qualitative data from the interview guide, content analysis was employed. The research findings confirmed robust positive correlations between independent and dependent variables. Using hypothetical variables (intervening variables), the study found that demographic variables (age, income, education, marriage, wealth, place of residence); socio-cultural variables (like inability to communicate in national languages, individual perception of public healthcare facilities, cultural practices, strict faith and attitude, social capital and poverty); and institutional variables (policies, limited health financing by the government, infrastructure, adequate and balanced distribution of health workers; few health facilities and poor distribution of health commodities and equipment; lack of basic amenities like water and sanitation; lack of citizen participation among others) explain the causal links between the independent and dependent variables. Hypothetical variables explain the causal links between the two variables(independent variable and dependent variable). The study concluded that an increase in the explanatory power of demographic variables like increased level of education and income of the citizens could help find durable solutions, hence, lead to more access to public healthcare services; Further, increased explanatory power of the intervening variables socio-cultural variables like social networks, capital, attitude and perception of health facilities could help provide solutions that could result to increased access of public healthcare. And furthermore, increases explanatory power of institutional variables (e.g. increase in financing, adequate and equitable distribution of health workers; availability of medical drugs and equipment; access to basic amenities (water and sanitation, increase in public participation could help explain the relationship between the two variables, and find solutions to can lead to increased access to public healthcare.At a policy level, the study therefore recommended that the government should use such knowledge to increase opportunities in demographic, socio-cultural and institutional factors in order for access to public healthcare to increase, especially among the poor households in the city county.At an academic level, more research should be conducted to establish why intervening variables do not explain adequately the causal relationship between the intervening variable and dependent variable. This constitutes a knowledge gap that is necessary to provide solutions in increasing access to public healthcare.

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Access to Public Health Care is arguably one of the most critical development agenda in the world. The importance of public health care has gained its prominence from several authorities in different forums. The Millennium Development Goals (MDG) include three health related items such as reduced child mortality, improved maternal health and fighting HIV/AIDS, malarial infections and other diseases (WHO, 2005). Improved health is also an important consideration in the most recent sustainable development goals adopted by the United Nations General Assembly (Dora et al., 2015). Furthermore, at a meeting in Abuja, African heads of state committed themselves to increase spending on healthcare despite constrained budgets. These developments have been driven by the economic and social benefits of improved health status.

Grossman (1972) developed a theory that showed that health stock is a special capital that produces healthy days which in turn are used in the production process. Aside from enhancing productivity, Grossman (1972) further showed that improved health status promotes well-being as it is a source of enjoyment and happiness of households and individuals. These theoretical benefits of improved health status have been supported by empirical evidence that shows the relationship between better public health status and enhanced productivity and well-being.

Tompa reviewed evidence from developed and developing countries over a period of more than 200 years and showed that improved physical and mental capacities among workers increased productivity levels. Other studies found similar results (Boles et al., 2004; Mitchell et al., 2013; Boman&Isiaka, 2015). Besides the link at micro level, analysis at macro level

showed that better public health status was positively associated with economic growth (Bloom & Canning, 2005; Mehmood et al., 2014; Oni, 2014). Another string of the evidence linked better health status to poverty reduction (Carrin&Poliyi. 1996; Peters et al., 2008).

Globally, all public health facilities cannot provide sufficient health care services that correspond to the challenges of the increasing demand and the huge expectation of the expanding population. Attaining public health care services for all people in the globe requires public health facilities and health management needs to respond to the demands of the ever dynamically changing world, the ever growing population and people's expectations for accessible and affordable health care service delivery (Halfdan& Carl, 1978).

In Kenya, with support of various stakeholders, the government has over the years since independence in 1963 initiated policy reforms and strategies earmarked towards increasing access to public healthcare. Some of these are outlined in various policy documents including Kenya Health Policy Framework (KHPF 1994–2010), Health Sector Strategic Plans, Vision 2030 operationalized through the medium term expenditure framework of 2008-2012, the Constitution 2010, and finally, the Health Bill of 2015. Notably, the government recognized ahigh quality of life as a key pillar towards accelerating Kenya's intentions of being a globally competitive and prosperous nation (GOK, 2008). Further the government provides a legal framework for ensuring a public health care delivery system that is driven by the people while bridging the gap on geographical access by providing for a devolved system of governance (G0K, 2010).

These initiatives can be argued are aimed at increasing access to public healthcare among the populace in the country. In the draft Health Bill of 2015, the government has declared access to reproductive health and emergency medical treatment as a right by all persons. Health care

Coverage further received the most recent boost from the government's most popularized Agenda Four whose aim is to ensure equitable universal health cover to all citizens.

Despite all the above stated initiatives to support access to public healthcare, access to public health care in Kenya is still a pipedream. The levels of hypothetical variables (e.g poverty, illiteracy, ignorance and unemployment rates and lack of insurance covers, few facilities, limited public health facilities, understaffed health facilities, untrained health workers among others) are not adequate to explain the causal links between the variables (I.V and D.V). They are therefore key impediments to continued inequality in access to public health care.

In Kenya, most of the citizens finance their health care from out of the pocket model which is highly inefficient. The health ministry is grossly underfunded and has not achieved previous goals which envisaged a 15% budgetary allocation to the health ministry based on the national budget. Health financing is therefore a week hypothetical variable that does not explain the causal link between the variables. This explains why Kenya has experienced little progress over the years in bridging the gap of the vulnerable and poor citizens in their access to public health manifested by poor indicators in health (Chuma and Okungu 2011).

The accessibility rate is about 40%, meaning that the remainder of 60% has no access to public health care. This leaves the larger population exposed to various diseases and to some extent to mortality rates. The situation is worsening with increase in population without an equally matching growth in resources to facilitate increased access to public healthcare. This has left most of the households exposed to ill health and to some extent death.

Several studies have focused on access to public healthcare but little has been achieved to increase accessibility to all the households in Nairobi City County (Obadha et al., 2019; Oraro-Lawrence et al., 2020; Kelly et al., 2020). The studies have not yielded desired resultsnor

provided solutions to the problems facing the sector. Such studies have not comprehensively explained why gaps exist between the rich and the poor occasioned by failure to increase the explanatory power of the hypothetical variables (intervening variables) demographic, socio-cultural and institutional factors to explain the causal relationship between the variables. Thus access to public healthcare remains unequal between the social classes in Nairobi City County. The academic discourses therefore have not resolved inequality in access to public health care between the rich and the poor manifested in such factors. This gap requires a further research.

The argument of this study is that hypothetical variables (intervening variables): demographic, socio-economic and institutional variables, have not fully explained the causal relationships between the key variables, hence, proper solutions have not been found to address inaccessibility in public healthcare. This has partly affected the capacity of policy makers to institute proper policies and actions to address challenges facing health sector.

These challenges call for immediate action by both the academia and the policy makers to take appropriate actions.

1.2 Research Problem

Access to public healthcare to all households in Nairobi City Countyis still a pipedream despite the various interventions by the government. Scholarly discourses have not provided solutions to ever increasing inequality in accessibility among the households in NairobiCity County.Studies on social class and access to public healthcare have not helped to reduce inequality in accessibility among the households in Nairobi City County. In addition, scholarly studies in intervening variables as detailed in the study questions and objectives (demographic, socio-cultural and institutional variables) have not yielded significant benefits in reducing inequality in access to public healthcare among the households in Nairobi City County. This explains why despite the scholarly studies, accessibility rate is just about 40% among the

households in Nairobi City County, meaning that the remainder of the 60% households has no access to public health care (KEMRI, 2019)! Thus, the demand for access to public health in Nairobi City County is way higher than the supply. This leaves the larger population of the households in Nairobi City County exposed to various diseases and to some extent to mortality rates.

This failure may partly explain why Nairobi City County has not achieved the objectives of its sector mission, namely: to provide quality healthcare services that is accessible, equitable and sustainable to the population of Nairobi City County. In addition, the Nairobi City County has not fully fulfilled any of its programs and health objectives including: to improve preventive and promotive health services; to improve curative care services; and to improve service delivery amongst others.

Consequently, failure to address such programs and objectives by the Nairobi City County has led to multiple problems that have direct negative impact on the households in the County. This has led to declining health standards that have now increased incidence and re-emergence of diseases; inadequate funding in health sector; high costs of healthcare; poor nutrition; inadequate laboratory services; inadequate health facilities; inadequate drugs, personnel and equipment; inadequate ambulances; dilapidated health services; unsecure health facilities; inadequate water supply; lack of public toilets among others. These have adversely affected access to public healthcare services among the households in Nairobi City County. These are research gaps that the study attempted to fill. The purpose of this study was to fill both policy and research gaps as shown in the study. Previous scholarly studies have not clearly demonstrated what roles intervening variables (demographic, socio-cultural and institutional variables) played in improving or modifying access to public healthcare in Nairobi County.

This study therefore attempts to fill these knowledge gaps occasioned by inadequate studies. Detailed analytical studies are imperative in this field in order to generate sufficient knowledge for policy makers and other stakeholders. In addition, policy maker need to access such knowledge in order to undertake strategic actions to address the problem. Research and Policy gaps are well spelled out. This study will attempt to fill these academic/knowledge and policy gaps.

1.3 Study Questions

In this study, social class is the independent variable; however,intervening variables (demographic, socio-cultural and institutional variables were used toinvstigate the relationship between social class and access to public healthcare) and were used to guide research questions.

The overall research question was: How does social class affect access to public healthcare in Nairobi City County? Selected intervening variables were used in the study to specifically answer the following questions?

1. Do demographic variables influence access to public health in Nairobi City County?
2. How do socio-cultural variables influence households' ability to gain access to public healthcare in Nairobi City County?
3. What effects do institutional variables have on households' access to public healthcare services in Nairobi City County?

1.4Study Objectives

The study's overall aim is to explore to what extent selected variables influence access to public healthcare in Nairobi City County. The overall objective was to determine the influence of social class on access to public healthcare in Nairobi City County.Specifically, to explore to

what extent selected variables influence access to public health healthcare in Nairobi City County. In this study, intervening variables used included: demographic, socio-cultural and institutional variables.

1. To investigate the influence of demographic variables in access to public healthcare in NairobiCityCounty.
2. To find out the influence of socio-cultural variables in access to public healthcare in Nairobi City County

3. To investigate the influence of institutional variables in access to public healthcare in Nairobi City County

1.5 Justification of the Study

This study attempted to investigate the influence of social class on access to public healthcare in Nairobi City County. In this investigation, the study usedintervening variables to explain the causal links between the independent and dependent variables. These explanatory variables were meant to answer the research questions in order to achieve the studyobjectives. Previous studies on causal relationships between the variables have been found to be inadequate and have not provided sufficient knowledge to providesolutions to the problem of inequality in access to public healthcare in Kenya, specifically in Nairobi City County. The academic discourses have not adequately explained the causal links between the variables, hence, found no solutions to why problems perpetuate inequalities in access to public health. Additional research is imperative to increase the explanatory power of the intervening variables between the variables. This would provide knowledge that would help find solutions to the problem. Additional Research Studies and Policy interventions are imperative. This study will also be of immense importance to other scholars who can deepen their studies on the subject. This study therefore will have the potential contribution in improving knowledge.

In addition, Policy makers have not put in measures to address this continued inaccessibility to public healthcare among the households in the Nairobi City County. Practical actions need to focus on factors that affect access to public healthcare.

At the moment, policy makers have not been able to address inaccessibility of public healthcare.

The additional knowledge sought in further research help research find solutions to problems affecting access to public healthcare.

At the same time, similar contribution will equip policy makers with new strategies to address inaccessibility to public healthcare.

1.6 Scope and Limitations

The study covered a period of about30 years, from 1990-1920. Access to public healthcare in Kenya between 1960-1992 was quite good. There were significant improvement in infant mortality, maternal and morbidity rates. Life expectancy increased. However, beyond the 1990s, health trends declined. Infant and mortality rates increased and life expectancy declined. This study therefore made an attempt to evaluate access to public healthcare between 1990s and 2020.

Nairobi City County fits the area of this study because it is a cosmopolitan place with residents originating from virtually different parts of the world. This is because of the local ethnic communities and also diplomatic communities since they are based in this county. Furthermore, the population in the City County consists of the high social class living in estates like Rhuda and Muthaiga as well as low end estates like Kibera and Mathare slums. Thus the study gains generalizability due to the heterogeneity of data.

Further, Nairobi City County is a center for the most learned elite from all types of professions. The most qualified health personnel work in Nairobi. All the big referral hospitals are also in Nairobi City County. Hence, this county has the most established hospitals in terms of trained personnel as well as physical infrastructure.

This study faced problems such as lack of co-operation and unwillingness to answer questions by respondents. However, the researcher explained to the interviewees that the information given would be treated with utmost confidentiality. The respondents were assured that the research was purely for academic purposes. This helped to mitigate the problem.

1.7 Definition and Operational Definitions of Key Variables

1. Social class - Independent variable

Social class refers to a group of people in a society who have same socio-economic status. The concept refers to a collection of individuals who share similar conditions. The concept has also been used to refer to a group of people who have similar levels of wealth, influence, and status. Sociologists have used three methods to determine social class: upper, middle and lower class. Gullup has used "five levels to define social class: upper, upper middle, middle, working and lower class". Gilbert (2006) defines social class, "as groups of people or families who are more or less equal in rank and differentiated from other families above or below them with regard to characteristics such as occupation, income, wealth and prestige".

The concept social class is used in social sciences and political theory to refer to economic stratification.However, Max Weber defines social class as "class or aggregates of individuals who have the same opportunity of acquiring good, the same exhibited standard of living". Sociologists see social class as a powerful form of stratification. In that regard, "placing people within such layers or strata means that some will be in higher or lower positions; others will have power, whereas others will be relatively powerless". Max Weber (1864-1920) argued that

social class was based on a person's market position which is basically how much money or wealth they have and their bargaining power to get the same.

Karl Marx social theory acknowledged two social classes: Bourgeoisie who are the owners of the means of production and the Proletariat, the workers who have sold their labor, referred to as the exploited masses. According to Karl Marx, these are a people who are in a relationship to the means of production. The bourgeoisie own capital and the proletariat own their labor. Karl Marx views such relationships exploitative, shown by "surplus value"

Karl Marx aimed to bring about a classless society where common means of ownership is practiced. He regarded capitalist society as being exploitative as everything was determined by money and economics. In his view, ruling ideas are imposed on lower class, and this explains persistence of capitalism. In that regard, Karl Marx, argued, each social class should have its own ideology and system of beliefs. Karl Marx advocated for a revolution whereby society would be classless.

This Marxist definition and interpretation of social class is paramount to the study. This is because society focused on access to healthcare based on socio-economic resources. The question as to who controls or directs the allocations of resources is of paramount importance to the study.

In this study, intervening variables income, education, occupation, wealth, place of residence and poverty will be used to identify social class; and at the same them use these intervening variables to explain the causal relationships between social class (independent variable) and access to public healthcare (dependent variable) in chapter four of the study.

2. Access to Public Health - Dependent variable

Gulliford defines access to healthcare as proximity to health facilities, availability of affordable insurance services, timeliness of care, availability of prescription of drugs and readily available health personnel (Gulliford, 2002). Penchansky and Thomas also defined the concept by analyzing the five dimensions of access, availability, accessibility, affordability, accommodation and acceptability (Penchansky, 1981). In this study, the definition advanced by Gulliford is adopted: access to healthcare is defined as proximity to health facilities, availability of affordable health insurance services, timeliness of care, availability of prescription drugs and readily available health personnel.This is the ability to get the required medical care from the public health service providers when in need. These are further defined into three basic indicators: availability, affordability and acceptability. Availability of services entails availability of health personnel, availability of drugs and equipment in the health facility while affordability of services refers to ability to pay user fee in the health facility. Further, acceptability of services involves satisfaction of the health personnel and the health facility. The importance of health care services cannot be overemphasized with studies showing that a healthy nation is a vital ingredient of its growth and development.

A wide set of literature since the 1970s has provided different definitions of access to health care (Donabedian, 1972; Aday and Andersen, 1974; Penchansky, 1977; Gulliford et al., 2002; Oliver &Mossialos, 2004; Peters et al., 2008). The earliest definition was offered by Donabedian (1972) who defined access as the utilization of services and distinguished between initiation, or first use, and continuation, that is, the subsequent use of health care. This definition ignored the supply side aspects of access to health care as the focus was on who receives care and for how long. A later study by Aday and Anderson (1974) identified two concepts relating to access to health care, namely, “gaining access”, that is, actually using health care and ‘having access”, or the potential to use health care. This conceptualization focused on the availability

of health care services. However, the fact that health care facilities are available does not necessarily mean that people receive the care they need.

Based on these conceptualizations, subsequent studies referred to access to health care in many ways. One set of studies referred to access to health care in terms of the time and money available to use health care services (Le Grand, 1982; Mooney, 1983; Olsen & Rogers, 1991). Others defined access to public healthcare as the extent to which health care was of high quality with consumers well informed about the costs and other information (Goddard &Smith, 2001). Some studies simply referred to access as the use of health care services (Penchansky, 1977; Mooney, 1983; Oliver &Mossialos, 2004).

Access to public health care has been measured by health system outcome indicators such as health care utilization or availability indicators and health care access indices. In terms of health system outcome indicators, mortality or life expectancy have been the most common tools used to measure access to health care. This perspective assumes that better access leads to low mortality rates and higher life expectancy (Aday and Andersen, 1974; Aakvik&Holmas, 2006). Other indicators of access to health care that have been used include health care utilization, the number of physicians or number of hospital beds per a certain number of people, or the number of general practitioner (GP) contacts per capita per year (Donabedian, 1972). Other studies have also measured access by building indices of access to health care from various indicators (Field, 2000; Iversen&Kopperud, 2005; Wang &Luo, 2005).

In this study, access to public healthcare will be explained in terms of proximity to health facilities, availability of affordable health insurance services, timeliness of care, availability of prescription drugs and readily available health personnel.

3. Intervening variables

Intervening variables are variables that are used to explain causal relationships between other variables. They cannot be observed in experiments. They show the association between Independent Variable and Dependent Variable. They explain why or how the relationships exist.

In this study, intervening variables were: Demographic variables, Socio-cultural variables and institutional variables that were used to help explain the causal relationships between Independent Variable (Social Class) and Dependent Variable (Access to Public Healthcare. These intervening variables form the questions and the objectives of the study.

3.1 Socio-cultural factors - Intervening variable

These are environmental conditions that play a part in healthy and adaptive behaviors of the people. Examples of socio-cultural factors of a positive nature are a strong sense of family and community support and mentorship, good education and health care, availability of recreationalfacilities and exposure to the arts. Examples of a negative nature are slum conditions, poverty, extreme or restrictive occupational pressures, lack of good medical care, and inadequate educational opportunities.Socio-cultural factors present a significant influence on access to public healthcare services. For instance, Azuh et al. (2015) point out that in Nigeria, socio-cultural factors such as the attitudes and beliefs of men play a significant role in women's access to quality health. Generally, culture reiterates the gender roles and responsibilities as well as the way of life for husbands and wives, which significantly deprive the woman of her rights to quality health, especially on reproductive health issues. According to Azuh et al. (2015), culture refers to the entirety of the unique spiritual, material, and intellectual features that characterize a society or group of people. The critical components of

culture incorporate arts, mode of life, fundamental rights of the human being, value structures, traditions, and beliefs. Accordingly, Azuh et al. (2015) highlight that religion, ethnicity, and traditional beliefs (myths) are considered the foundation of culture and significantly affect beliefs, norms, and values surrounding health, especially childbirth and women.

In Kenya, socio-cultural factors significantly impact access to public healthcare. Generally, access to public healthcare in African context including Kenya is hindered by certain religious and cultural beliefs among other factors. Specifically, in Kenya, the people opt for traditional healers instead of public healthcare due to poverty and traditional beliefs (Wairiuko, 2014). Therefore, culture has important influence on access to public healthcare. This study measured socio-cultural factors using attitudes, communication, beliefs, social resources and perceptions/perspectives.

3.2 Demographic factors - Intervening variable

These are the socioeconomic characteristics of a population expressed statistically. Thesetypically include such factors as age, gender, level of education, amount of income, maritalstatus, occupation, the average size of a family, the average age at marriage etc.

Studies on health care inequalities have shown different results. For example, in the 1970s in UK, visits to the family doctor were more frequent among people in disadvantaged social classes, but measures of utilization/need were considered, the gradient between social classes reversed, and the working classes actually are consulting less, meaning that for the same level of needs, disadvantaged classes might have less access to the family doctor (Davidson & Whitehead, 1988). Cooper, Smaje and Arber (1998) and McNiece and Majeed (1999) established non-correlation between the use of medical practitioners based on social class, although they did not stratify the analysis by any measure of need. Further studies have however

found that general medical practice was higher in less well-off areas and in people with lower occupational income, while the opposite trend was seen for use of specialists (Luschen et al., 1997; Krasnik et al., 1997).

Blaxter (1990) found out that poorer families seemed more stressed with illness in terms of the disruption of their lives and ability to accommodate minor sicknesses, while still getting on with their lives. Socio-demographic factors such as age is a factor which varies the health care seeking behaviour from person to person. A study of Engeda et al., (2016) found that age was significantly associated with visiting modern health care facility. In contrast, Amin et al., (2010) study examined that age and education factors were less pronounced in the differentials of health seeking behaviour of maternal care and child health care in rural areas (Amin et al. 2010).

The lowest socio-economic class had the highest non-utilization rate and the highest public sector utilization rate (Jeckins, 1987). Igun (1996) is of the view that inadequate utilization of health facilities is as a result of social and environmental factors. There is an absolute shortage and the situation is often complicated by the distribution of health resources that exist. Also non utilization of health facilities could relatively reflect such factors as attitude of health personnel, insufficient awareness of the need for community knowledge and involvement and social inaccessibility. Finally, infants and older people are in need of health services more than the middle aged people since they are more prone to diseases.

This study measured socio-cultural variables using age, gender, marital status, poverty and social networks (2002).

3.3 HealthInstitutional factors - Intervening variable

Health institutions mean organizations whose primary purpose is the care or treatment of patients or the promotion of public health. This is where health services or health support

services are provided. It also means a hospital, nursing home, maternity home, health center, dispensary etc.

The health system in Kenya consists of public and private sectors. The private sector provides healthcare coverage to about 10% of the population, whereas the public sector provides the remaining 90% of the population. In this study, health institutions are supported by factors like leadership and good governance, health policies, health facilities, health infrastructure, supplies and medicines, health workers, health financing and social insurance among others. These factors enable institutions to achieve their core functions.

The Kenya healthcare system defines six levels of the hierarchy as:

Level 1: County Services

Level 2: Dispensaries

Level 3: Health Centers and Maternity and Nursing Homes

Level 4: Sub-County Hospitals

Level 5: County Referral Hospitals

Level 6: National Teaching & Referral Hospitals

In this study, institutional factors were measured using: Leadership and Governance, Health Policies, Health Facilities, Health Infrastructure, Supplies and drugs, Health Workers, Health Financing and Health Insurance.

1.8 Structure of the Thesis

Eight chapters are well outlined in this thesis. The first chapter gives an introduction pertaining to the study with key conceptual and contextual discussion brought out. Such concepts pertain to key variables; social factors, demographic factors together with socio-cultural factors as well

as access to public health care. The context is where the study covers and this entails persons across cadres in Nairobi City County

Chapter Two is well arranged extensively covering review of literature by first presenting those theories deemed key to study and also extends to review empirical literature based on study variables and the likely influence on access to health care and how variables jointly link to each other, and finally summarizes the perceived gaps that arise within literature, identification and discussion with a representation of variables on a diagram well illustrated.

The information presented in Chapter Three pertains methodology of the study in question with key sub sections considered including how it was informed under philosophy and the design used. The population and how it was arrived at was also presented and how data derived, coupled with other sections like operationalization and analysis aspects.

Chapter Four analyzed the effect of social class and access to public healthcare.

Chapter Five analyzed and interpreted the effect of Demographic intervening variables on access to public healthcare. Results helped to determine the correlation between the two variables.

Chapter Six analyzed and interpreted the effect of Socio-cultural intervening variables on access to public healthcare. Results helped to determine the correlation between the two variables.

Chapter Seven analyzed and interpreted the effect of Institutional intervening on access to public healthcare. Results helped to determine the correlation between the two variables.

Chapter Eight outlined the Summary, Conclusion and Recommendations of the study.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter reviewed existing body of knowledge in the empirical literature on access to public healthcare. In fact, literature review is a focused discussion of previous research, facts and ideas on the study subject. The focus of this study was the influence of social class (explained using intervening variables: demographic, socio-cultural and institutional variables) on access to public healthcare in Nairobi City County.

It made a summary of literature gaps. In the last section, it chose a conceptual framework for explaining the variables in the study.

Previous scholarly publications have focused on various factors that affect affordability, physical accessibility and acceptability of service (Penchansky& Thomas, 1981). Such publications have for example focused on material factors (Lynch, 2000), unemployment (Ross, 1995), income (Dunlop, 2000), economic resources (Link, 1995), perspectives and experiences (De Nava, 2013), gender (Amercy, 2009), minorities (Blendonet, 1989), race, ethnicity (De Navas, 2013) and many more but have not adequately explained the links between the key variables (I.V and D.V in the study.Consequently, disparities in access to public healthcare continue to attract further research.

Theories have also been advanced such as Karl Marx and Max Weber to explain, predict, and understand factors influencing access to public healthcare. The methods used, evidence adduced and conclusions made still leave gaps in research and other dimensions of scholarship. Despite all these theories, the relationship between the variables remainsobscure, hence, making it difficult to craft effective solutions.

Thus, a new perspective is imperative to address the persistent nature of inequality in access to public healthcare. This chapter therefore, reviews literature using intervening variables to explain the relationships between the intervening and dependent variables in the study. The literature review focuses on how scholarly works, books and other documentary materials have approached in different ways the research problem. The reviews focus on the problem being investigated and critically states weaknesses and strength of such studies. The review is presented in three sections namely demographic, socio-cultural and institutional variables (intervening variables) to explain the causal relationship between the variables.

2.2 Literature Review

Researches which analyze access to health care are categorized into those at micro level and those at macro level. At micro level, the first research in the public health domain that examined access to public health care was one by Alderman and Gertler (1989). Exploiting investigation data and pertaining a nested multinomial logit model, this research analyzed access to public health care to establish in what way impressive operator fees at public health care services facilities influence access. It established that an increase in worker fees centrals to a reduction in access to public health care facilities tailed by an upturn in the use of private health care in its place of an increase in self-care.

An analysis conducted by McGinnis et al (McGinnis et al.2002), projected that medical care was accountable for only 10%–15% of preventable mortality in the U.S whereas Mackenbach, (Mackenbach, et al. 1996; 1989) analyses indicate that this percentage could be an underrate, they support the vast position of social class factors. McGinnis and Foege (Foege, M. 1993) established that half of all deaths in the U.S. comprise behavioral causes; further verification has disclosed that health-related behaviors are strongly created by social factors, including income, education, and employment; Jemal, et al., (2001) scrutinizing U.S. death data and

established that "potentially preventable causes related with lesser educational standing account for almost half of all deaths mid working-age adults in the U.S.

2.2.1 Social class and Access to Public Health Care

The social class impact of access to public health care also is supported by the strong and extensively perceived relations among a wide-range of health care indicators and measures of individuals' socio-economic resources or social position, income, educational attainment, or rank in an occupational hierarchy. In United States of America, as well as European data, this relationship habitually respects a stepwise gradient pattern, with health services effective incrementally as social position rises. This stepwise gradient pattern was first noted in the United Kingdom (Marmot, et al. 1978). High-quality health care services include the correct care, at the accurate time, reacting to the service users' needs and preferences, whereas lessening impairment and resource waste. Quality health care services increase the likelihood of desired health results and is coherent with seven measurable characteristics: effectiveness, safety, people-centeredness', timeliness, equity, integration of care and efficiency.

Nevertheless, better health status is related to the magnitude to which individual access public health care. The evidence in this concern implies that access to public health care, mainly in nations with a high burden of diseases, has made a difference to people's health care (Gu et. al., 2009). This has encouraged interest amid policy-makers and academics in access to health care as confirmed by analyses conducted by Gullifordet at al 2002); McIntyre et al. (2009); Rutherford et al. (2010; Morreale et al. (2014); and Ganesh, et al. 2015). Furthermore being a advancement factor, improved access to health care status also contributes to the well-being of the people in the country (Sun et al., 2015). Since health is positively correlated to work force involvement, earnings and household savings, individuals with better health status not only enjoy being healthy but also derive happiness from the fruits of their hard work. When people

are unhealthy they cannot work and their household will not be able to satisfy their basic needs, leading to unhappiness.

These theoretical foundations and benefits of improved public health status have been supported by empirical evidence that displays the link among improved health status and enhanced productivity and well-being. Tompa's (2002) review of evidence from advanced and emerging countries over a period of more than 200 years exhibited that better physical and mental capacities among health care workers improved productivity levels. Other analyses established related outcomes (Boles et al., 2004); Mitchell et al., 2013); Boman&

Isiaka, 2015). Furthermore, scrutiny at macro level indicated that improved access to public health care status was positively correlated with national economic growth (Bloom & Canning, 2005; Mehmood et al., 2014); Oni et al. 2014). Alternative series of the evidence related to improved health care status relate to poverty alleviation (Carrin&Politi, 1996); Peters et al (2008).

Therefore, it has been argued that low income and material deprivation can have severe health results. Nevertheless, it is progressively discussed that health disproportions are not just associated to level of income, but that large inequalities of wealth within society in general have a negative effect on health. Economic inequality in Britain has increased vividly over the last three decades (Annandale et al., 2014). This can have potentially adverse effects on individuals' health. Wilkinson (2005) argued that the least health inequalities are seen in cultures with the smallest income differentials and greater social cohesion. The social gradient of health is influenced by the existence of relative deprivation. The poorer health of middle-income earners relative to the most affluent is less to do with the absolute amount of income they earn than with their perceived lack of material possessions relative to others, and their anxiety to achieve greater social status

2.2.2 Demographic variables

Demographic variables are important in explaining causal relationships between the variables (I.V & D.V). Consequently it one of the most significant determining factors of access to public healthcare, especially in developing countries. According to Islam and Begum (2020), demographic factors such as the place of residence, education level, income, and gender are some of the critical determinants of household behavior towards access to quality public healthcare across the countries, especially among developing countries. Remarkably, the people residing in rural areas experience enormous challenges to access quality public healthcare than individuals living in urban areas. For instance, Islam and Begum (2020) assert that the majority of the people residing in rural areas within Bangladesh are exposed to limited access to healthcare facilities than individuals living in urban areas. Generally, public healthcare facilities in most rural areas lack life-changing medical infrastructure and expertise, leading to the majority of residents being denied access to healthcare services.

Moreover, most healthcare facilities in rural areas offer limited healthcare services. They lack the capability to handle complex health situations limiting access to quality healthcare for the majority of the people living in rural areas who cannot foot transportation and other expenses to urban areas for complex health issues. On the other hand, urban places offer most residents significant access to public healthcare services as the facilities are many. Moreover, a considerable number of the public healthcare facilities in urban centers are able to handle complex health situations, making the majority of the residents of urban centers privileged to access quality healthcare services than their counterparts living in villages.

On the same note, gender as a demographic factor determines access to quality public healthcare services received by populations worldwide. Globally, especially in the low-and middle-income countries, the gender norms, roles, and relationships attached to women significantly impact

their health and general access to healthcare services. At the forefront, Azad et al. (2020)highlight that gender roles, socially constructed beliefs, and attitudes attached to specific genders may lead to healthcare access inequalities in the event the disease prevalence among men and women is equal. Moreover, the study points out that low education levels, economic privileges, lack of autonomy, and decision-making power among women contribute to the inequalities between men and women in healthcare access. The study reiterates the position that women experience several barriers to access quality public healthcare services. Therefore, gender is regarded as one of the critical determining factors towards accessing quality public healthcare globally, especially in the low-and middle-income countries.

Similarly, income level as a demographic factor impacts access to public healthcare services among populations across the countries. According to the National Academies of Sciences, Engineering, and Medicine (2018), the income level of individuals determines their ability to afford health insurance which plays a significant role in their access to healthcare services. The individuals earning low-income experience financial barriers leading to their inability to afford health insurance that can guarantee access to advanced public healthcare services, unlike the high-income earners able to afford higher health insurance. Lastly, education also impacts access to healthcare. For instance, the study by Abdalla,Katz and Darmstadt(2021) deduced that demographic factors encompassing level of income, education, place of residence, and gender, among others, play a significant role in either promoting or barricading access to public healthcare services across the globe.

Darker, Donnelly-Swift and Whiston(2018) conducted the study titled demographic factors and attitudes that influence the support of the general public for the introduction of universal healthcare in Ireland. The study aimed to determine the demographic factors and attitudes that impact the general public to back the introduction of universal healthcare (UHC) in Ireland.

The study employed quantitative research methods to collect data from the respondents. The study used a sample size of n= 972 making it a true representation of the national data. The study found that demographic factors and attitudes such as location, GMS status, opinions on healthcare being free, and government prioritizing spending on healthcare influenced support for the introduction of universal healthcare in Ireland significantly. Even though the study succeeded in highlighting demographic factors that determine support for the introduction of the UHC, it failed to provide finer details on how demographic factors such as location impede access to public healthcare services. However, the current study goes an extra mile to detail how demographic factors such as location, income, education, and age among others promote or inhibit access to public healthcare.

Schlichthorst, Sanci, Pirkis, Spittal and Hocking(2016) authored a study titled why do men go to the doctor? Socio-demographic and lifestyle factors associated with healthcare utilization among a cohort of Australian men. The main objective of the study included an investigation of socio-demographic factors that determine healthcare utilization among Australian men. The study used data from the Australian Longitudinal Study on Male Health (Ten to Men), the main evidence-based platform capturing male health focusing on the health outcomes, behaviors, and associated risk factors. The study found that an increase in age resulted in increased healthcare utilization. However, remoteness of place of residence, financial challenges, and completion of secondary school resulted in reduced chances of visiting a general practitioner. Although the study exceedingly reiterates that remoteness of the residence, younger age, low education level, and financial challenges pose a hindrance to utilizing healthcare among men, it fails to offer evidence that can be used as a reflection of both genders. The study focused only on men and left out women. Therefore, the current study explores how demographic factors with a special focus on genders, education, and place of residence, income, age, and marital status among others influence access to public healthcare services.

The study titled “The gender gap and healthcare: associations between gender roles and factors affecting healthcare access in Central Malawi conducted by Azad,Charles, Ding, Trickey and Wren(2020) sought to investigate the health inequalities and linkages between gender prioritization, sociocultural factors, and household decision-making in central. Stratified sampling by place and gender was employed as the research methodology to collect data used in the study. The study found that women were less likely compared to men to utilize the necessary healthcare and acquire community-sourced healthcare financial aid. The study revealed that gender norms, beliefs, and responsibilities such as decision-maker with regards to healthcare, house chores, and general family affairs contribute to the limited access to healthcare services witnessed among women and girls. Even though the study confirms the findings by other studies that gender norms result in limited access to healthcare among women, its findings cannot be used as a general representation of communities in other low and middle-income countries. The study used a stratified systematic sampling design to sample respondents instead of a general sample design such as a cross-sectional survey design. Therefore, the current study will use a methodology that will provide findings that can be used as a mirror of communities in other LMIC.

Islam and Begum (2020) conducted the study titled “The Impact of Socio-Economic and Demographic Factors on Health Seeking Behavior of Urban Households, Bangladesh”. The study aimed to confirm the health-seeking behavior of urban residents in Sylhet city, Bangladesh through examining the socio-economic and socio-demographic factors. The study employed both qualitative and quantitative research methods to collect data from the respondents. The study found that the majority of the household heads are male and they are significant in choosing healthcare for the entire household. Others such as age, education level, occupation, and income level play a significant role in residents choosing the mode of healthcare (private or public. However, the study found that education level had limited

influence in determining the choice of traditional or alternative healthcare as the majority of the respondents chose alternative healthcare. Although the study provides critical insights regarding healthcare access behavior among households in Sylhet City, Bangladesh, the findings of the study cannot be used as a representation of other urban centers of LMICs. First, the study was only conducted in some parts of the city and it used a small number of females than males leading to biases in findings regarding gender.

Abdalla et al. (2021) conducted a study in Kenya, Nigeria, and South Africa that sought to assess the gender inequalities in the effects of COVID-19 by investigating the inter-sectionality of gender with educational and socioeconomic factors. The study was titled "Gender and the impact of COVID-19 on demand for and access to health care: analysis of data from Kenya, Nigeria, and South Africa" and used quantitative research methods. The main finding of the study encompassed the assertion that more women than men experienced a decline in the inability to see a healthcare provider. Other findings included the assertion that women without post-secondary education were more afflicted than the group with post-secondary education and financial difficulties resulted in reprioritization of preventive and routine care among women and men. The study has a generalization limitation because it only focused on healthcare access challenges with regards to Covid-19. Therefore, the current study goes an extra mile to investigate the demographic factors such as gender, age, and education among others that hinder access to healthcare concerning all health conditions.

According to Nancy and Katherin (1990), education provides knowledge and skills that allow better access to information and resources that promote health). In addition, studies like (Ross et al. (1995) have examined years of completing education and concluded that early years of education affects access to resources. Ross (1995) show that people with high education have better access to healthcare than those without or at low levels of education. Better education

increases health resources and opportunities and those without cannot access healthcare. The upper class and to some extent the middle class enjoy better access to healthcare. It was also indicated that the lower classes have less or no education at all. This deprives them of the benefits of being educated as they have no opportunities to easily access healthcare. This is major policy issue that has continued despite efforts by various governments to redistribute education for all the population. Access to healthcare will continue to affect the lower class unless urgent measures are taken to address redistribution of education opportunities among all the population.

Another body of research found that social groups with no income or less income have less access to healthcare than those with high incomes (Nancy &Katherin, 1990). High incomes provide means of purchasing healthcare. They argue that high incomes provide better nutrition, housing, and recreations which all combine improve access to healthcare. They conclude that the distribution of income is linked to mortality rates. The study shows that access to healthcare is unequal between different social groups. The upper classes in society have more disposable incomes and therefore can afford more resources and opportunities to access healthcare. On the other hand, the lower classes have less income and therefore receive less access to healthcare. This inequality is perpetuated due to unequal distribution of incomes among the people. Efforts have been made to redistribution incomes but such efforts have not addressed the problem adequately. If redistribution is not addressed, millions of people will die due to lack of access to healthcare. Urgent measures are needed to address the problem in order to avert looming crises. Despite the challenges, the study contributes new knowledge that can be used to augment the existing ones. In this way, access to healthcare can be maximized so that more people access healthcare. It will also help researchers take stock of what knowledge is available and what needs to be added. Further knowledge will also guide policy makers to precisely address the problem by redistributing incomes to the population.

Employment is another demographic factor that has been reported to have a relationship with access to public healthcare, (Ross (1995) Noted that there is a direct connection between employment and access to healthcare; people who are employed have better access compared to the unemployed. The research shows that being unemployed affects access to healthcare; and the length of unemployment effect on access to healthcare. However, in some health systems, the unemployed have entitlement benefits which can provide inhibition to the severe effects on health. It is true that entitlements reduce the negative health effects. However, threats of unemployment and job insecurity affect access as well. In the same study, results show that high rates of low birth weight were common in areas where the population was not employed (Catalano et al. 1992). In another study by Kasl (1980), job threats were linked to high blood pressure. Employment differs according to prestige, qualifications and rewards and all of them have different impacts; but they are linked to mortality rates at different proportions.

Gregoria et al. (1997) argued that low status jobs expose workers to toxic substances which are a threat to access to healthcare. The research correctly points out that job strain and lack of control over work is greater at the lower occupational status. This implies that those at the top have fewer risks and therefore are able to access healthcare. In the same manner, Ross et al. (1995) shows that inequality in healthcare is also based on forms of employment, especially the distribution between professionals and subordinate workers. Those with employment opportunities have better health than those without. The employed have better socio-economic status and can therefore use such resources to address health challenges. Some use such resources to procure health insurance coverage which give them access to both specialized care and private health facilities. However, those who are not employed lack both financial resources and good health. They do not have access to specialized health services nor access specialized wing of government facilities like Kenyatta (Gregorio et al. 1997). This is a gap that needs to be filled.

Similarly, Small (2001) conducted a research on healthcare access and found similar findings: access to healthcare services varies by economic status. For instance, the research show that 40% of those who have not graduated from high school are uninsured compared with 10% of college graduates and that more than 60% of the uninsured are low income. The research further shows that those who lack insurance receive less access to healthcare than those who are covered.. In contrast, individuals with much lower disposable incomes do not receive the same healthcare services as the wealthy individuals (Dunlop et al., 2000). In the same study, higher mortality rates show that higher mortality rates were higher with less income, less education, lower occupational status (Wood et al., 1999).

Monheit (2000) shows that economic resources are critical in access to healthcare. In addition, people who have been deprived socio-economic resources and opportunities tend to be marginalized (Golberg, 2004). This marginalization leads to poor access to healthcare. Socio-economic deprivation acts as a barrier to access to public healthcare. This explains why many people deprived tend to have worse health outcomes characterized by morbidity, infant mortality and low life expectancy.

Deaton (1999) also argued that individuals with more disposable income have better opportunities to medical services. Those with lower income have limited access to healthcare. In addition, higher socio-economic resources provide pleasant lifestyles which are conducive to good health (Wilkinson, 1996). Underinvestment in public goods increases health inequality especially in more stratified societies (Deaton A. 1999). This means that those with low incomes have less access to healthcare. Consequently, this leads to high rates of mortality and morbidly among the lower class. The research conducted conforms to the research topic and the purpose for doing the research. The research also looks beyond these economic statuses to address other factors like behavior /lifestyles which too have a significant impact on the access to health

services. In addition, the research examines the influence of demographic factors and finds that it also played a significant part on the ability to access health services. This holistic approach is the strength of this research. Limited or lack of access to healthcare affects a person's overall physical, social and mental health status, and has significant bearing on quality of life. The overall goal is to promote access to health services to people across the population. This research contributes to knowledge but this cannot be achieved if gender discrimination persists. It is the responsibility of policy makers to address these factors and find urgent solutions to the problem. All the publications discussed above clearly state the problem under investigation. Access to healthcare is unequal among the people. This has been caused by the different demographic and economic positions occupied by different social classes. Those with high incomes, education and occupations have better resources and opportunities to access healthcare. Those in the lower social categories lack these resources and therefore lack access to healthcare.

However, this research draws heavily from studies in USA, Canada and Britain and more developed countries. The studies have proposed many ways of addressing demographic challenges, but specific actions need to be put in place. The policies recommendations should be specific and target oriented towards the most affected social groups, especially the lower social class. There are too many recommendations but urgent prioritization is important. The studies therefore do not address the challenges unique in other countries. All the studies use key concepts to conduct the research. In these publications, income, education, occupations and gender are used as intervening variables demographic indicators of social class and the ability to access to public healthcare services.

2.2.3Socio-cultural Variables

Socio-cultural are important intervening variables that explain causal relationships between the variables (IV & D.V). They therefore have significant influence on access to public healthcare services. For instance, Azuh et al. (2015) point out that in Nigeria, socio-cultural factors such as the attitudes and beliefs of men play a significant role in women's access to quality health. Generally, culture reiterates the gender roles and responsibilities as well as the way of life for husbands and wives, which significantly deprive the woman of her rights to quality health, especially on reproductive health issues. According to Azuh et al. (2015), culture refers to the entirety of the unique spiritual, material, and intellectual features that characterize a society or group of people. The critical components of culture incorporate arts, mode of life, fundamental rights of the human being, value structures, traditions, and beliefs. Accordingly, Azuh et al. (2015) highlight that religion, ethnicity, and traditional beliefs are considered the foundation of culture and significantly affect beliefs, norms, and values surrounding health, especially childbirth and women. Mosadeghrad (2014) highlights that socio-cultural factors, especially gender roles and attitudes, determine women's access to health. For men who want children, they do not care about healthcare provider's opinions about the health of the pregnant women and the children due to their strong belief in cultural traditions, attitudes, and beliefs. Therefore, socio-cultural factors that significantly influence public healthcare services' access include attitudes, traditional practices, and social resources, among others.

Azuh et al. (2015) present how socio-cultural factors, particularly attitudes and gender roles reinforced by socio-cultural norms in Africa, particularly Nigeria, needs to be changed to incorporate men in spreading positive attitudes and knowledge towards the fight against maternal mortality. Across Africa, increased maternal mortality rates are associated with retrogressive reproductive cultural practices, low education levels, and high poverty levels. Therefore, focusing on changing men's attitudes towards reproductive health will significantly improve access and reduce maternal mortality rates. On the same note, cultural practices that

deny the existence of people with disabilities also limit access to public healthcare services among populations. The study conducted by Soltani et al. (2017) revealed that disabled individuals in Iran experienced limited access to public health services due to the socio-culture that denies disability, little support from the policymakers and healthcare facilities. Without establishing strategies that promote the socio-cultural acceptability of the individuals with a disability, more vulnerable populations such as people with disabilities will continue to experience huge barriers such as being shamed, disrespected, and cared for in their quest for quality public healthcare services.

On the same note, language and ethnicity as socio-cultural factors also impact access to healthcare services among populations across the globe. The language differences between healthcare providers in culturally diverse environments create a barrier to adequate access to quality healthcare services. Mosadeghrad (2014) notes that due to the language barrier, the patients did not understand the directive of the healthcare provider nor observed the directives. They are reiterating that employing healthcare service providers able to communicate in the host community's language and remain socio-culturally sensitive helps promote access to public healthcare services. Similarly, ethnicity determines the ability of populations to access public healthcare services, with the dominant ethnicities accessing quality healthcare than the minority ethnicities. For instance, in Australia, indigenous people have limited access to public healthcare facilities due to higher costs, language barriers, and rampant racism (Davy et al., 2016). Therefore, socio-cultural factors such as attitudes, norms, beliefs, language, and ethnicity play a significant role in promoting or limiting access to quality public healthcare services.

Access to public healthcare is influenced by many factors including individual life factors, social and community factors and socio-economic, environmental and cultural conditions.In a

study by De Navas et al. (2013) on the perspectives and experiences faced by the Brazialian – born immigrants in the USA, the researchers provide a good background to the study. The study clarifies that access to healthcare is unequal between the immigrants and the USA born citizens (Almeida et al., 2013). This is specific and helps the research proceed with clear objectives and the problem to be dealt with. In addition, De Navas et al. (2013) give a vivid description of the research area and providing update information on the issues around perspectives and experiences of the Brazilian-born immigrants. This reinforced by previous studies on the same subject by Avila et al. (2013). Giving the history of the problem under investigation makes it easier to analyze the problem (Lebrun et al., 2010).

Saeed et al. (2016) conducted a study titled "Effect of socio-economic factors in the utilization of different healthcare services among older adult men and women in Ghana". The study sought to investigate the effect of socio-economic factors on the utilization of healthcare services among older adult men and women in Ghana. The study utilized a qualitative research method and involved 5573 respondents. The study found that men with higher income preferred private health facilities while men with higher education, health insurance, and those who viewed their health as very bad, bad, or moderate liked public health facilities. Moreover, self-employed men and those in informal employment favored health facilities outside the formal public health service. On the other hand, the study found that women in primary and secondary education liked private health facilities while those with insurance, those in upper and middle-class income, or those who viewed their health as bad, moderate liked public health facilities. However, self-employed women and those in informal settlements liked the traditional treatment. The study successfully provides insights about the preference of health facilities with regards to some socio-economic factors among older men and women but fails to go to extra mile to determine the cultural aspects contributing to such findings. Therefore, the current study

seeks to provide insights into socio-cultural factors that impact not only the preference of health facilities but the general access to public healthcare services.

The study by Azuh et al. (2015) titled “Socio-cultural factors of gender roles in women’s healthcare utilization in Southwest Nigeria" aimed to examine the impact of socio-cultural factors on healthcare usage among women during pregnancy and childbirth. The study employed random sampling to attain 260 eligible respondents from the eight wards in the local government. The study found that the husband's perception of pregnancy complications, age at marriage, the breadwinner of the family, and treatment place decisions significantly influence the utilization of healthcare services by mothers. The study emphasized determining socio-cultural factors that determine usage of healthcare services by mothers leaving out other community members. Therefore, the current study fills the gap by examining how socio-cultural factors influence access to public healthcare services not only among mothers but entire community members.

The study by Soltani et al. (2017) titled “Cultural barriers in access to healthcare services for people with disability in Iran used qualitative research methods to acquire finer details about the cultural barriers from the respondents. The study found that the main cultural barriers to accessing public healthcare services among people with disabilities in Iran encompassed denial of disability by the people with disability, reluctance to provide health services by the health service providers, shame, and inadequate sociocultural support. Even though the study succeeds in highlighting the cultural barriers hindering people with disabilities to access public healthcare services, it lacks generalization for the entire population of Iran. Therefore, the current study seeks to examine cultural factors that hinder access to public healthcare services not only among the people living with a disability but across the entire population.

Abubakar et al. (2013) conducted the study titled “Socio-cultural determinants of health-seeking behavior on the Kenyan coast: a qualitative study”. The study sought to assess the health-seeking behavior of parents at the Kenyan Coast and the determining socio-cultural factors. The study used qualitative research approaches to sample 53 respondents comprising of mothers, fathers, and caregivers from two rural clinics at the Kenyan Coast. The study found that biomedicine from the health facilities and purchased from the over the counter was the most popular first point of treatment. Moreover, traditional healers were found to play an important role in healthcare delivery as healers were consulted for several reasons including attribution of causation of ill-health to supernatural sources, chronic illness lacking cure from modern medicine, and prevention against possible ill-health. Although the study succeeded in highlighting some of the socio-cultural factors determining the health-seeking behavior of parents, the current study goes further to examine the traditional and spiritual beliefs that trigger decision-making for accessing public healthcare or traditional healers.

Ugwu and de Kok. (2015) conducted the study titled “Socio-cultural factors, gender roles and religious ideologies contributing to Caesarean-section refusal in Nigeria”. The study sought to investigate the critical socio-cultural factors that reinstate resistance of Caesarean section in a Nigerian Community. The study employed a mixed research method encompassing qualitative and quantitative research techniques. The study found that a considerable number of maternity clients refused CS and a majority of expectant sought maternity services away from formal hospitals as more than 90% of SCs in the focal hospital were emergencies. However, the study's findings cannot be used to generalize all the novel medical interventions because they focused on the acceptance of CS only among Nigerians. Therefore, the current study seeks to investigate the influence of socio-cultural factors on acceptance and access to general public health services and not only SC services.

Likewise, Lebrun et al. (2010) use a qualitative approach to gather data for the research. The research uses focus group discussions to collect qualitative data. This gives an in-depth understanding of the perspectives and experiences being studied. The data is obtained from purposively selected target population (Brazialian –born immigrants). The 35 women purposively selected study. The sample provides statistical information of qualitative nature. The results obtained from the sample can be used to estimate the characteristics of the entire population. This method is good because it provides in-depth understanding, hence, targets specific groups. The results show that migrants face many challenges in accessing healthcare. These challenges include social cultural factors, communication barriers and interpretations. These are barriers that limit access to healthcare. These findings are significant to the study.

Schneider et al. (2002) also pointed out that migrant status is an important factor in accessing healthcare. The study shows that migrants lack many resources that are vital in accessing healthcare. For example, migrants lack finances and insurance covers, and this is compounded by language barriers. Migrant status has a relationship with access to healthcare services. It influences access to proper healthcare, as is the case with migrants in the USA. Immigrant status is therefore a theme that deserves much discussion given that it determines the access to healthcare services. Furthermore race, ethnicity and poverty combined, have an important impact on access to public healthcare. They play a major role in denying a portion of the population from accessing equal healthcare (Braveman, 2007). In addition, adolescents, children born of low income homes, homeless, minors, and refugees are poor and cannot afford health insurance (Blendon et al., 1986). These people cannot therefore access public healthcare due to cost factors. These factors influence access to public healthcare. This gap requires to be filled. It calls for a further research despite the studies already conducted. This research contributes to knowledge that can be advanced to increase access to public healthcare among all the population. It is also important for policy makers to undertake interventions that focus

on socio-cultural differences among the population so that they can design programmes and policies that are specific to the problems under investigation.

In another study by Amariata et al. (2011), the researchers focused on gender and found that females have less access to healthcare than male, due to various economic and socio- cultural factors. Moreover, the researchers explain the role of gender in access healthcare. The extent of gender inequities varies across and within countries, and is rooted in the different cultural practices and gender norms within these different countries, and differences in the status and autonomy of women.

The World Health Organization estimated in 2011 that 358,000 women die every year during pregnancy and child birth (WHO, 2011) often from preventable causes. These deaths occur mostly due to lack of access to skilled healthcare and emergency services during pregnancy and immediately after childbirth, as well as lack of contraception needed to avoid unwanted pregnancies as a means of birth spacing (Stevens, 2000). More than half of these deaths occur in sub-Saharan Africa (SSA), and one-third in South Asia, together, these regions account for 87% of all maternal deaths (WHO. 2012). These figures are in spite of the remarkable progress many of these countries have made in reducing maternal mortality rates following implementation of such policies as the Alma Ata Declaration in 1978, the Safe Motherhood initiative by the World Bank in 1987 (Mahler,). More recently, the Millennium Development Goals (MDGs). MDG-5 aims to reduce maternal mortality rates by 75% between 1990 and 2015, and achieve universal health services for women by 2015.

The provision of maternal healthcare services has been repeatedly shown to be essential in curbing maternal health deaths (Simkhada et al., 2008).Factors such as access to antenatal care (Carroli et al., 2000), skilled assistance at child birth (Koblinski, 1999), delivery at healthcare facility, access to emergency obstetric care (14), and appropriate postpartum care (Ronsmans,

2006), have been effective in reducing maternal mortality. Significant associations were found between several dimensions of gender inequities(with the exception of decision-making autonomy) and reported use of maternal reproductive health care services. Several pathways of influence between the outcome and exposure variables were also identified. Dimensions of gender inequities (with the exception of decision-making autonomy)differentially influenced woman's use of reproductive health care services, thus highlighting the urgent need for concerted and sustained efforts to change these harmful traditional values if several of these countries are to meet Millennium Development Goal. This research makes a clear distinction between genders: men and women. Quite often, this term is used to mean only women. This differentia makes is it possible to discuss men and women separately using different measurements (Ridgeway, 2004). Her focus is on women, with example drawn from Namibia, Kenya and India. The methodology used to collect quantitative data is effective and appropriate data is collected as designed. However, the sample somehow is limited to only three countries of Namibia, Nepal and India, this sample is small and is likely to affect the results of the research. Too small sample can lead to unreliable and invalid results. A wider sample incorporating more countries would be appreciated.

Mercy (2009) explains that gender norms are predetermined by cultures and the societies where people live. These factors have been shown to vary across and within countries. And that these norms govern differences in roles, rights and opportunities available for men and women. Amrita points that gender iniquities refer to discrimination and differential treatment of men and women in ways that are unfair, avoidable, unjust and unnecessary (Whitehead, 1992). In communities where women fall in lower social status, they are denied education, healthcare, economic and employment opportunities. They also have limited choices with regard to marriages and reproductive health matters (UNPF, 2011).

However, the Millennium Development Goal -3 aims “to promote gender equality and empowerment of women” with specific focus on eliminating barriers to education and employment and rights to healthcare (Kebeer, 2005). On the other hand, Amrita states that gender iniquities are multi-dimensional and affect women’s’ access to healthcare in multiple ways compared with men (Zen, 2001).

Another body of research examined access among the minorities in the USA. The findings show that minorities have much lower access to medical services compared to the majorities (Kleiman, 1987). The whites who are the majority have much better access to healthcare services. The research shows that these whites have better socio-economic status than the minorities who are mainly black, Hispanics and Indians among others .In addition, Link et al. (2000) discussed the effects of disadvantaged minorities in the USA. Due to disadvantaged class position, the minorities use less health facilities Whites (Blendon et al., 1989). This inequality persists across income groups and it is found even with patients with chronic or serious illness (Strogatz, 1990). The underutilization of healthcare services has been associated with adverse outcomes in minority infants (Braveman et al., 1989) and elderly persons (Sommer et al., 1991). This study shows that race plays a significant place in people’s ability to access to healthcare services. Similarly, race and poverty were found to be more severe among Caucasian and African Americans (De Navas et al., 2013). According to a 2013 study, 27% of African Americans and 11% of Asians lived in poverty. It was also found that 12% of Caucasians lived in poverty. The impoverished populations were unable to afford health insurance. In 2013, 23 % of the “poor” and “24%” of “lower-income” lacked health insurance in the US. This impoverishes the households.

This shows that the ability to secure medical services is still heavily affected by the race of individuals. As opposed to the whites, the minorities have less access to healthcare and this has

led to high mortality rates. The whites enjoy privileged status or social status and this coupled with high incomes, access them good healthcare. This ensures that they have better health outcomes-high life expectancy, less mortality rates and less morbidity (Kleinman et al., 1987). The children of these minorities face even more severe challenges given that they cannot even access healthcare at infancy due to lack of insurance (James. et al., 1999). This has led to serious diseases among the minorities and their children alike. Minority is therefore one of the main factors when discussing access to medical services. It influences the levels of access to healthcare. In this research, minority is the independent variable that has some influence on access to medical services. Access to healthcare services becomes the dependent variable.

However, socio-economic factors defined by for example, income, education, employment and wealth, are the intervening variables that help explain the relationships. In addition, (Turrell, 2002) confirms that disadvantaged groups deprived off socio-economic factors are seriously affected. Deprivations include poor housing, education and occupations. Rose has shown that inequalities in health are based forms of employment; for instance, those at the top have better access and therefore less risk (Roseet al., 1995). They cannot have access to good healthcare and these results in high infant mortality rates, high morbidity and early death. Socio-economic factors (Pamuket al., 1998) are therefore very important to access to healthcare discussion. The lack of these resources creates undesirable inequalities in health (Deaton, 1999). The minorities lack these factors; hence lack access to healthcare (Kleiman.1987). In addition, Braveman et al makes a conclusion that race determines access to public healthcare (Braveman et al., 1989).

Race gives the whites more socio-economic resources like income, education and occupation which increase their capabilities to access better opportunities to healthcare (Braveman et al., 1991). On the other hand, the non-whites have less socioeconomic resources and therefore have no capabilities to access healthcare. There is need to understand racial differences in health

status and in access to healthcare. Yet there appears to be little understanding of these racial differences. The purpose here is to fill in some gaps in knowledge and to evaluate how such differences are influenced by health insurance. This is the limitation that the study tries to address.

Studies have shown that poor including the immigrants have less access to healthcare than the rich (De Navas et al., 2015). Further, Almeda et al. has observed that access to healthcare among the immigrants is poor and unequal compared to the originals (Almeida et al., 2013). Avila has taken considerable time to discuss and emphasize the problems faced by the immigrants in access healthcare (Avilaet al., 2013). However, poverty cuts across all nations and it is important that we do not mere look at third world and Asian countries. Even in America, the Blacks, Hispanics and Indians are classified poor against the context of the white majority. So while the research contributes to new knowledge, it is imperative that pro-minority/poor policies are designed and urgently implemented. This will reduce mortality rates and increase life expectancies for all the population.

In addition, another body of research show that people who do not understand the language spoken in a given situation have less access to healthcare than those who understand the language (Dennis, 2015), in his research has shown that language barriers have been discussed extensively and the results show that they influence people's access to adequate healthcare services. Dennis is, for instance, among those who have argued that language and communication is a vital element when accessing medical services. Without effective health provider and patient communication in a language that both understand, there are exist risks of misdiagnosis, misunderstanding and poor medication.

Dennis (2015) adds that health care providers across countries have encountered language barriers and this has affected their abilities to offer good healthcare services. In one study,

patients with limited English who needed care but did not get, an interpreter reported that they did not understand their medication instructions.

Another perspective from a body of research examines access to healthcare among rural people vis-a-vis-urban population. In a research conducted in Canada, Lyn found out that rural population have less access to healthcare compared to urban population. Universal health insurance coverage is limited and therefore access to healthcare among the rural population is low. The results also show that rural population where people have lower economic resources people have inadequate access to health services as compared to urban population. Urban areas have better socio-economic infrastructure-incomes, education, occupations and wealth and these give them better opportunities and resources more than the rural population. This health inequality persists despite tremendous efforts by the Canadian government to provide equal access to all its citizens. This is a gap that requires further research and public intervention.

Access to healthcare is unequal in Canada because of unequal distribution of socio-economic resources. Those with lower disposable incomes, low levels of education and ranked low in employment were also more likely to visit surgeons, healthcare providers and other health outlets compared with those with more. This unequal distribution of social goods is an issue that requires prompt action. In not checked, health inequality would perpetuate for many years to come.

Health inequality has been shown to be a major problem in all the publications discussed in this study. It evident that the problem continues to perpetuate, claiming millions of lives in the globe. This publication contributes more knowledge in this field and the same will help mitigate some of the challenges faced in addressing access to healthcare challenges. Specifically, this publication complements and refines both qualitative and quantitative methods used in this study. The study provides more detailed information in explain complex issues. However, the

publication has some limitations that make findings more difficult to generalize. Some results are quite difficult to analyze.

A body of research shows that mentally ill people have less access to healthcare than other others who are not mentally ill (Marmot, 2010). These are people who are discriminated against due to their mental disorders. They experience all sorts of injustice in society let alone increased inequalities, health risks behaviors, reduced educational opportunities. The author clearly shows that problem of inaccessibility by the mentally ill persons. Mental illness is factor that determines access to healthcare. People who have no mental illness have better access to healthcare.

Marmot (2010) shows that despite spirited efforts, policy makers have not been able to address the problem sufficiently. This explains the gap that continues to affect mentally ill people. The study uses mental health, social class and access to healthcare as key concepts. This is useful in confining the study to the study variables. Marmot (2010) uses materialist approach as advanced by theorists like Karl Marx to show how resources are distribution according to class. Max Weber theory of social stratification is also implied in this study. Even further, Marmot uses cultural and social capital explanations to show how the mentally ill persons are discriminated in society and denied all the basics that could enable them access healthcare. These theories help illuminate the problems faced by the mentally ill people. The results show that mental illness affect access to healthcare. People who are mentally ill are discriminated and denied all opportunities to access healthcare. They end with bad habits that only alienate them further but also increase inequality in healthcare. This is a gap that requires urgent research and policy intervention. This literature has strong relationships with other previous literature addressed in this review. The publication identifies the problem and makes proposals on how the problem can be solved. Like the others, the research and policy recommendations fall short,

hence, perpetuating health inequality among the mentally ill people. But it is emphatic that mental illness affects access to healthcare. This knowledge is useful and it can be used to augment what others have said in the subject. It actually enriches the knowledge required to deal with the phenomenon. This publication therefore contributes to knowledge on how this problem can be addressed. The publication also helps to identify the gaps and see how new solutions can be sought. This publication helps to increase knowledge on the research area of the study. It also improves the capacity to search for information especially in area such this one. It gives opportunity for further search in books, articles and journals in a more effective and efficient manner.

Another study by international organization of migration (IOM) showed that adolescents from Africans, Indigenous Americans and Hispanics had lower access to healthcare services than white adolescents (IOM. 2001). These disparities are as a result of socio-economic status among the different races. The publication focuses on the distribution of access to healthcare services among different races in the United States. In this publication, the African Americans, the Indigenous Americans and the Hispanics get lower access to adequate healthcare services due to their ethnic and race. Race and ethnicity are therefore important factors in access healthcare. The publication correctly focuses on the problem to the study, namely inadequate healthcare for the African, Red Indians and the Hispanics in the United States of America. Race and ethnicity are important in the USA because they determine access to healthcare. The whites who are the majority have better access to healthcare. The study points out that the African Americans, the Indigenous Americans and the Hispanics have fewer socio-economic resources income, education, employment and wealth and therefore can afford access to healthcare. They have better opportunities and options to access healthcare compared to the firmer. This is important because it shows the problem of health inequality in the USA. This is the gap that has not been addressed sufficiently despite the fact that USA is a developed world.The

publications show that access to healthcare services is limited or disproportionate between the non-whites and the whites. The nonwhites get less access to healthcare because of their race and ethnic backgrounds. Access to healthcare was distributed according to resources; the whites had better socio-economic resources than the non-whites. The whites can access more healthcare services due to the health resources at their deposal including health insurances. This resource allocation had increased inequality in health care among the populations in the USA. This publication contributes to knowledge and provides some solutions to the problem.

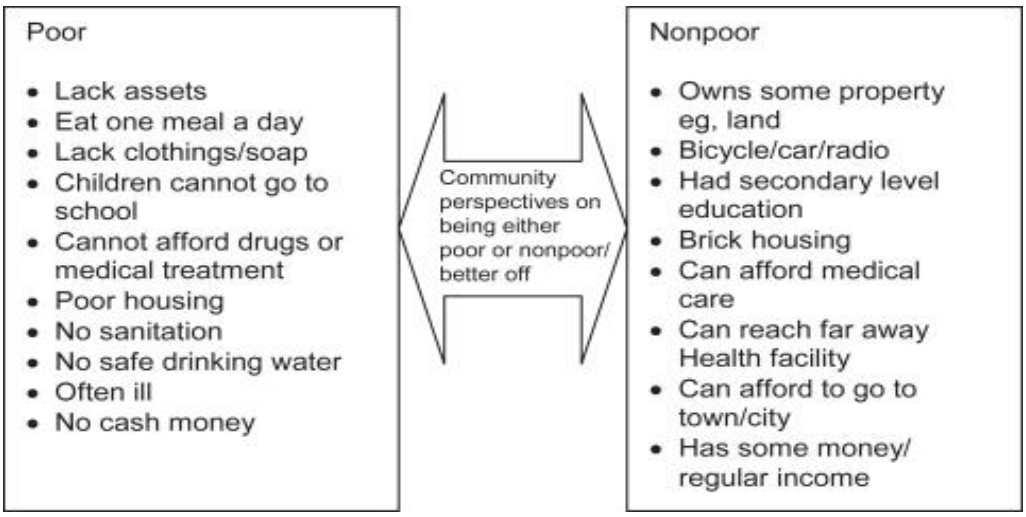
Research has been done and policy interventions have been put in place but access to healthcare continues to be a challenge. This publication therefore is important because it increases knowledge to the study of access to healthcare. The study therefore does not deviate from the field of this study, but merely adds knowledge. This publication helps this research to achieve its objectives. The key issues in this publication are that access to healthcare is not universal among the American citizens. The non-whites have less access to healthcare compared to the whites. The whites have better socio-economic resources than the non-whites. This places them at an advantaged position. Hence, they have better health outcomes, characterized by low infant and mortality rates. Above all, they have high life expectancy compared to the non-whites. Race and ethnicity were important factors that defined access to healthcare. They significantly influenced individual's ability to secure healthcare services.

White further confirms that people of this kind are from low socio-economic backgrounds and therefore end up with negative health results characterized by mortality rate and low life expectancy (White, 2002). Keruly also affirms that races of low income have poor access to public healthcare partly because of lack of insurance (Keruly, 2002). These are the same kind of people who do not get health services immediately due to lack of insurance covers; the healthcare are high and they cannot afford (James et al., 1999). In addition, Scneider shares the

same view that health services are seriously affected by lack of health insurance (Schneider et al., 2002).

Conversely, another study has shown that people with negative perceptions and perspectives have less access to healthcare than those with positive modes perspectives (Julie et al., 2004). The study focused on the poor as the most vulnerable group in society. The poor are vulnerable and bear the greatest burden of diseases. Perspectives and perceptions on dependent on a variety of factors, including: technical qualifications, accessibility to services, interpersonal and personal relations, availability of correct drugs, health supplies, medical staff, and amenities in medical facilities (Brawley, 2000). Julie follows up research process in the study. This systematic process makes possible to discern the concepts and their relationships. The study used community perspectives and perceptions as the independent variables and access as the dependent variable. The overall goal of the study was to probe the ability secure quality healthcare for the poor. Particularly, to show how perspectives and perceptions influence access to healthcare among the poor. This clarity of goals and objectives makes it easier for the research to proceed. The study focused on the poor. This is often the lowest social class which faces multiple socio-economic problems, resulting in poor health outcomes characterized by high mortality rates and low life expectancy. Yet, the ability to access proper healthcare is vital for promoting and maintaining overall health; it is also important in preventing diseases, reducing unnecessary diseases and even preventing early deaths. Figure 2.1 below shows the distinction between the poor groups and non-poor groups.

Figure 2.1: Poor and Non-Poor



Julie uses customized methodology to gather data, select samples and analyze and interpret data. The participants were those of low socio-economic status. This strategy enables the study to focus on specific characteristics of the respondents of interest to the study. The technique allows the researcher to rely on own judgment when choosing the sample. This is the strength of this study. Julie also uses various techniques to collect data: these techniques include Focus Group Discussions, In –Depth interviews, Key Informant Interviews amongst others. These are important techniques for collecting qualitative data. This is important in measuring the integrity and validity of the research findings. In addition, Julie gives comprehensive results of the study based on the methodology applied.

Perspectives and perceptions showed that the poor had poor access to healthcare. These perspectives and perceptions were modeled by factors such as availability of social amenities such as clean drinking water, good infrastructure, supply of sufficient medical equipment and medical supplies, good interpersonal relationships, as well access of services to the vulnerable populations. These perspectives and perceptions deny equal access to healthcare among the poor. This is the gap that needs to be filled. The results help the study to confirm or reject the hypothesis in the study. The findings show that perspectives and perceptions have a directly related to the access to healthcare services. This correlation is positive and forms the basis of

rejecting the null hypothesis. This study is therefore very important to the research problem being addressed in this study. The study contributes to more knowledge.

It is important that policy makers address the perspectives and perceptions of the poor on the areas discussed. Policy makers should focus and improve on factors that affect access to healthcare. In particular, they should address issues related with healthcare facilities, the inadequate numbers of healthcare staff and shortage of essential drugs, poor attitudes of the health staff, high costs of medical services, and inaccessibility of healthcare facilities among others. These factors have to be addressed so that the poor can access acceptable access to healthcare.

As discussed previously, disparities lead to ill health and therefore poor people living in developing countries are at higher risk (World Bank, 2000). The relationship between poverty and healthcare is quite complex; in this study, poverty leads to ill health but on the other hand, ill health maintains poverty. This relationship leads to an obvious conclusion that poverty is a significant factor in access healthcare. Those who are poor have less access to healthcare. Unfortunately, this assertion is biased against the developing countries. As see elsewhere in this stud, even the minorities, the black races and the Hispanics are in the U.S which is a very advanced country but have poor access to healthcare compared to the whites in that country; the blacks in the UK have poor access to healthcare compared to the whites, given that UK is a developed country. Poor people are found in all parts of the world, be they in developed or developing countries, only that the density of poverty is more pronounced in developing countries.

Aday's conceptual framework describes four dimensions of access, and they include the following: geographical accessibility, availability, financial availability and acceptability (Aday et al., 1974). In addition, Penchansky gives an analysis of the five dimensions of access

to healthcare; these include availability, accessibility, affordability, accommodation and acceptability (Penchansky and Thomas, 1981). This conceptual framework shows the determinants of healthcare services such as policy frameworks and macro environment, poverty levels and vulnerability, varying individual and household characteristics. These helps explain, predict and understand the phenomenon under investigation.

Mathonnat (2010) cites various challenges that need to be addressed in order to increase access to healthcare among the poor. Poverty is serious challenge to access to public healthcare. The poor in his view cannot afford costly healthcare and this leads to poor health. Those with resources continue to access public healthcare while the poor continue to register deaths. Poverty is therefore an important factor that has significant influence to access to public healthcare. These include finding ways that ensures that the poor or most vulnerable people have a say on matters related to new strategies, development, implementation and accountability in a way that guarantees improvement in access to healthcare among the poor themselves.

Pietta et al. (2004) observed that those with less social resources have less access to healthcare than those with the same. These resources include money, goods and services, and less tangible goods like love, affection, and status within society.This study shows that social networks, social support determine access to one's health. The study argues that secure attachments are necessary for food, warmth, and other material resources which all support access to healthcare. The research argues that all these resources including love, security, and non-material resources are all vital for accessing healthcare. This study also argues that life-course perspectives are critical for the development of bonds and attachments, which are all important to access to healthcare. In this view, secure attachments at infancy satisfy human needs and increases affection of bonds.

Another perspective comes Makaryus et al. (2005)who examined social networks such as size (the number of network members), density boundaries, and homogeneity, frequency of networks, extent of reciprocity and durations and found those with less social networks had less access to healthcare compared with those with the same. For example, patients with less information to physicians had less access to healthcare due to lack networks. There are also cases where some patients cannot identify their diagnoses on names of their medications at the discharge, indicating ineffective communication with the physicians**.**

Cassely (1976) examined social support and found that those without social support have less access to healthcare than those with same. McCrmick. (**2000)** confirmed that the elderly persons who are sometimes isolated had worse health access and this was compounded further by lack of health insurance**.**Cassely has shown that various types of assistance received from networks significantly influence individual's ability access healthcare services. In this study, social support provides resistance to morbidity and mortality (ibid). Less autonomy at work (, less job security all affect access to healthcare. Kelly emphasizes even further that stress negatively affect health; it reduces resilience and increases vulnerability to illness (Kelly, 1997). On the other hand, Siegrist puts emphasis on the fact that stress is harmful to health partly due to lack of rewards, benefits lost and this compels the vulnerable persons to addiction in high risk behaviors (Siegrist, 1998).

The study is concerned about access to healthcare services which is disproportionate among different groups in the population. Those with less social resources, social capital, social support and social networks have less access to healthcare. Social isolation is bad for heath and this has been demonstrated by many cases of unemployed and retired people as having poor health than the employed. Lack of these resources only increases infections and more death among the households (Kizitoet al., 2008).The key concepts in these studies are; access to healthcare;

social resources, social capital, social support systems and social networks. The social resources (social capital, social support and social networks) are independent variables which affect or influence access to healthcare (dependent variable). Kawachi and Berkman put considerable emphasis on social capital. They identified three ways in which social capital affects health and these include: high levels of social capital influences health through spread of healthy norms; social capital facilitates wider diffusion of health information and knowledge and other effects (Kawachi&Berkman, 2011). In addition, threats or unemployment and job insecurity affect access to healthcare (Catalano et al., 1992). These are important concepts that guide the study. They provide a structure for the study.

Psycho-social approach helps to explain the problem under review. In this explanation, lower socio-economic classes tend to experience more negative life events (White, 2002), less job security (Marmot, 1997), less autonomy at work and therefore end up with poor health. Kriegler discusses at length the increasing and decreasing life factors, In his analysis, culture influences health at different times in individuals be it in the past living conditions and events **(Kriegler, 2001).** However, Marxist and neo-Marxist theories are also at play, especially when faced with social class and its formations. Karl Marx and Max Weber are the lead proponents of these theories respectively.

Cultural explanations also help to explain the phenomenon. For example, cultural explanations have suggested that people in lower social classes prefer poor health lifestyles and habits, eat more fatty and unhealthy foods, tends to engage in habits such as smoking more and also tend to exercise less than either the middle or the upper classes. People of this kind have less social support and this affect their capacity to access healthcare (Elstad, 1998).

Bordieus has emphasized that culture determines or frames behavioral choices of the people; these include high risk life styles, smoking, drinking, and unhealthy diets (Bourrdieus, 1970).

This explanation also suggests that such groups have less to spend. Again the Marxist and neo-Marxist theories also apply here. Each theory has its strengths and weaknesses. These theories help to describe, define and explain the phenomenon.As explained, the results show that people with less social resources, social capital, social support and social networks, have less access to healthcare compared with those with plenty of these values (Kawachi&Berkman, 2011). Lack of these factors including threat to unemployment and job insecurity threatens access to healthcare; Kasl has even suggested that these factors explain the increased high blood pressure among the individuals without these resources (Kasl et al. 1980). Employment is a social resource, which differs according to prestige, qualifications and rewards and has profound influence on access to public healthcare (Gregoriaet al., 1997). In addition, Mare has argued that persons without these resources (socio-economic) have high mortality rates (Mare et al., 1990).These aspects greatly impacted individuals' ability to access to healthcare services. People in lower social classes suffer poor access than people in upper or middle classes.

These publications have considerable relevance to earlier publications discussed. They point to the fact that access to healthcare is dependent on multiple factors. These factors are not proportionately distributed and the upper and middle class have more and therefore have a better access to healthcare. The lower classes have less or none at all and therefore have less access to healthcare. This is a serious challenge for both researchers and policy makers. These publications contribute to more knowledge and the same is useful in finding solution to this persistent inequality in healthcare.

2.2.4 Institutional variables

Institutional variables are important in explaining the causal relationships between the variables (I.V & D.V). They impact access to public healthcare services across the nations. For instance, in the developed countries, the perception of unfair healthcare services accessed by low

educated and low-income earners due to complex health financing systems remains rife. Moreover, such perceptions of inequality due to institutional factors such as healthcare financing systems contribute to the increasing debates and politics on the appropriate strategies to enhance equal, affordable, and accessible public healthcare services in developing and developed nations. Other institutional factors that influence access to public healthcare services include health financing systems, human resources, drugs and supplies, health facilities infrastructure, and waiting time, among others. According to Immergut and Schneider (2020), public financing by the government promotes access to public healthcare services and reduces health expenditure for the populations by controlling costs, distributing resources, and establishing universal health.

On the other hand, advancing private finance systems such as individual out-of-pocket payments deepens access to public healthcare services inequality. It lowers the general public's confidence by locking out low-income earners and disadvantaged families from accessing quality services. For instance, individuals in developed nations have low confidence in public hospitals when public financing is insufficient.

Similarly, in developing nations such as Nigeria, the affluent and poor have little confidence in the public hospitals, which operate with little financing from the government. The public health system in Africa remains under poor conditions due to little funding from the government, and the rich are notorious for pursuing quality healthcare in foreign nations in Europe, North America, and Asia while the poor are left with no option but to attend the poor quality public healthcare services (Oleribe et al., 2019). Therefore, health financing plays a significant role in determining the quality of public healthcare services delivered to the general public. Another component of the institutional factor that influences access to public healthcare services among populations includes the availability of drugs and supplies in public health facilities. According

to Ashigbie et al. (2020), the availability and affordability of non-communicable diseases drugs in public healthcare facilities in Kenya, similar to other low-and middle-income countries, remains poor. Moreover, only 19% of the population has medical insurance. Therefore, the majority of the people are left to access drugs throughout of pocket, which is significantly unaffordable.

On the same note, weaknesses in the supply chain of medicines in public health facilities are a common problem. Ashigbie et al. (2020) note that delay in the supply of drugs to public health facilities result from the poor relationship between the supplier and retailers (facilities) and funding shortfalls. The challenges of availability and affordability of medicines and supplies on time lead to preventable deaths and jeopardizes accessibility to quality healthcare delivery. Therefore, drugs and supplies serve as a critical component of institutional factors that can potentially promote or inhibit access to quality public health care. Another issue of institutional aspect that determines access to quality public health care includes waiting time. The developing nations are in dire shortage of health professionals and delay resulting from waiting time to see specialist results in increased deterioration of patient's health status. For instance, Leitemu and Gitonga (2019) confirm that in Tanzania, access to quality health is significantly jeopardized by delays to see a specialist as the average waiting time to see a doctor ranged from 4 to 6 hours per patient. Such a sad state undoubtedly reduces the morale and risks augmenting the health situation of patients, thus leading to negative perceptions to access public healthcare services.

Another issue touching on institutional factors that determine access to healthcare services that deserve focus includes human resources within the healthcare system. Pan American Health Organization (2017) reiterates that human resource is one of the ingredients critical in the realization of universal access and universal health coverage in the American region.

Accordingly, employing, training, and equipping healthcare professionals and personnel plays a significant role in ensuring improved access to quality public healthcare services across the nations. However, poorly trained, equipped, and understaffing health professionals impede access to quality public healthcare significantly for populations. Specifically, developing countries found in Africa continue to grapple with challenges of human resources as public healthcare facilities are characterized by understaffing and poor equipping of health professionals, as witnessed in Nigeria (Oleribe et al., 2019). Therefore, institutional factors like demographic and socio-cultural factors significantly influence access to public healthcare services.

The publications focused on the following themes: health policies, public participation, governance and leadership, availability of resources, infrastructure, health financing, health workers, health facilities and health insurance. And Gulliford emphasizes that access to healthcare is measured in terms of affordability, approachability and suitability but not only supply of health facilities (Gulliford et al., 2002). This is the only way in which all the population can access public healthcare regardless of social status (Shawn et al., 2014). This is important because it is the combination of all these factors that constitute a good health system. The publications show the problem being addressed, the concepts used and how they are defined, theories applied, results and conclusions, relations with other publications, benefits of the publications and how they contribute to understanding of the topic, key insights and arguments of the study and strengths and weakness of the publications.

Government is a major player in the health sector but there are other stake holders. Other stakeholders include faith based organizations, and private health facilities, households, community and others. The major stakeholders in healthcare system are patients, physicians, employers, insurance companies, pharmaceutical firms and government. They provide, receive,

manage or pay for healthcare. They have interest in health and they are critical in determining health outcomes. Like the previous studies, these are independent variables (intervening variables) that explain the relationship between the two variables in the study (social class and access to public healthcare). They are the hypothesized variables used to explain causal links between the two variables in the study. They are predictor variables of the dependent outcome.

Access to healthcare is a fundamental health policy issue. However, the factors that constitute to access to healthcare have not been well understood. Accessibility of healthcare services is vital to promote and maintain proper healthcare, and through early diagnosis prevent and manage diseases, reducing unnecessary patient disability and premature deaths, and achieving health equity and democracy for all households in the County. This is so because access to healthcare currently is unequal: the distribution of access to healthcare is unequal between social groups in the County.

This inequality in access undermines growth and development of the economy as unhealthy population can be counterproductive in economic development. Failure to access healthcare increases poverty and marginalization among the lower social economic groups in the County.

Kaseja proposes a model that integrates decentralization and health system commodities as a panacea to healthcare problems in Africa (**Kaseja, 2006**). These components comprise information, delivery, and outcomes systems. In addition, Kaseja suggests that dialogue among the stakeholders is vital and that would increase demand, responsibility and accountability in access to healthcare matters. On the other hand, Odaga argues that unless these reforms are implemented, access to public healthcare will still be a daunting task (Odaga, 2008).

This study primarily stresses the importance of these factors and how they influence their impact on access to healthcare services. Like previous studies, access to healthcare increases

productivity, educational performance, life expectancy, savings and investments (Kaseja, 2006). This is importance reflects the importance of the study. The study is concerned about access to healthcare because of these virtues. This is central to this research. Access to healthcare has considerable outputs including: increase in equity, economic returns, and social and political equity. Again this study reinforces the importance of access to healthcare as previously discussed, increasing the validity and reliability of the research.

Never the less, the study cautions that access to healthcare cannot be achieved because of the many challenges in Africa, including Kenya the focus of this study. These limitations have increased inequality in access to healthcare globally, leading to millions of death (Von Schirnching, 2002). According to this study, disparities in access to healthcare have increased with a third of the population in poverty (Taylor and Taylor, 2002). The study shows that millions of children have died to preventable diseases to perpetual inequality in access to healthcare (Gwatkinet al. 2000).

This explains why Mosadeghrab emphasizes that health facilities be expanded to the lowest levels in order to provide access to all communities (Mosadeghrab, 2003). Further, Wakida puts emphasis to the fact that that health services should be decentralized to rural areas (Wakida, 2005). This author attributes these mortalities to scarcity of resources. The importance here is that lack of resources, lead to death because the people cannot access healthcare-resources influence access to healthcare.

Muchkuri et al., (2009) also discusses these themes extensively and applies similar methodologies as Kaseja to investigate the problem. Both conclude that these health facilities are scarce and therefore inadequate to provide adequate access to healthcare. This is despite the various interventions by the government and other stakeholders. This is the existing limitation

that the study attempted to address. This further explains why 80% of lives are lost due to infectious diseases (Ndeteiet al., 2013).

Muchukuri uses methodology that is quite appropriated and customized to suit the study. Field surveys are used in various urban settlements in Nakuru; focus group discussions are used to gather qualitative data from various respondents including political, religious leaders, health personnel, non-governmental organizations, and the community. Interviews with key government officials and key informant interviews help increase the validity and reliability of the data collected. This gives us both qualitative and quantitative data needed for the study (Polit& Hunger, 1999).

Muchukuri (2007) explicitly show that access to healthcare is limited by these multiple factors. A good health system is vital. This means that the population should have good health in order to combat illness without financial constraints or burdens. It is important to promote good health, prevent and manage diseases, reduces illness, and ultimately prevents early deaths. We should aim to promote health equity for the entire population. This ambition cannot be realized unless these barriers are removed from our environment. The study shows that although literature has been published, results still show that lack of these resources adversely affects access to healthcare. These resources are not having enough despite the fact devolution had brought about considerable changes in the health sector. There are counties that have less of these factors, and therefore have limited access to healthcare. At the household level, there are households that are affected by lack of these resources, and therefore have less access to healthcare. This therefore means that unequal access to healthcare is felt both at a household and county level. The failure to provide all these resources affects health delivery and this has significant consequences on household uptake of healthcare services. This disparity affects the efforts of the county governments to increase access to healthcare since devolution in 2013.

Another body of research shows that health policies affect access to healthcare in a very significant way. Policies set out general plan of action that is used to guide desired health outcomes. They are fundamental as they provide guidelines to the health providers about how to make decisions. Policies define visions for the future which in turn help to establish targets and points of reference for the short and medium term of health systems. They help clarify priorities; they establish roles and expectations for different groups, whether doctors, nurses or administrators. Policies also provide standardization in daily operational activates. They communicate to employees the desired outcomes of the organization. They help employees understand their roles and responsibilities within the organization. These are independent variables (intervening variables) that explain the relationship between the two variables in the study (social class and access to public healthcare). They are the hypothesized variables used to explain causal links between the two variables in the study.

It has also been shown that devolution as a policy dimensions affects access to healthcare. The study defines healthcare and outlines why access to healthcare is very important. This definition of concepts clarifies issues for both the dissertation author and audience. This study puts emphasis on the importance of availability and access to healthcare both at a local and on a global level, and all levels state that access to healthcare should produce a healthy, skilled and productive population (WHO/SDG, 2015). This is in line with the overall goal of this study, thus: to increase access to healthcare for the whole population.

This research also shows that access to healthcare is deemed a basic human right guaranteed by the constitution of Kenya (Constitution, 2010). The study clearly states that access to healthcare should be universal for the entire population. This desire is guided by various health policies including Health Policy 2014-2030 that guides the achievement of constitutional objectives. The long term goals are contained in Social Pillar in the Vision 2030 **(**GOK, 2014).However,

these constitutional imperatives are constrained or determined by various factors. The overall goal of the social pillars is to guarantee the provision of equitable, equal and affordable healthcare services to all Kenyans.

The publication shows that the problem the author is addressing is unequal access to healthcare. Poor policies affect access to healthcare. The key variables are health policies, access to healthcare and constitution of Kenya.

This publication uses behavioral theories to discuss the effect of policies on access to healthcare. The study used framework for linking health inputs (investments) and outputs (outcomes), (GOK, 2014b) to study the effect of health policies on ability to secure healthcare. The findings indicate that good policies lead to improved access, improved demand, and improved quality of care.

The publication therefore concludes that access to healthcare is influenced by good and pro-people health policies. Policies that poorly designed, poor focus and unmatched objectives affect access to healthcare services. Therefore, it is imperative that policies are made good and objective oriented in order to increase access to healthcare. Failure to design objective oriented policies lead to poor health and increased infant and mortality rates especially among the poor.

Kimani and Maina (2015) identified how policies as (an independent variable) affect access to healthcare (dependent variable) and what needs to be done to improve access to healthcare. This study supports previous studies by adding more knowledge in the field of research. This knowledge not only helps researchers and policy makers but households reduce direct and s indirect spending and thereby preventing catastrophic health expenditures. The main arguments are that poor policies affect access to healthcare and it's the lower classes that depend on public medical facilities who suffer most. They had narrower choices in the private healthcare services.

On the other, the upper and middle class can still access healthcare from private facilities. This publication supports and analyses quantitative data to more refined information that helps explain some complex issues in the study.

A study by Esther et al. (2018) examined governance and leadership. The study shows that governance and leadership affect access to healthcare. Survey shows that strong governance and leadership are necessary to ensure good access to healthcare. They ensure that resources are adequate and used for the intended purposes, namely to improve access to healthcare. Good governance and leadership at all levels is necessary to ensure that resources to the health sector are adequate and improve healthcare for the population. Efficient governance and leadership increase efficiency, effectiveness, equity, response and sustainability of health services. All these lead to positive health outcomes.

Figure 2.2: Leadership and Governance Functions

A study by Atela et al. (2015) show that poor governance and leadership (lack of efficiency, effectiveness, responsiveness, transparency and accountability) affect access to healthcare.Health systems which are poorly managed affect how low income groups access healthcare services, since they depend largely on public health facilities. Poor governance and leadership lead to poor health outcomes and the lower social class are most affected. The upper and middle class largely depend on private or specialized public wing, which are managed very well, for access to healthcare. The upper and middle class have better opportunities and resources but the lower social classes do not have the options. It is therefore important that public facilities dependent lower social classes are managed well. They must be efficient, effective, responsive, transparent and accountable so as to increase access to healthcare. If these facilities are badly managed, poor health outcomes will affect the lower social classes, leading to increased premature death. This has considerable negative impact on the growth of the economy and national development in general. This study increases existing knowledge on the problem under investigation and does prevent catastrophic expenditures among families.

Audibert et al. (2005) show that health infrastructure affect access to healthcare. Audibertet al (2005) clearly spells out without adequate infrastructure, access to healthcare is limited and this affects populations who cannot access private facilities. In addition, Audi Bert shares the same sentiments that infrastructure is an important factor in access to public healthcare. In fact, the study makes even more emphasis on the importance of infrastructure in access to healthcare. Other health infrastructure has also seen major upgrade including water and sanitation. Most health facilities have piped water and boreholes in at least 61.6 facilities (GOK, 2017). Most facilities have refrigerators, with over 50% in rural areas and 67% in urban areas (Health Assessment Survey, 2017). However, essential medicine is inadequate (The Health World Report, 2006). Lack of or scarcity of these resources has adversely affected access to healthcare.

The study is addressing the problem of unequal provision of healthcare to the population. The lower social class has less access to healthcare due to their complete dependence on public healthcare facilities. These public health facilities lack the necessary infrastructure. But the upper and lower class largely depend on private health facilities which have excellent infrastructure. This is due to their better socio-economic position and access to a wider scope in opportunities that would allow them to access such specialized facilities. Infrastructure is poor in public health facilities despite considerable resources voted to them.

The key concepts in the publication include health infrastructure, access to healthcare, and health systems. The study uses a framework that links health investments (inputs), outputs and out comes (GOK, 2014b). Investment in the Health sector leads to increase in access in healthcare services, increased demand of medical services and improved quality of care. The findings indicate that the ability to access healthcare services is limited due to lack of poor infrastructure. Lack of adequate digital x-rays, digital ultra sounds, specialized equipment and son affect access to healthcare. Most public facilities lack adequate infrastructure, especially medicine or essential drugs. The lower social classes are affected most as they solely dependent on public facilities for healthcare. Unless urgent measures are implemented, lack of infrastructure in our health facilities can lead to more infant and morbidity rates among the population. This has the effect of derailing economic growth leading to increased poverty.

Wafula (2018) examined availability of health facilities. The study found that there has been massive expansion of health facilities in the recent past. Over 8,616 facilities were increased to 11,324 in 2017. This increase saw also apparel increase in density from 19 to 24 facilities for 100,000 people (MOH, 2017). According to the World Health Organization every 30,000 people should have access to 15 healthcare facilities, 45 dispensaries should be available for every 19,000 people and each person should live in a 5 kilometers radius from a healthcare

facility. Unfortunately, those who cannot afford private facilities like the ones in Kenyatta National Hospital end up with very poor health outcomes (Kimalu, 2001). Brawley has also discussed extensively the impact of poor infrastructure, poor health workers working conditions, inadequate supplies and the general shortage of drugs in public health facilities in Uganda (Brawley, 2000). Unless health systems address these concerns, access to public healthcare remains a mirage to the wider population in the County. The study is addressing access to healthcare that is inadequate among the population. Access to healthcare is inadequate because the delivery system does not have adequate facilities to promote access to healthcare among the entire population.

The reviewed studies indicate that access to healthcare services is limited especially in the lower social classes due to lack or poor health facilities. The upper and middle class shun public health facilities and prefer private or specialized public facilities for their healthcare needs. The upper and middle class has better socio-economic opportunities and this provides them the necessary opportunities and resources to access private healthcare. However, the lower social classes have fewer of these socio-economic and financial resources and therefore cannot access private healthcare. Because public facilities are old, dilapidated and ill-equipped, there is no care provided. This means that these categories of social class go without healthcare. This is the problem being addressed in the study. This is a very serious situation as the lower class constitutes 70% of the total population in the County, whose health outcomes are characterized by high infant and morbidity rates, and low life expectancies. This sick population cannot contribute to GDP and therefore undermines growth and development. Unless this scenario is addressed urgently, millions of households in the lower social class will perish and this has serious impact on the overall development of the Country.

Further, another perspective comes from Kaseje (2006). The study shows that demand has been on the increase due to increasing population size and incidence of diseases. This demand has been escalated by increased millions in the population against a background of declining financial resources. In Kenya, medical personnel increased at a rate of 8% annually between 2013 and 2016 (GOK, 2016). WHO recommends that 3.0 medical and health officers should only serve 10,000 people. However, it was that in Kenya 10,000 people had access to only 0.25 of medical officers. It was also observed that there was a shortage of 3,801 general practitioners and 6,696 clinical officers in 2015 (MOH, 2014c); Moreover, at the primarily level 10,000 people were served by 13.5 health officers. There are over 5,000 doctors in Kenya but only about 1,000 works in public facilities (Wang'ombe et al., 1998).This leaves the majority of the population without adequate quality healthcare. The majority cannot afford private healthcare and this only increases inequality in access.

In other countries in Sub-Saharan Africa, shortfalls show that clinical officers stood at 93%, doctors at 82% and of these, 65% were male (with the distribution standing at 91% laboratory technologists, 84% clinic health workers, 75% doctors). At the national hospitals level, 2015 data show that 59.8 were females (29% doctors (KiambatiandKiio, 2013). These disparities are explained by gross –under production natural attrition, retirement and migration of professions all conspired to reduce access to healthcare among the population. The study is addressing inequality or inaccessibility of access to healthcare among the people. This is the problem in the study. Over 70% of the households in Nairobi County have limited or no access to healthcare, compared to about 10% and 20% of upper and middle class who have better access to healthcare. This health differences arise as a result of unequal distribution of socio-economic resources. The upper and middle classes have access to these socio-economic resources, while the lower classes are deprived.

Another body of research examined health financing and the results show that that low funding affects access to healthcare. Audibert, de Roadenbeke again shows that low financing leads to poor health outcomes (Audibert, de Roadenbekeet al., 2005). Furthermore, poor health outcomes are primarily caused by less financing (Dukhan, 2010. This poor state of healthcare is further explained by the fact that only the high income population can access healthcare; the majority have limited care at all (Wamai, 2004). The poor have less access due their low income status. The can neither afford medicines nor service provided at private health clinics. This leads to high mortality rates and low life expectancy levels. Poor financing is therefore an important measure of access to public healthcare.

The Kenya Government depends on its contributions, donor funding, private sector and households/out-of-pocket expenditure (GOK, 2012). The government expenditure on health has been declining over the years: 5.2% in 2011/12, 6.1% in 2012, 6.8%, and 6.7 in 2015/16 of total expenditure (GOK, 2012). The total expenditure failed to meet 15% recommended by African Union (AU, 2001). Out-of-pocket spending continues to be the major expenditure for funding, being 24% of total health expenditure in 2015/2016 (GOK, 2015). Health financing affects the capacity of health systems to equip and provide all the infrastructure need to support effective healthcare. The lower social classes who rely on public health facilities cannot access healthcare because of the poor funding. On the other hand, the upper and middle class have options to use private healthcare and therefore don't have to worry about underfunded public facilities.

The study examined health insurance and the results show that lack of insurance coverage affects access to healthcare. Health insurance has been found to be good for increasing access to healthcare. National Hospital Insurance Fund has since 2013 many significant changes aimed at improving insurance coverage. It has focused on management, membership and accounting systems. It has increased membership to about 160, 000 households, and targeted 70% for the

financial year 2018/2022. So far it has realized 33 billion in the current year, and 45 billion is expected in 2022. New strategies have been designed to include health subsidy programs for 41, 666 older persons with sensitive diabetes. However, only about 10% Kenyans have health insurance but even then, private insurance is not available to the lower class; it is only the upper and middle class who have access to private insurance (Kimaniet al. 2012).

2.3 Research Gaps

Most of the scholarly publications have not adequately explored the relationships between the variables. Such under-explorations explain why access to healthcare persistently remains unequal between social groups. The lower social groups and the most vulnerable ones do not access full healthcare. The most vulnerable populations including women, children, street families and PWDs persistently continue to have limited access to healthcare. Unanswered questions regarding these issues have left many lower households without sufficient basic essential goods and services, and this ultimately affect access to healthcare. Limited explorations have also left many informal settlements where the majority live, without clean water and sanitation. Similarly, unanswered questions in the existing publications have left many persistent socio-economic inequalities among the social classes an attended to. Distribution of socio-economic resources has not been adequately defined and this explains the persistent inequalities in access to healthcare.

Evidence in all the publications studied show that relationships between socio-cultural influences and access to public healthcare services have not been properly answered and this explains why uneven distribution persists between social classes. For example, migrants, people with disabilities, women, and children have less access because adequate information is not available for policy actions. Topical areas like Communication, religion, social capital have not been sufficiently researched on and this explains why access to healthcare remains a challenge.

In general therefore, inadequate information is not available with regard to equipment, medicine, health personnel, financing and insurance coverage in the County. This failure to link these independent variables with dependent variables (access to public healthcare) has limited the County's capacity to address the problems afflicting health sector.

2.4 Conceptual Framework

This study chose a Conceptual framework that would help address the deficits identified in the empirical literature. Conceptual framework is an analytical tool used to get a comprehensive understanding of the phenomenon. It is used to explain key concepts and the relationships between them that need to be studied. It is a concise description which shows the major concepts, hypothesized relationships and the linkages among them. It emphasizes on how variables interact under given conditions. It establishes a perspective through which the researcher views the problem under investigation. It increases clarity of the research problem.

It also provides justification for the study based on either formal logic or experience. As such conceptual framework consists of an argument, which incorporates different views leading to adoption in some ideas or concepts in favor of others. It is therefore an argument that the concepts chosen (Independent variable: Social class /using various explanatory intervening variables) and (Dependent variable; Access to public healthcare).

The model identified assumes that all important factors converge in order to provide maximum access to healthcare. Such factors include the many dimensions of access to healthcare; availability of services, affordability, transportation, health literacy, skills in communication with health givers and social support among others. On the other hand, health care consumers need skills in health matters.

Health services have to go through multiple processes to access healthcare services (Sofaer, 2009). However, the concept of access entails healthcare opportunities and constraints. Access to healthcare requires individuals to respond to health needs, pursue opportunities and manage constraints. These processes occur in the contexts of economic and environmental conditions that are quite often experienced differently by different social classes. Addressing barriers to access is essential to reducing health inequalities and increasing access to healthcare.

The study presents an overview of existing perspectives of access and a conceptual model that synthesizes social class and access to healthcare. The framework guides research on access to healthcare among different classes.

This study is informed by areas of earlier research that address access to healthcare. These perspectives answer the research questions guided by the intervening variables such as demographic, socio-cultural and institutional variables. These hypothetical variables help to explain the causal relationships between the variables in the study. These intervening variables are also used to frame both the research questions and the objectives of the study. The research questions are as follows:

- What impact does social class have on access to public healthcare?
- What impact do demographic factors have on access to public healthcare?
- How do socio-cultural factors influence access to public healthcare?
- What role do institutional factors play in access to public healthcare?

One perspective comes from a body of research that examined social class in the USA. For example, the study finds that access to healthcare is not evenly distributed between the different races living in the USA; the Blacks, the Red Indians, and the Hispanics. The study examined

color and social cultural factors and concluded that the whites had better access to healthcare. This was because of the fact that they had access to high incomes, better education and good employment opportunities that gave them insurance coverage. The non-Whites have fewer incomes, education, and occupations, hence, have less access to healthcare.

These outcomes borrow heavily from the Marxist stratum model which divides society into a simple hierarchy of working class, middle class and upper class. The outcomes also relate to the Weberian socio-economic approach which correlates access to healthcare with incomes, education and employment.

Another body of research examined gender iniquities; it focused on access to healthcare by pregnant women (WHO, 2011). The results show that pregnant women lacked access to qualified healthcare and emergency services, contraceptives and therefore could not prevent pregnancies (Stevens RD. 2000). Most of these deaths occur in Africa and Asia mainly (WHO, 2005). Maternal health services need to be used to stop these deaths (Carro G. et al. 2000); a skilled child birth is important to avert such deaths (Koblinksky MA. 1999) and delivery at health facilities is important to stop such death amongst pregnant women (Ronsmans C. 2006).

Studies also examined access to healthcare by migrants (Carmona R. et al. 2014). The findings show that immigrants lack socio-economic and socio-cultural benefits and therefore have less access to healthcare (Almeida LM. et al. 2013). Due to this failure to access healthcare, they have high mortality rates compared to on-migrants (Avila RM et al. 2013).

In addition, other studies focused on rural-urban settings. The findings show that rural populations, for example in Canada, have less access to healthcare compared to the urban population; access to healthcare lacks equity (A day CA. 1973). Those in the rural areas have less access to healthcare compared to the urban population.

Another research on elderly people shows that they lack adequate access to healthcare (McCormick, MC. et al. 2000). Those more than 65 years lack health insurance and therefore face many challenges in accessing healthcare (ibid). Further research shows that adolescents of African, Indian and Hispanic races have less access to healthcare compared to the white adolescents in the USA (IOM, 2001). This was partly so because their parents or their backgrounds lacked better incomes, education, employment and occupations.

Another body of research shows that lack of access to modern facilities, infrastructure, health personnel, health financing, and insurance and so on affect access to healthcare, especially among the lower social economic groups (Kaseje D. 2006). These groups lack access to healthcare due to poverty and lack of socio-economic resources like incomes, education, and occupation amongst others. Poor institutional resources leave them with limited options in access healthcare. The upper and middle social class have the option to get to private health facilities where care if good and affordable. The majority of the population has to rely on poor public facilities to access healthcare.

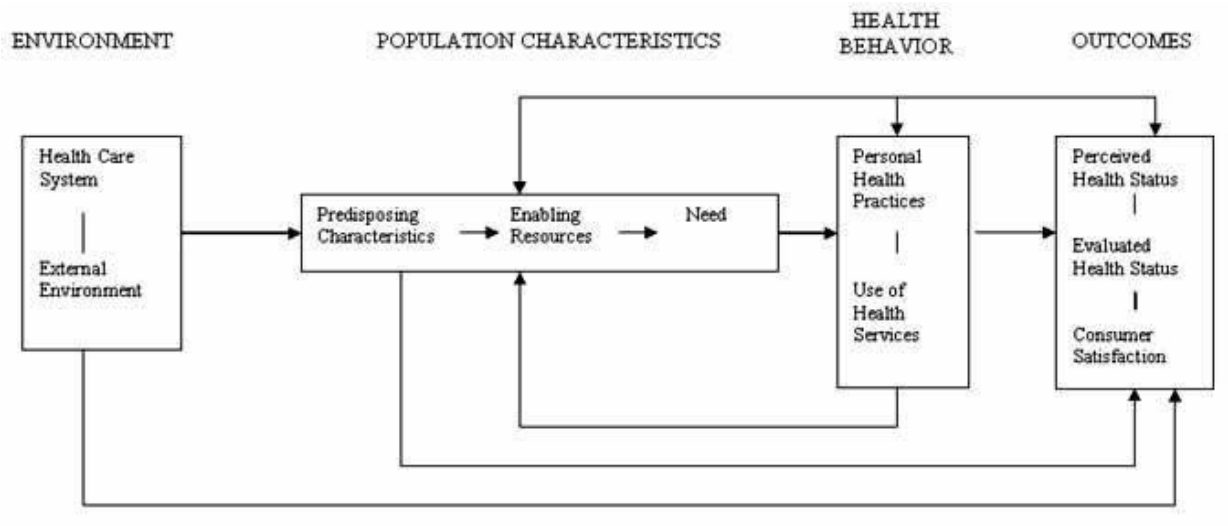
Many other factors that affect access to healthcare are included in the review; demographic factors; age, gender, income, education, employment, marital status, wealth; socio-cultural factors; culture, social resources, social capital, communication, attitudes and habits among others (Keruly JC. 2002; Schneider EC. rt al. 2002).

The conceptual model proposed for adoption in this study is the behavioral model of health services developed by Ronald Andersen, (Andersen, R. 1968). This model focuses on three dimensions: predisposing, enabling and need factors (Andersen, R. R. 1995). Predisposing factors include age, sex and race/ethnicity. In the study these are shown as socio-demographic factors that indicate the social status of the individual. These factors influence access to healthcare. This section also includes health beliefs, attitudes and values that have influence on

access to healthcare (shown as socio-cultural factors in the study). Other enabling factors include income and insurance. These are factors that facilitate or limit access to healthcare. The need factors include patients' perceptions and health needs.

These three are factors that influence access to public healthcare. This model acknowledges the significance of external factors that include physical, political and economic aspects of the environment (Andersen, R. 1995). The proposed model is as shown in figure 2.3 below:

Figure 2.3: Andersen Conceptual Framework



The model includes the basic structure of the behavioral model of health services. This model shows the various factors that influence access to healthcare (phenomenon). In the model, the predisposing, enabling and need factors (Andersen R. 1995) influence access to healthcare. In this model, the individual is the unit of analysis. A person's demographics, for example, income, education, occupation, and communication skills are important factors that influence access to healthcare. These are used in the study as demographic factors.

Other factors are socio-cultural factors which include culture, values, habits, social capital, social support, social cohesion, language, and others also influence access to healthcare. For

instance, social support may hinder or influence access to healthcare; social cohesion too has influence in access to healthcare (Musa D. et al. 2009).

A range of factors influence access to healthcare. These include links between health providers, official office operations, communication skills, respect for patients and provider perceptions, quality of relationships between patients and health providers: education, employment etc (Andersen, R. 2002). These factors influence access to healthcare.

Then, there is the delivery system, supply of providers, and services available (Andersen, R. 2002). The other includes the market dynamics which include payment systems and insurance coverage (Cunningham, PJ 1999; Rosenthal, MB. et al. 2005). All these factors seemingly influence access to healthcare, but are not on their own sufficient to influence access to healthcare.

Andersen also cites the social environment as critical in its role on access to healthcare. The elements in the social environment include but not limited to social relationships, social cohesion and support, trust, and civic engagements (these are socio-cultural factors in this study). These elements constitute to the variable of social capital. Social capital has been linked to increased access to healthcare (Kawachi I. et al.2011), lower mortality rates (Hatchinson, RN. et al. 2009), high physical activity (King D. 2008), lower likelihood of smoking (Mohnen, SM. et al. 2012) and lower use of alcohol (Winstanley, EL. et al. 2008). All these factors affect access to healthcare.

Other important factors are infrastructure, roads, public transportation, health facilities, health financing, health staffing, health policies and even governance (these have been used in the study as institutional factors). All these in one way or another affect access to healthcare. Others include mutual trust, and respect (Sofaar, S. 2009).

Section 2.6 shows the hypotheses within the conceptual framework of this study. There is a positive a positive influence between the independent and dependent variables. In hypothesis one, demographic (predisposing) have a positive influence on access to healthcare. In hypothesis two, socio-cultural factors (need) have a positive influence on access to healthcare. In hypothesis three, institutional factors (enabling) have a positive influence on access to healthcare.

Andersen behavioral model therefore helps to explain the factors that influence access to healthcare. It illustrates how variables are related in the study. This model also provides basis for establishing the hypotheses for testing. In the study the hypotheses are broken into three.

Demographic factors defined by income, education, employment and occupation have profound influence on access to healthcare. According to Karl Marx, these factors created class divisions in society. Those with these resources had better access to healthcare compared to those without. In his analyses, these were the bourgeoisies who own the means of production. On the hand, under this capitalist system, the proletariat had least access to healthcare, because of their deprived position in society. It is for that reason that Karl Marx advocated for a classless society, where human needs and not profits mattered.

But this is just utopian as it was impossible to create a classless society anywhere in the world. Even where communism has been attempted, classes still emerge. Distinctions of wealth, income, education, culture or social networks might still emerge. Exploitation and poverty persist despite efforts to abolish them. A revolution to create a more equitable distribution of wealth and political power would still not be possible.

Even where Max Weber preferred provision of equal opportunities within a competitive capitalist system, the results would not be any different. Class, status and power would still

classify society into hierarchical categories and the class at the top would just act like the Marxist bourgeoisie.

2.5 Summary

This chapter had four sections namely, introduction that outlined the importance of the topic and the problem under investigation, the literature review of relevant literature under three explanatory variables: demographic factors (disposing factors), socio-economic factors (need factors) and institutional factors (enabling factors).

The literature showed that people of lower socio-economic status had less access to healthcare compared to those with high social economic status. They had less access to healthcare, due to their deprived and disadvantaged position in class social hierarchies. This is what Karl Marx termed “the proletariat”. The policy makers had not adequately addressed theses lack of social goods and if they did, they were lopsided in favor of the high social economic status. This category of social groups ended up with poor health outcomes, characterized by high infant and mortality rates; and low life expectancy.

On the other hand, socio-cultural factors addressed migrant status, discrimination among people with mental illness, racial disparities and language barriers, age factors among the elderly people, social capital values and culture among others. The literature shows that people in these categories lacked access to healthcare, due to their positions in society. They were isolated from the main stream of the population and subjected to deprived situations. According to Max Weber, these are people in low class, without prestige, social honor or power in society.This increased poverty among them, making extremely difficult to access healthcare. The policy makers did little to increase socio-goods among these people and these compounded their health outcomes.

Similarly, socio-groups with less social status positions and deprived from normal life conditions failed to access healthcare in private or high income health facilities in public sector. The facilities including poor governance in the health systems, poor delivery of services, lack of medicine, drugs, equipment, lack of transport, poor health facilities, low level funding and lack of adequate insurance among pathetic social conditions limited access to these lower social status and dismantled groups. Consequently, they ended up with poor health characterized by high infant and mortality rates; and extremely low life expectancy. The policy makers invested less in public health in proportion to the population.

A persons' social class has significant impact on physical health, ability to receive adequate access to healthcare, and life expectancy (Barr D. 2008). In this scenario, lower social class people experience a wide array of health problems as a result of economic status. They are unable to use healthcare as often, and when they do, it is of lower quality. This increases mortality rates due to low or non-life insurance coverage (William, M. 2010).

The Conceptual Framework aims at demonstrating the factors that lead to the use of health services. The model synthesized the concepts of demographic, socio-cultural and institutional factors as causal and moderating factors in access to healthcare. The Andersen conceptual framework focuses on the individual as the unit of analysis. It adopts the health outcomes as the end point of interest. The model guides future research on the factors that influence access to healthcare. The model posits that these causal factors are important in access to healthcare.

2.6Hypothesis of the Study

This study is guided by the intervening variables (demographic, socio-cultural and institutional). These are explanatory variables that attempt to show the causal relationship

between independent variable (social class) and access to public healthcare (dependent variable).

The study sought to address the following hypothesis;

i. H_0: There is no significant relationship between demographic variables and access to public healthcare services

   H_1: There is a significant relationship between demographic variables and access to public healthcare services

ii. H_0: There is no significant relationship between socio-cultural variables and access to public healthcare services

   H_1: There is a significant relationship between socio-cultural variables and access to public healthcare services

iii. H_0: There is no significant relationship between institutional variables and access to public healthcare services

   H_1: There is a significant relationship between institutional variables and access to public healthcare services

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides details on the methodological approach used in the study. The elements used include research design and its related components, target population, sample design, data collection methods and the procedures. The chapter also comprises the data analysis methods employed. The chapter finally discusses validity and reliability issues on the study and concludes with a discussion on ethical issues.

3.2 Site Description

Study site refers to the location where the study was carried. This study purposively selected Nairobi City County from the 47 Counties of Kenya. Following the adoption of the 2010 constitution, Kenya was divided into 47 Counties. The City County of Nairobi has an area of 696.1 km^2 and is found between 36^0 45 ' east and 1^0 18' south latitudes. It falls at an altitude of about 1,798 meters. The Nairobi City County also offers a mix of rural and urban economic systems; it depicts a traditional and modern ways of living life. The City County houses University of Nairobi where the study was taking place.

The City County also houses other institutions like Parliament, Ministry of Health and Education whose members had been identified as useful sources of data. The reason for choosing Nairobi City County was based on the fact that it has people of all social classes living in urban and informal settlements compared to the other counties. The County has a combined population of about 4 million people drawn from all parts of Kenya and beyond. Some of the urban settlements comprise high income areas like Karen, Westlands, Kileleshwa, Lavington, Muthaiga, some middle income areas like Parklands and Embakasiand low income areas

especially in informal settlements like Kibera, Kawangware and Kangemi. Informal settlements in particular have very high population densities.

The population comprises male and female at 52% and 48% respectively. This is a ratio of about 1.08. The labor force (15-64 years) is almost equal (approximately 49/51%) between male and female. The age population (65 years and more) is again approximately equal between both sexes; however, the male population is slightly higher with approximately 55% and that of female being 45%. This is so because of the influx of males from the neighboring district in search for employment. The City County is divided into 17 sub-counties, formerly divisions, used in picking the sample of the study. The sub-counties are sub-divided further into divisions, as shown in Appendix 3:

3.3 Research Design

Research design in this study can be defined as the strategy and structure that were used to address the research objectives. Also, it can be defined as a plan for collecting, measuring and analyzing data (Creswell, 2013). Among the available research designs, descriptive research design was used to develop a "snapshot" of the phenomenon. The design provides a description of an event, or helps define a set of attitudes, opinions, or behaviors that are observed or measured at a given time and in a given environment. The focus of descriptive research is on the careful mapping out of a circumstance, situation, or set of events to describe what is happening or what happened.

Descriptive studies may be either cross-sectional or longitudinal. In this study, cross-sectional design was adopted. The study involved looking at data from a specific point in time. It helped to make references about possible relationships between the variables. The purpose of using the cross-sectional design in this study was to determine to what extent different classes in the

sample differ on some outcome of independent variable. Cross-sectional design measures variations in the responses to independent variables in the sample. Everyone is asked the same questions and their answers are tabulated and compared. Data was collected at point in time and this explains why cross- sectional design is a "snapshot" measurement, with results specific to that moment.

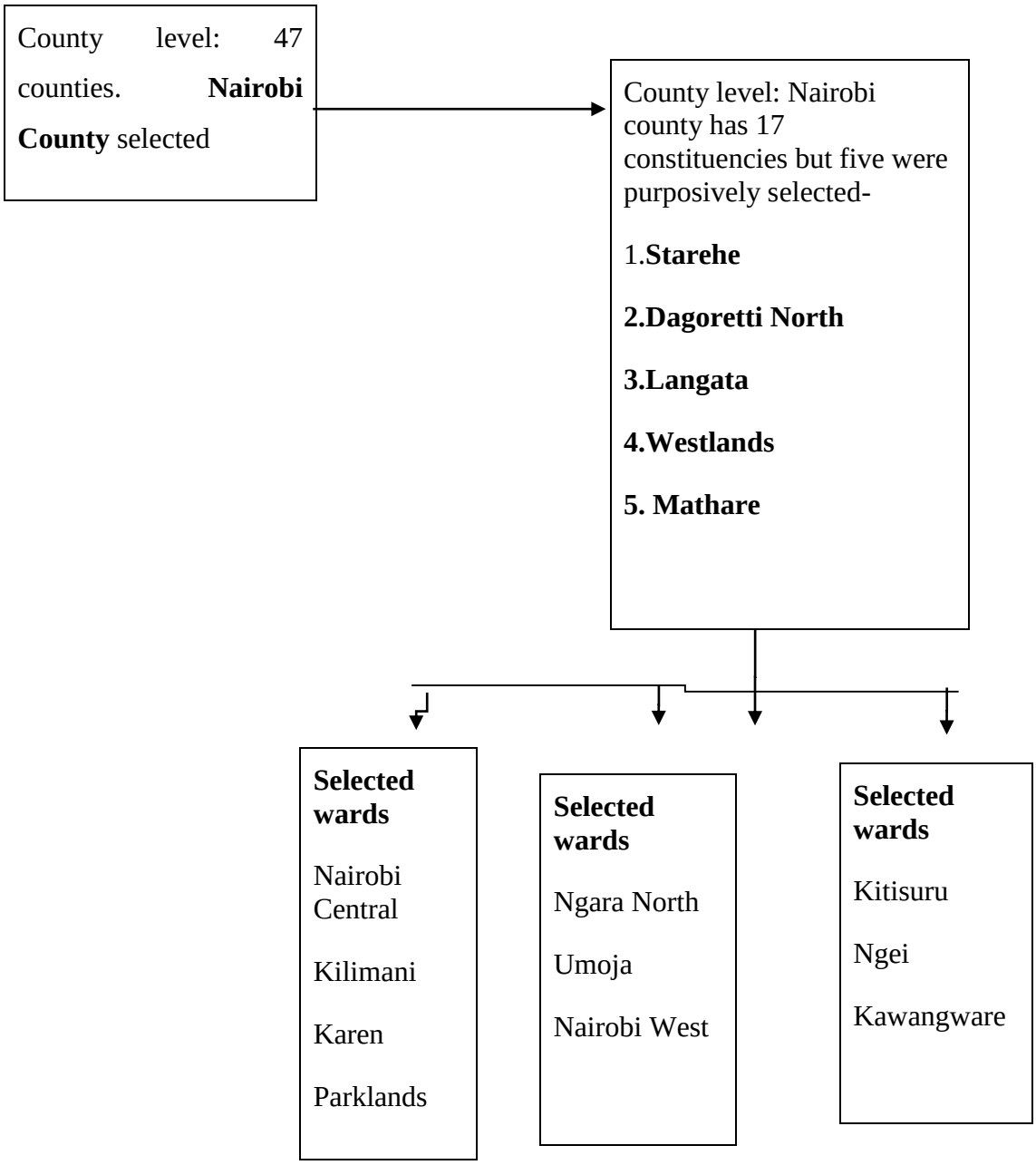
3.4 Target Population

With regards to Pilot and Beck (2010), population is the aggregate or the entire elements, subjects or members that form an identified set. The target population in this study was the households in Nairobi City County. A total of 1066 households were therefore interviewed with the view of getting their perceptions about access to public healthcare. Households were sent questionnaires which were employed for the purpose of carrying out all the interviews.

3.5 Sampling Design

The study employed a multi-stage random sampling technique to select the sample. A sample was chosen randomly at each stage of the process. The sample was narrowed down by applying random sampling. This is taking of samples randomly in stages using smaller and smaller sampling units at each stage. Then a sample is taken at random and everyone within the group is sampled. A sample of 1066 households was randomly chosen for the study, as shown on figure 3.4 below:

Figure 3.4: Multistage sampling



3.6 Data Collection Methods and Procedures

Data collection methods, according to Blumberg, Cooper, and Schindler (2014), refer to the process of gathering data after the researcher has determined the intended data type (nominal,

ordinal, interval, or ratio) for each of the research objectives/questions as well as the features of the sample unit. That is, whether a participant can articulate his or her ideas, thoughts, and experiences. The study utilized primary sources of data. Primary data are information collected in the field for the first time and is dependent on the objectives and the question of the research. Primary data was collected using semi-structured questionnaires and interview guide.

The questionnaire was structured in the sense that it had only closed ended questions. The questionnaire was divided into four categories, that is, demographic data of households, socio-cultural data, institutional factors and access to healthcare services. In- depth interviews were used because they are useful in providing detailed information on beliefs, attitudes, and This method allowed the researcher to use random method to determine the chosen groups for selection. This allows the population to be divided into a number of groups without any restrictions. It also allows for the freedom to select carefully the sample to be used. It is also useful when collecting primary data from a geographically dispersed population such as the one in Nairobi City County. It was also found useful in exploring new issues in details. The objective of using in-depth interviews was to obtain detailed information, views, meaning ant interpretation of issues under investigation.

The interviews were conducted in the presence of the participants and the researcher. It was important that the interview environment was kept comfortable and relaxed for the benefit of the participants. The researcher would occasionally provide refreshment. The in-depth interview sessions were primarily meant to provide data about: participants' opinions about the importance of health insurance covers, participants'' perception on the medical services they receive from medical facilities, attitudes of the healthcare worker at the medical facilities and the impact that healthcare facilities had on the participants. The study explored perspectives and experiences on how socio-cultural factors/variables influence access to public healthcare.

This is a good technique for getting respondents to talk about their personal feelings, thoughts, opinions and experiences. The exercise of data collection lasted for 90 days. At the end of each day the teams met to deliberate or recheck the questionnaires for completeness.

3.7 Data Analysis Methods

Data analysis is explained to be the process whereby interpretation and drawing of meaningful information from the available data is done. Collated data from the participants will be entered after data presentation, and cleaned so they could be used in data analysis (Kombo& Tromp, 2006). The purpose of data analysis is to find meaning in data so that the derived knowledge can be used to make decisions or to extract useful information from the data and taking decisions based upon data analysis.

Both descriptive and inferential data analysis were employed for quantitative data in the questionnaire. The descriptive data was analyzed and presented in form of frequencies. The data were displayed in tables. Cross tabulation was used to analyze each variable against the dependent variable; access to public healthcare. Correlation analysis, which is inferential, was also employed to assess the correlation between explanatory variables and the response variables. The motive of correlation analysis was to obtain more explanations about the response variable in relation to all the available independent variables. With regards to the qualitative data from the interview guide, content analysis was employed. This is a technique that is used to understand and interpret the content of the qualitative data. The objective of using this technique was to determine the presence and meaning of certain themes, words, concepts, phrases, interviews, discussions and etc. The analyzed data was then categorized using common themes and presented in frequency tables. The analysis was designed to show the relationships between the independent and dependent variables, using explanatory intervening variables.

3.8 Validity of the study Instruments

Validity of a research data refers to the truthfulness or falseness of data obtained through the use of research tools and can be divided into internal and external validity of the instruments used in the research Burns & Grove, 2001). Validity would typically indicate how plausible the research data used in the study is. Validity is applied in the design and methodology of the research study.

As per Kumar (2005), there exist two methods of determining the validity of data collection tools. Validity was determined by the logical connection amongst questions and the goals (Kumar, 2005). Validity may be examined in three dimensions; content validity, construct validity and criterion validity (Orotho, 2009). To ensure that the content is valid, design of the tools was as per the variables under study and their aspects of assessment. On the other hand the maintenance of the construct validity was achieved via restriction of the questions to the variables conceptualizations and making sure that variables aspects fall within similar construct. This validity concept shows the severity of the factors which influence access to healthcare truly reflect what influence access to healthcare, rather than being related to chance variables. It also shows how well this research has been done. It explains the correlation between variables.

Internal validity explains the cause and effect of the study. Providing relationships between variables is good. The information obtained, may not have a direct relation to the study but could have some effects the result if the study happens to be threatening to the internal validity of the gathered research data (Burns & Grove, 2001). Internal validity of this study faced threats from perceptions and perspectives of the study respondents on socio-cultural factors. The process of selecting the participants to be involved in the study could influence the study results,

and the subsequent compromise of validity to the research. Choice of health officials, health workers and even the hard to reach participants could compromise internal validity.

3.9. Reliability of the Study

Reliability is the extent to which the research instruments consistently measure what they are meant to measure in the research study (Polit&Hungler, 1990). Reliability would allow other researcher given the same research instrument used in the research to find the same results in a different study using a different sample group and comparable characteristics (De Vos, 1998).

The lower the difference the instruments produce in isolated analysis of the attributes the more reliable the instruments. This means that instruments that are not valid could not also be reliable (Polit&Hungler, 1999). To ensure reliability in this study, the scores were repeated many times to check correlation. The scores were taken at different times, and this helped estimate tests-retest reliability.

3.10 Ethical Consideration

The research protocols were approved by the National Commission for Science, Technology and Innovation on 14th July, 2015 ending 18th December 2015. On the same date of 14th July, 2015, Permit No. NACOSTI/P/15/7814/6977 was issued for the same. The research received approval for field of the research on health facilities through the Kenyan Ministry of Health. Other approvals were provided by the Ministry of education (Nairobi City County Government Health Department).

All household participants in the study were voluntary participants, and were all residents of Nairobi County and were at least 15 years of age. Participants were provided with adequate information about the research and what it entailed. This was done through formal letters sent

to the participants beforehand and an oral or a written consent was then receive before any participants could be allowed to participate in the study. There was confidentiality in the manner in which data was collected and stored for the purposes of research. All the participants to the research were properly introduced and their various tasks and responsibility shared with the groups. The participants were also made aware of the uses of the research and why it was important to carry out the research.

3.11 Chapter summary

This chapter described the methodology used in this study. It began by presenting an overview of the panel data in order to justify the methods selected because this study is based on data collected for 1066 sample of households in Nairobi City County African during the period 2015 to 2020 in the WDI and WHO databases. The chapter then highlighted the modeling approach and the specification used, notably the ARDL model. The estimation techniques were presented, followed by the plan of analysis. The results of this plan are presented in the following chapters.

CHAPTER FOUR: SOCIAL CLASS AND ACCESS TO PUBLIC HEALTHCARE

4.1 Introduction

This chapter analyzed the influence of social class on access to public health. To some extent, income, education, occupation and wealth directly support better health because wealthier people can afford the resources that protect and improve health. In this chapter, these are the intervening variables that help to explain the causal relationship between social class (independent variable) and access to public healthcare (dependent variable). The findings help us to conclude the effect of social class on access to public healthcare.

4.2.1 Income and Access to Public Health Care Services

The study sought to establish the effect of income levels on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the level of effect income levels has on access to public healthcare. The findings are presented in table 4.1. The findings indicate that 746 (70%) respondents were low income earners with no access to public healthcare followed by middle income earners at 20% (213) who had limited access to public health care and finally the high income earners at 10% (107) who had full access to public healthcare access. Earnings here included monthly, annually wages and salaries, rents, interests, dividends, pensions and social security. High income earners have full access to public health care. This is because they can afford to meet high costs of healthcare. They also have health insurance that can be used to boost their capabilities to access sophisticated healthcare services.

On the other hand, the middle class households can access some limited access to public healthcare. They have average social health insurance policies that can help mitigate high costs of healthcare.

Finally, the lower class earners barely afford public healthcare due partly to lack of adequate earnings and more so to lack of healthcare insurance to cushion expenditures. The findings are presented in table 4.1 below:

Table 4.1: Income and Access to Public Health Care Services

Level of Income	**Lack of access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
High income	0	0	107	107
Middle income	0	213	0	213
Low income/no income	746	0	0	746
Total	**746**	**213**	**107**	**1066**

Sources: Author (2021)

The correlation results indicate that there is a positive relationship between the independent and dependent variables. Income is important and has significant influence on access to public healthcare. It explains the causal relationship between independent and dependent variables. Hence, the null hypothesis is nullified and the alternate hypothesis is upheld. Social class has important influence on access to public healthcare.

4.2.2 Education and Access to Public Health Care

The study sought to establish the effect of education levels on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the effect education level has on access to public healthcare. The findings are presented in table 4.2.

The findings indicate that 20% (213) of the respondents did not attend school. Yet attending schooling increases chances of earnings and other related financial asset investments. Schooling also helps increase skills and knowledge can improve capabilities to access healthcare. Schooling also improves opportunities for accessing employment and this category lacks all these investment opportunities. This is therefore a lower social class, which if anything earns below 23,670 (KNBS, 2019). In Marxist theory, this group would be the so-called lumpen proletariat. They lack access to public healthcare because of the prohibitive costs. On the other, the findings indicate that 42% (448) attended primary education. This category earn less than 23,670 or are just above the margin (KBS, 2019).Like the lower class, this social category lack the requisite resources to access public healthcare owing to their financial earnings limitations. A few of them could be exceptions with some earnings above 23,670 but these are outside the definition of lower class.

Results also indicate that 24% (256) attended secondary education. This category earns between 23,670-199,999 (KNBS, 2019). They are the middle class and therefore have fair resources to access limited healthcare both at the public health facilities. They also have some form of social health insurance that can be used to mitigate catastrophic healthcare costs.

However, 14% (149) had tertiary and university education. Their earnings are above 200,000 and above. This category is upper class that somehow could fit Marxist definition of bourgeoisie or in the Weberian hierarchical position of prestige, honor and authority. They are the upper class whose investments and assets support full access to public healthcare facilities. Findings indicate that this category shun public health facilities and prefer private facilities that provide superior healthcare. Besides higher education, this category has other materialist benefits like high occupations characterized by high incomes.

Table 4.2: Education and Access to Public Health Care Services

Level of education	Lack of access to public healthcare	Limited access to public healthcare	Full access to public healthcare	Total
None	213	0	0	213
Primary	0	448	0	448
Secondary	0	256	0	256
University and above	0	0	149	14
Total	**213**	**704**	**149**	**100**

Source: Author (2021)

The results show that the intervening variable (education) explains a causal relationship between the independent and dependent variable. The connection between the independent variable (education, explanatory variable) and the dependent variable (access to public healthcare) is positive. There is a linkage between education and access to healthcare outcomes. Lack of education worsens health outcomes. This means that social class has an important influence on access to public healthcare.

4.2.3 Residence and Access to Public Health Care

The study sought to establish the effect of place of residence on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the effect place of residence has on access to public healthcare. The findings are presented in table 4.7. The findings show that 60% (640) of the households live in low level residential areas like Eastleigh,

Mathare Valley, Kibera, Kawangware. These are lower class households. These areas are congested and lack basic infrastructure and households lack access to public healthcare. The findings also indicate that 30% (320) live in medium level residential areas

like Parklands, Eastleigh and South B/C. These households are middle class and can access limited access to healthcare at the public health facilities.

However, 10% (106) of these households live in high cost level residential areas like Lavington, Muthaiga, Woodley, Kileleshwa, Karen and parts of Langata. Their earnings are above 200,000 and other investments make them have full access to public healthcare. They also have health insurance that helps cushion them against high costs of healthcare. This segment is the upper class who can afford any kind of healthcare including overseas treatment, as shown on table 4.3 below:

Table 4.3: Residence and Access to Public Health Care Services

Place of Residence	**Lack of access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
Upper level residence	0	0	106	106
Middle level residence-	0	320	0	320
Lower level residence	640	0	0	640
Total	**640**	**320**	**106**	**1066**

Source: Author (2021)

The results show that the intervening variable explains the causal relationship between the independent and dependent variables. Place of residence explains the causal relations. This implies that social class has important influence on access to public healthcare.

4.2.4 Wealth and Access to Public health Care

The study sought to establish the effect of wealth on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the effect wealth has on access to public healthcare. The findings are presented in table 4.4. The results show that wealth was not evenly distributed in the County: 14% (154) households were the upper class with earnings above 270,000. Wealth may include ownership of houses, value of properties, financial assets, and value of financial assets. This category was therefore in upper class, which the class of the wealthy individuals and they could have access to healthcare at the public health facilities. This theory advanced by the Marxists is anchoring theory for this study as it explains the relationship between social class and access public health care services. They have high health premiums. This facilitates their entry to top quality facilities in the public sector.

In addition, the findings indicate that 14% (154) of the respondents were very wealthy and had full access to public healthcare, 26% (272) were wealthy and had limited access to public healthcare, while the 60% (640) were not wealthy had no access to public healthcare. The results are shown in table 4.4 below:

Table 4.4: Wealth and Access to public Health Care Services

Wealth category i.e. financial & assets	**Lack access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
Very wealthy	0	0	154	154
Wealthy	0	272	0	272
Not wealthy	640	0	0	640
Total	**640**	**272**	**154**	**1066**

Source: Author (2021)

The intervening variable explains the causal relationship between the independent variable and the dependent variable. The independent variable has a positive relationship with the dependent variable. This implies that social class has an important influence on access to public healthcare. There is a positive correlation between the independent variable and dependent variable.

4.2.5 Occupation and Access to Public healthcare

The study sought to establish the effect of occupation on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the effect occupation has on access to public healthcare. The findings are presented in table 4.5. The results indicate that 48% (512) households were engaged in lower occupations (manual workers). These were households who earned below 23,670 (KNBS, 2019), and were therefore in lower social class. The category had no access to public healthcare facilities. This was so because their earnings were too small and they lacked social health insurance to caution them against high costs.

The findings further show that, 25% (267) of the households earned between 23,670-199,999 and were in middle occupations (non-manual). This category was in middle class whose earnings and other related incomes made them access limited healthcare in public health facilities. This location earned some limited prestige, power and authority as defined by Max Weber. So limited healthcare insurance was available and this augmented their capability to procure public healthcare that provided specialized services.

However, 15% (160) were in highest occupations position of power for example being a manager or political position. This is a highly placed category with high investments and good asset bases. They can therefore access full healthcare in the public health facilities. They are supported by high social insurance premiums and can access public healthcare at any time. At

the bottom are 12% (127) unemployed households who have no earnings. These are households who Marx termed the "lumpen proletariat" or who Max Weber placed at the lowest social hierarchy. They have no resources and can therefore not access healthcare at all. They are at the border with the lower class, as shown on table 4.5 below:

Table 4.5: Occupation and Access to Public health Care Services

Occupations	**Lack of access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
Lower occupations	512	0	0	**512**
Middle occupations/non-manual	0	267	0	**267**
Upper level occupations	0	0	160	**160**
Unemployed	127	0	0	**127**
Total	**639**	**267**	**160**	**1066**

Occupation is an intervening variable that explains the causal relationship between the independent (social class) and dependent variables (access to public healthcare). It has an important influence on access to public healthcare. This confirms the positive correlation between the independent and dependent variables. Hence, social class has an important influence on access to public healthcare.

4.2.6 Poverty and Access to Public Health care

This section presents results from qualitative data on the influence of poverty on access to public healthcare. The findings are presented in prose form. The minority group had a high income of above Ksh.200, 000 per month (KNBS, 2019) and was perceived to be rich in the society. This allowed them to access a wide array of healthcare services from the public healthcare facilities.

The middle class group whose income ranges between Ksh.36, 700-199,999 per month had moderate access to public healthcare facilities. These services were occasionally facilitated using medical insurance plans. (Medical insurance cover or plans?) Therefore, they had a relatively good access to healthcare services in public healthcare facilities.

The majority of the households had more limited resources and therefore much fewer healthcare services available to them than the other cadres. Their income was found to be below Ksh.23, 670 per month and could not afford them alternative medical services.

From the research, it was found that the poverty situation of a household affected their access to public healthcare. There was a direct correlation between poverty and access to healthcare services. This means that social class has an important influence on access to public healthcare.

4.3 Conclusion

This chapter examined intervening variables that explain causal links between independent and dependent variables. The intervening variables analyzed included amount of income, level of education, occupations, wealth, place of residence and levels of poverty. The findings showed that income, education, wealth, place of residence, and poverty explain causal links between

the key variables (social class and access to public healthcare). The results show a positive correlation between the key variables.

The study scrutinized existing literature on the issues affecting access to healthcare services in Nairobi City County. The sample of the study comprise of 1066 respondents of Nairobi City County as unit of analysis. The literature review conversely, did uncover that there is an over-emphasis on social class in relation to inequality in access to health care services and whereas it is a significant factor, but, this study identified several other factors which influence and impact on access to health care services achievements and are significant in determining life chances.

Understanding the determinants of access to health care services has received increasing analytical attention in African countries where people are dying from diseases that are curable and preventive.

The main findings of the study obtained from the relationship between social class and access to health care indicate that in the long run, access to health care services in Nairobi City County is driven by the income level, area of residence and level of education. Moreover, the results indicate that income, residence, and education are key determinants of access to health care services.

Findings from the study revealed that social class is the most determining factor for the access to better health care services. The conclusion encompasses the findings of the independent and dependent variables. The influence of social class on access to health care services, in which income level is considered as the main determinants of individual well-being. The results of the study indicates that 746 which is 70% of the total respondents represent people in the low income level who are likely to have no access to health care services. The other groups are the

middle income earners who are accounted for 20% (213) have limited access to health care services and the most fortune only accounted to 10 % (107) have highest chance of access to better health care services in the context of the Nairobi City County in Kenya.

The influence of education as a proxy of social class on the well-being of a person is an integral part of being healthy. A person is unhealthy if he or she lacks basic knowledge, the ability to reason, emotional capacities of self-awareness and emotional regulation, and skills of social interaction. The findings of the study indicate that people with no basic education accounted for 20% (213) of the respondents and they are likely to have no access to health care services. According to Marxist Theory of social class, this group would be the so-called lumpen proletariat. They lack access to health care services due the high costs. The 24% (149) of respondents have attended secondary education. The study findings of this group have fair resources to access health care services but limited. The other category that is earning 200,000 shillings and above, is considered upper class.

The area of residence is critical factor to accessibility of health care services in any society. Access to health care services is also determined by the supply and demand for health services. The demand affects access to health care services by individual's attitude towards the disease, their knowledge of availability of health services and financial and cultural aspects of society members. In this study 60% (640) of households respondents live in low level residential areas like Eastlands, Mathare valley etc., are considered as the lower households class who lack accessibility to health care services in the Nairobi City County of the context of the study.

The findings also indicate that 30% (320) live in medium level residential areas like Parklands, Eastleigh and South B/C. These households are middle class and can access limited access to healthcare at the health facilities. In This study only 10% (106) of the households survey in the Nairobi City County have better access to more specialized health care services than those of

lower and medium class that cannot access this health services. The results show that there is a positive relationship between the independent variable (intervening explanatory variable-place of residence) and the outcome variable (access to public healthcare, the dependent variable).

The influence of the wealth on access to public health care services was considered as key determinants to accessibility of quality services. The findings indicated that there inequality in term of wealth distribution in the economy. This is because health services inequalities are considered to be systematic differences in the opportunities among difference groups of individuals to achieve optimal health care services, leading to unfair and avoidable differences in health care services outcomes. In table 4.4 14% (154) of the households in the study were the only one in the upper class or the very wealthy people who can afford most specialize health care services in the society. They wealthy or middle class accounted for 26% (270) and they have limited access to public health care services but not like those who not wealthy with 60% (640) who cannot afford basic health care services.

Poverty is also one of the factors that bring inability to access public health care services. From the research, it was found that the poverty situation of a household affected their access to healthcare services. There was a direct correlation between poverty and access to healthcare services.

The issues of poverty among groups of people is one of the disadvantage for people to access public health care services due their ability to pay for the services rendered by the health care providers. The minority group had a high income of above Ksh.200, 000 (KNBS, 2019) per day, year month or week and better economic position in society. This allowed them to access a wide array of healthcare services from the public healthcare facilities. Social Class therefore has important influence on Access to Public Healthcare in Kenya, as is the case study of Nairobi City County.

CHAPTER FIVE: DEMOGRAPHIC VARIABLES AND ACCESS TO PUBLIC HEATHCARE

5.1 Introduction

This chapter presents data analysis, presentation, interpretation and discussion based on the outcomes of the causal relationship between the variables. Demographic variables are hypothetical variables that were used to explain the causal links / relationships between the Independent Variable (Social Class) and Dependent Variable (Access to public healthcare). This chapter examines the causal effect of intervening variables on access to public healthcare. The intervening variables analyzed here include age, gender and marital status.

5.2.1 Age Variable

The study sought to establish the explanatory effect of age on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the level of influence age had on access to public healthcare. The findings are presented in table 5.6.

The results in table 4.1 indicate that most of those who had less access to public healthcare were 40% (426) of respondents' aged between15-29 years and 15% (160) above 65 years of age lacked access to public healthcare. These categories form the bulk of the lower social class and cannot afford access to public healthcare facilities due to high costs. These groups also lack health insurance to supplement healthcare costs.

On the other hand, 45% (480) are upper and middle social classes whose earnings are 270, 0000 and above (upper class) and 26,000-270,000 (middle class) who can afford to access full access and limited access to healthcare respectfully. Age intervening variable was measured by years in age, young and old. They also have health insurance covers that can cushion high costs of healthcare in private wing of public health and private facilities, as shown 5.6 below.

Table 5.6: Cross Tabulation of Age and Access to Public Healthcare

Age Distribution	No access to public healthcare	Limited access/Full access to public healthcare	Total
15-29	426	0	**426**
65 years and above	160	0	**160**
Others	0	480	**480**
Total	**582**	**480**	**1066**

Age as an interveningvariablehad a positive explanatory power to explain causal relationship between independent variable and dependent variable. It was able to explain the causal relationship between the independent and dependent variables. Age therefore is an important intervening variable that explains causal links between the variables. It confirms that there is a positive correlation between social class and access to public healthcare.

5.2.2 Gender Variable

The study sought to establish the explanatory effect of gender on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the level of influence gender has on access to public healthcare. The findings are presented in table 4.2.

The findings show that females were 60% (640) while male respondents were 40% (428). Of the 640 female respondents, 320 (50%) lack access to public healthcare, 192 (30%) have limited

access to public healthcare, and 128 (10%) have full access to public healthcare.On the other hand, out of the 426 male respondents, 170 (40%) lack full access to public healthcare, another 170 (40%) have limited access to healthcare; and 86 (20%) have full access to public healthcare, as shown on table 5.7. The findings show that a larger percentage of female have no access to healthcare compared to male. It is also worth noting that only 10% of female respondents had full access to healthcare compared to 20% of male who indicated that they had full access to public healthcare. The intervening variable gender was measured by male and female status

Table 5.7: Gender Variable

Gender	Lack Access to public healthcare	Limited access to public healthcare	Full access to public healthcare	Total
Female	320	192	128	**640**
Male	170	170	86	**426**
Total	**490**	**362**	**214**	**1066**

The results confirm that gender explains causal links between independent and dependent variables. Gender as an intervening variable had important influence on access to public healthcare. This implies that social class has a positive influence on access to public healthcare.

5.2.3Marital Variable

The study sought to establish the explanatory effect of marital status on access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the effect marital status has on access to public healthcare. The findings are presented in table 4.6.

The findings indicate that 60% (640) of the respondents were married and had no access to public healthcare. On the other hand, results indicate that 30% (320) of respondents were single or separated and had limited access to public healthcare. This category is characterized with less spending on family matters and therefore has some savings. This savings increases their earnings and are able to have limited access to healthcare.

However, the results indicate further that 10% (106) are respondents who are either widowed or divorced. The intervening variable marital status was measured using married, single/ separated, widowed/ divorced as shown on table 5.8 below:

Table 5.8: Marital Variable

Marital Status	**Lack of access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
Married	640	0	0	**640**
Single/ separated	0	320	0	**320**
Widowed/divorced	0	0	106	**106**
Total	**640**	**320**	**106**	**1066**

The analysis showed that the intervening variable, marriage, explains the causal relationships between the variables (independent and dependent variables). Marriage explains the positive correlation between the variables. This confirms that social class has an important influence on access to public healthcare.

5.3 Conclusion

This chapter examined intervening variables that explain causal links between independent and dependent variables. The intervening variables analyzed included age, gender and marital status. The findings showed that age, gender and marital status explain causal links between

the key variables (social class and access to public healthcare).The results show a positive correlation between the key variables.

The explanatory effect of intervening demographic variables on access to public health care is fundamental in the sense that the correlation between the independent and dependent variables is positive. Age has a significant explanatory effect on access to public healthcare. The findings of the gender show that a larger percentage of female have no access to healthcare compared to male. It is also worth noting that only 10% of female respondents had full access to healthcare compared to 20% of male who indicated that they had full access to public healthcare. The findings are presented in table 5.8 based on the influence of marital status on access to health care.

The findings indicate that 60% (640) of the respondents were married and had no access to healthcare. On the other hand, results indicate that 30% (320) of respondents were single or separated and had limited access to public healthcare.

The results indicate further that 10% (106) are respondents who are either widowed or divorced. The findings further show that this category had full access to healthcare facilities, as shown in table 5.8.This confirms question one: Do demographic variables have influence on access to public healthcare in Nairobi City County? Age, gender and marital status have been found to explain causal links between the two key variables.

In addition, the results confirm study objective one: To investigate the influence of demographic variables on access to public healthcare in Nairobi City County. Age, gender and marital status have been found to explain causal links between the independent and dependent variables. Finally, the findings nullify hypothesis i: There is no significant relationship between demographic variables and access to public healthcare and upholds the corresponding alternate hypothesis: There is a significant relationship between social and access to public healthcare services. Social class therefore has important influence on access to public healthcare in Kenya: a case for Nairobi City County.

CHAPTER SIX: SOCIO-CULTURAL VARIABLES AND ACCESS TOPUBLIC HEALTHCARE

6.1 Introduction

The study sought to establish the explanatory effect of socio-cultural intervening variables on access to public healthcare. Intervening variables analyzed included attitudes, communication strategies, faith and social networks. The objective here was to establish their explanatory causal links between the independent and dependent variables. This would help explain the correlation between social class and access to public healthcare. Cross tabulation analysis was done to establish the frequency distribution and the level of influence of socio-cultural intervening variables on access to public healthcare

6.2.1 Attitudes and Access to Public Health Care Services

This section presents results from qualitative data on the influence of attitude in access to public healthcare services. The findings are presents in prose form. The majority did not like nor understood the new regulations. The new regulations were perceived to favor the rich and upper classes in the society and not the average person. This negative perception of the regulations further locked more households from the necessary needs of accessing proper medical services form public healthcare facilities.

However, minority understood and followed the new regulations. Generally, the new regulations provide more access to healthcare services for the well-off in society, that is, the upper and middle class social groups. There is therefore a linkage between the intervening variable (attitudes) and access to public healthcare. This relationship is positive. This study therefore concluded that attitudes (explanatory variable) played a part in the households' ability to access public healthcare services. The null hypothesis is nullified and the alternate hypothesis is upheld, as shown on table 6.9 below:

Table 6.9: Attitudes and Access to Public Health Care Services

Literacy Level (i.e. English and/or Kiswahili)	Lack access to public healthcare	Limited access to public healthcare	Full access to public healthcare	Total
Very high	0	0	106	106
Low	0	320	0	320
Not high or low	640	0	0	640
Total	**640**	**320**	**106**	**1066**

Source: Author (2021)

6.2.2 Communication and Access to Public Health Care

This section presents results from qualitative data on the influence of communication on access to public healthcare. The findings are presents in prose form. The research found that a majority of the low income groups did not adequately understand or communicate in English or Kiswahili languages. This hindered their ability to effectively communicate their needs once at the public healthcare facilities, as they could not be allowed to communicate in their best spoken languages.

The middleclass group had comparatively better communication skills and could effectively communicate in either English or Kiswahili languages. Their ability to communicate increased their access to the particular health requirements that they needed. This could be directly associated with their socio-economic status.

Similarly, the minority group comprised of the upper and affluent groups could communicate properly with healthcare workers. They also could communicate in either English or Kiswahili properly. This allowed them better access to medical services. Therefore, this

finding showed that there is a direct correlation between ability to communicate and the access to healthcare services. This finding effectively upheld the researcher's nullification of the null hypothesis and the affirmation of the alternative hypothesis, as shown on table 6.10 below:

Table 6.10: Communication and Access to Health Care

Literacy Level (i.e. English and/or Kiswahili)	**Lack access to public healthcare**	**Limited access to public healthcare**	**Full access to public healthcare**	**Total**
Literate	0	0	170	170
Semi-literate	0	320	0	320
Illiterate	576	0	0	576
Total	**640**	**320**	**106**	**1066**

Source: Author (2021)

6.2.3 Faith and Access to Public Health Care Services

This section presents results from qualitative data on the influence of faith on access to public healthcare. The findings are presents in prose form. It was through the study that the minority group in the upper-class did not have trust in the healthcare facilities. The group particularly noted the dilapidated state in which the healthcare facilities were in, and the insufficient number of healthcare staff in the facilities. The middleclass showed some faith in the public healthcare facilities.

Majority of the low income groups expressed trust in the health facilities despite the insufficient facilities such as clean running water, proper sanitation and laboratory services. It was noted that low income groups did not have an option even if the services in the public healthcare facilities were not enough. The majority did not have the financial capability that the middleclass and the upper class. Therefore, they had faith in the facilities that they could access.

The faith that different groups had showed a direct correlation to the access they had to public healthcare services. This had an impact on access to healthcare services. This correlation between social class and access to public healthcare nullified the null hypothesistwo and upheld the corresponding alternative hypothesis.

6.2.4 Social Resources and Access to Public Health Care Services

This section presents results from qualitative data on the influence of social resources on access to public healthcare. The findings are presented in prose form due to the qualitative nature of information obtained for this study. The upper class in the study had more economic resources at their disposal. These allowed them more access to healthcare services they needed. Apart from general medical services, they also had access to specialized medical care at their disposal whenever they required such care.

The middle class group in this study showed a medium little knowledge about the important of social resources to accessibility to public health care services. The middle class group had a slightly more about benefits of social resources to their disposal compared to the low income groups. This allowed them to gain better access to medical services from the public facilities. The majority of the households had fewer and more limited access to social resources which gave them a deeper appreciation for the limited resources they could access. The low levels of social resources also limited their access to healthcare services. Social resources were found to

have a direct correlation to the access of healthcare services. The positive relationship indicated that having more social resources also guaranteed households more access to healthcare services. This finding nullified the null hypothesis and confirmed the alternative hypothesis.

6.2.5 Perspectives and Access to Public Health Care

This section presents results from qualitative data on the influence of perception and perspectives in access to public healthcare services. The findings are presents in prose form. From the sample data collected it was observed that majority of participants were not adequately satisfied with the services provided by the County health facilities. The healthcare staff was reported to handling their clients poorly. This made the access to medical services unsatisfactory for the household members.

Conversely, households in the middleclass reported that the services in the public health facilities were satisfactory. The middle class also noted that the services were not always available and accessible but expressed satisfaction with the services that were provided. It can be observed that the satisfaction of the middleclass with the healthcare services was mainly due to their ability to access a wider range of services from public healthcare facilities due to their financial and economic capabilities.

The minority of the responses was from the affluent and upper class group. This group expressed their dissatisfaction with the services provided in healthcare facilities. However, they also noted that their dissatisfaction did not hinder them from accessing any services they needed from the healthcare facilities as they could access the more costly health services. Therefore, the availability or unavailability of services was a non-issue to this class of participants.

This shows that the perceptions that people have has a direct correlation to the type of services that they could access and their ability to access any services from the public health facilities.

There was a positive correlation between perception and ability to secure healthcare services. This finding confirmed the objective of the study and the questions that the researchers sort to answer through the research. The finding also effectively nullified the null hypothesis and instead upheld the alternative hypothesis.

6.3 Conclusion

This chapter examined intervening variables that explain causal links between independent and dependent variables. The intervening variables analyzed included attitudes, perspectives, communication strategies, faith in health facilities, and social resources. The findings showed that attitudes, perspectives, communication, faith and social resources explain causal links between the key variables (social class and access to public healthcare). The results show a positive correlation between the key variables (social class and access to public healthcare).

The results show that 640 respondents lacked access to public healthcare because of poor attitudes towards the healthcare system. This means that attitudes are important variables and influenced by the individual's experience combined with positive or negative reinforcement. Attitudes and behaviour are linked; however, attitude is only one factor, social norms and group pressure also influences individual behaviour. Negative attitudes and behaviour come from people not having adequate knowledge as well as negative social norms and group pressure. The explanatory intervening variables on access to public health care services as proxies by attitudes, communication and faith have difference effect on access to public health care for individual member of society. This study concluded that attitudes as explanatory variable played a part in the household's ability to access health care services.

Some general knowledge will be helpful in understanding the topic of communication in the health service. Effective patient communication enhances compliance, e.g. the way the recipient

of care complies with both advice given as well as prescriptions. This is important in order to decrease the risk of mistakes in the treatment, or complaints over health care staff (Cacioppo, Petty, & Crites, 1994; Leutar&Raic, 2008; Latimer, 1998; Latimer, 1998' Godina&McCov, 2000; Levinson &Chaumeton, 1999; Perla, 2002; Frymoyer &Frymoyer, 2002; Cecil,& Killeen , 1997).

He study confirmed that 576 were illiterate and could not therefore access public healthcare. 320 of the households were semi-illiterate and could only access some limited access to public healthcare. Only 170 were literate and therefore could afford access to public healthcare. This category is able to communicate effectively with the healthcare providers. Literacy therefore is very important and it is an area that deserves policy intervention. This includes literacy which is measured by how the person competency for example literate is when a person can be able to write and read in both languages that is English and Kiswahili, semi-literate a person can be able to only speak either English or Kiswahili and the illiterate one cannot write nor read either Kiswahili or English language.

This confirms question two of the study: Do socio-cultural variables have influence on access to public healthcare in Nairobi City County? Attitudes, perspectives, communication, faith and social resources were found to explain causal links between the two key variables.

In addition, the results confirm study objective two: To investigate the influence of socio-cultural variables on access to public healthcare in Nairobi City County. Attitudes, perspectives, communication, faith and social resources were found to explain causal links between the independent and dependent variables.

Finally, the findings nullified hypothesis ii: There is no significant relationship between socio-cultural variables and access to public healthcare and upheld the corresponding alternate

hypothesis. There is a significant relationship between socio-cultural variables and access to public healthcare services. Social class has a positive correlation with access to public healthcare.Social class therefore has important influence on access to public healthcare.

CHAPTER SEVEN: INSTITUTIONAL VARIABLES AND ACCESS TO PUBLIC HEALTHCARE

7.1 Introduction

This chapter analyzed and interpreted the explanatory influence of institutional variables on access to public healthcare. The intervening variables were used to explain the causal relationships between the variables. The variables presented, analyzed and discussed in this section were leadership and governance, policies, health infrastructure, health facilities, drugs and supplies, health workers, health financing and health insurance. Cross tabulation analysis was done to establish the frequency distribution and the level of influence of institutional variables on access to public healthcare. The outcome helped to determine the relationship between social class and access to public healthcare.

7.2.1. Health Policies

Health policies discussed were intended to achieve specific goals interlia: preventive and health services; curative health services through provision of health personnel, drugs and equipment; health spending; maintenance of health facilities and equipment and environment and sanitation. The findings indicate that minority upper class 10% (107) found that health policies were not effective. The policies could not be relied upon to deliver their set objectives.

The middle class 40% (426) found that health policies were moderate as they could deliver some of their objectives.

However, the majority 50% (533) found that policies were very effective. They could assist them achieve most of their health objectives, as shown on table 7.11 below:

Table 7.11 Health Policies

Health Policies	Health Policies are Very Effective	Health Policies are Moderately Effective	Health Policies are not Effective	Frequency%
Upper class			107	10
Middle class		426		40
Lower class	533			50
Total	533	426	107	100

The results show that health policies as an intervening variable that could be used to explain causal links between the independent and dependent variable. It showed that social class had a correlation with access to public healthcare. Such correlation between independent and dependent variables was positive. This means that social class has a significant influence on access of public healthcare.

7.2.3 Leadership and Governance

Leadership and governance in this study refers to ability to do well for the organization. This includes being transparent and accountable in the health sector. The minority 15% (160) considered leadership and governance to be poor, lack transparency and accountability. The middle class 25% (266) found that leadership and governance was average with some limited transparent and accountable.

However, the majority 60% (640) found that leadership and governancewas good, transparent and accountable, as shown on table 7.12 below:

Table 7.12 Leadership and Governance

Leadership and governance	There good leadership and governance in the health sector	There is average leadership and governance in the Health sector	There is poor leadership and governance in the Health sector	Frequency %
Lower Class			160	15
Middle Class		266		25
Upper Class	640			60
Total	640	266	160	100

The results showed that the intervening variable, leadership and governance explained causal links between the independent and dependent variables. The correlation between social class and access to public healthcare was positive. Social class therefore had important influence on access to public healthcare.

7.2.4 Public health facilities

Public health facilities include hospitals, health centers, and dispensaries in the public health sector.The study found that 17% (181) of the households considered the public facilities fully accessible.

33% (352) of the households considered public health facilities moderately accessible.

However, the majority 50% (533) considered public health facilities inaccessible as shown on table 7.13 below:

Table 7.13 Public health facilities

Public health facilities	Inaccessible	Moderately accessible	Fully accessible	Frequency %
Upper Class			181	17
Middle Class		352		33
Lower Class	533			50
Total	533	352	181	100

The results show that intervening variable (public health facilities) explains the causal link between the independent and dependent variables. The correlation is positive and it confirms that social class has important influence on access to public healthcare.

7.2.4 Health workers

Health workers in the study include health professionals, doctors, nurses, pharmacists, technicians and etc. The results show that 10% (106) of the respondents were dissatisfied with the services offered by the health workers. 30% (320) of the households were partially satisfied with the services offered the health workers.

However, the majority 60% (640) were fully satisfied by the services rendered by the health workers, as shown on figure 7.14 below:

Table 7.14 Health workers

Health workers	Fully satisfied with the services	Partially satisfied with the services	Dissatisfied by the services	Percentage%
Upper Class			106	10
Middle Class		320		30
Lower class	640			60
Total	640	320	106	100

The intervening variable (health workers) explains the causal relationship between the independent and dependent variables. The correlation between the variables is positive. This implies that social class has an important influence on access to public healthcare.

7.2.5Health Infrastructure

Health infrastructure in the study includes physical infrastructure, inpatient beds, equipment, transport and technology (I.C.T). The results show that 10% (106) of the respondents observed that there is poor health infrastructure in Nairobi County.Another 25% (266) of the respondents found that there is fair health infrastructure in Nairobi County.

However, 65% (653) of the respondents found that there was good infrastructure in Nairobi County, as shown on table 7.15 below:

Table 7.15 Health infrastructure

Health infrastructure	There is Good Infrastructure in Nairobi City County	There is Fair Infrastructure in Nairobi City County	There is Poor Health Infrastructure in Nairobi City County	Percentage %
Upper Class			107	10
Middle Class		266		25
Lower Class	693			65
Total	693	266	107	100

The results show that the intervening variable explains the causal relationship between the independent and dependent variables. The results show a positive correlation between the variables. This implies that social class has important influence on access to public healthcare.

7.2.6 Health financing

Health financing include government funds, donor funds and private funding. It also involves pooling funds together, purchasing and payment of social security funds to National Hospital Insurance Fund among others.

The results show that 20% (213) of the respondents acknowledged that there was good financing in the health sector in Nairobi City County.

The other 30% (320) respondents acknowledged that there is fair financing in health sector in Nairobi City County.

However, the majority 50% (533) respondentsacknowledged that there was poor financing in the health sector in Nairobi City County. They stared at catastrophic health expenditures at all times, as shown on table 7.16 below:

Table 7.16 Health financing

Health financing	There Poor financing in the Health sector in Nairobi City County	There is Fair financing in the Health Sector IN Nairobi City County	There is Good financing in the Health Sector in Nairobi City County	Percentage %
High income earners			213	20
Middle Income earners		320		30
Lower Income earners	533			50
Total	533	320	213	100

The results show that the intervening (health financing) explains the causal link between the independent and dependent variables. The correlation between the key variables is positive. This implies that social class has an important influence on access to public healthcare.

7.3 Conclusion

This chapter examined intervening variables that explain causal links between independent and dependent variables. The intervening variables analyzed included Health Policies, Leadership and Governance, Health Infrastructure, Public Health Facilities, Health Workers, and Health Financing. The findings showed that these intervening variables explain causal links between the key variables (social class and access to public healthcare). The results show a positive correlation between the key variables (social class and access to public healthcare).

Access to public healthcare depended on good leadership that was effective, transparent and accountable. However, the majority of the respondent 640 (60%) found that there was good leadership in the management of healthcare, and therefore, had full access to public healthcare. 266 (25%) of the respondents noted that there was average leadership and governance in the health sector. Due to so, they only managed to access limited access to public healthcare. Only 160(10%) found that there was poor leadership and governance in the health sector. Leadership and governance was therefore an important intervening variable and urgent measures are needed to address challenges facing the management of health sector.

Health financing was also found to be a very important intervening variable that had potential influence on access to public healthcare. The study found that 533 (50%) found that there was poor financing in the health sector; hence, they had poor access to public healthcare. 320 (30%) found that there was fair financing in the health sector and this only provided limited access to public healthcare. However, only 213 (20%) found that there was good financing and therefore had full access to public healthcare. Again this demonstrates the importance of financing. The sector should be fully financed to enable the majority access adequate public healthcare. More budgetary allocations should be made to improve the sector's performance.

Access to public healthcare depended on qualified healthcare personnel. 640 (60%) of the respondents could access public healthcare because they could have the services of qualified

heath workers. 320 (30%) could only access limited healthcare because health workers were not within their reach. Only 106 (10%) could have full access. This is a matter that requires urgent action.Human resources for health are critical and they are the requisites for the delivery of healthcare. For access, HRH has to have quality and be well distributed throughout the County. However, despite impressive growth, the country is far from having adequate trained health workers, and meeting the WHO targets of 3 workers per 10,000 populations. Qualified personnel included nurses, doctors, laboratory technicians, and many more others (Wang'ombe J. et al. 1998). It was further established that health outcomes were better off, where social programs like education were provided adequately.

Households who neither had access to well-equipped health facilities (Kimalo, P. 2001) with health personnel nor given adequate education and programs had very poor health. 533 (50%) of the respondents lacked access to public healthcare because of poor facilities. 352 (33%) only managed limited access while 181 (17%) managed to access full public healthcare. Public health facilities were therefore very important and they had important impact on access to public healthcare. Urgent attention was necessary to improve public health facilities. Kibera, Mathare and Kawagware, for example health outcomes were unequal and he majority even went without. On the contrary, areas like Muthaiga, Karen, Kilimani, West lands had these facilitations in plenty. Hence their health outcomes were good.

Institutions help individuals or groups to live healthy. They increase their freedom and choice to live healthy, a life they value. Access to the provision of healthcare was a basic right guaranteed by the 2010 constitution (Constitution. 2010). Vision 2030 also targets that the entire population should have access to quality healthcare (Vision 2030). Importance is now attached to universal healthcare. These are institutional documents; hence, they are classified as variables for the study.

Devolution has granted County governments the role of coordinating and managing healthcare services. The national government on the other hand is managing national and referral hospitals, laboratories, budgeting for national health services. If managed well, the individual and the population will access healthcare. This defines further the importance of health institutions, as they are critical in managing access to public healthcare.

Health infrastructure too had important contribution to improving access to public healthcare. The study results showed that 693 (65%) of the lower class could not access public healthcare because of poor health infrastructure. 266(25%) of the respondents only managed limited access to public healthcare. Only 107 (10%) managed to access full public healthcare. This inequality in access to public healthcare poses a serious health challenges among the majority and it is matter that requires urgent attention. Improved infrastructurealso increases access to healthcare and yet, the densities of health facilities falls far below the WHO minim thresh hold (WHO, 2005). The provision of medical supplies and the maintenance of equipment were vital, yet the study found that these were inadequate and therefore, affected access (Kimalo, P. 2001).

All these gaps have perpetuated inequality in health care. This has denied the individual or the people the capacities they need to make free choices; the freedom they need to live a good life; the capacity to engage in various enterprises. The most affected here are the household in informal settlements and the areas categorized as low-income areas. The gaps are further exacerbated by shortage of key medical equipment, essential medical supplies, and drugs.

All these discourses confirm that there is a relationship between the variables, thus, the independent (social class) and (access to public healthcare) dependent variable.

In this chapter, the findings confirmed that there is a positive correlation between class identity and perceived modes of institutional organization in the health sector, which implies better

accessibility to public healthcare services by the largely upper residents of Nairobi and lack of access by the lower classes.

This confirms question three of the study: Do Institutional variables have influence on access to public healthcare in Nairobi City County? These intervening variables: health policies, leadership and governance, health infrastructure, health facilities, health workers and health financing were found to explain causal links between the two key variables.

In addition, the results confirmed study objective three: To investigate the influence of institutional variables on access to public healthcare in Nairobi City County. These intervening variables: health policies, leadership and governance, health infrastructure, health facilities, health workers and health financing were found to explain causal links between the independent and dependent variables.

Finally, the findings nullified hypothesis iii: There is no significant relationship between institutional variables and access to public healthcare and upheld the corresponding alternate hypothesis. There is a significant relationship between institutional variables and access to public healthcare services.

The results confirmed that social class has a positive correlation with access to public healthcare. Social class therefore has important influence on access to public healthcare.

These results help identify gaps that require further research; they also help policy makers to carry out interventions that focus precisely on health inequalities, and meticulously formulate policies that aspire to provide healthcare to the entire population in the County.

CHAPTER EIGHT:SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This chapter in 8.2gave a summary of the findings in the three chapters (4, 5, 6&7). The second section 8.3 outlined the conclusion of the study. The last section 8.4presented section on additional research and policy recommendations.

8.2 Summary of Findings

This study examined the influence of social class on access to public healthcare in Nairobi City County. The study was examining four research questions: what is the impact of social class on access to health care?Do demographic factors influence access to public health care services in the Nairobi City County? How do socio-cultural factors influence access to public health care? How do institutional factors influence households' ability to gain access to healthcare service in Nairobi City County?

The study scrutinized existing literature on the issues affecting access to healthcare services in Nairobi City County. The sample of the study comprised 1066 respondents of Nairobi City County as unit of analysis. The literature review conversely, did uncover that there is an over-emphasis on social class in relation to inequality in access to public health care; and whereas it is a significant factor, this study identified several other factors which influence and impact on access to public health care.

Understanding the determinants of access to health care services has received increasing analytical attention in African countries where people are dying from diseases that are curable and preventive.

The main findings of the study obtained from the relationship between social class and access to public health care indicate that in the long run, access to health care services in Nairobi City County is driven by the income level, area of residence and level of education. Moreover, the results indicate that income, residence, and education are key determinants of access topublic health.

Findings from the study revealed that social class is the most determining factor for the access to better public health care. The influence of income level is considered as the main determinant of individual well-being. The results of the study indicates that 746 which is 70% of the total respondents represent people in the low income level who are likely to have no access to health care services. The other groups are the middle income earners who are accounted for 20% (213) have limited access to public health care and the most fortunate only accounted for 10 % (107)who have the highest chance of access to better public health care in the context of the Nairobi City County in Kenya.

The influence of education as a proxy of social class on the well-being of a person is an integral part of being healthy. A person is unhealthy if he or she lacks basic knowledge, the ability to reason, emotional capacities of self-awareness and emotional regulation, and skills of social interaction. The findings of the study indicate that people with no basic education accounted for 213 of the respondents and they are likely to have no access to public health care. According to Marxist Theory of social class, this group would be the so-called lumpen proletariat. They lack access to public health care due the high costs. The 448 and 256 have primary and secondary education respectfully and both categories have limited access to public healthcare. 149 respondents have university education and above and these have full access to public healthcare.This category earns 200,000 shillings and above, and is considered upper class.

The area of residence is a critical factor to accessibility of public health care in any society. Findings show that 106 households live upper residential areas and therefore have full access to public healthcare. This category forms the upper class of household in Nairobi City County. On the other hand, 320 are middle class who live in middle level residential areas, have limited access to public healthcare. The majority 640 households live in the lower level residential areas. This category lacks access to public healthcare.

The influence of the wealth on access to public health care was considered as a key determinant to accessibility of public healthcare. The findings indicated that there is inequality in terms of wealth distribution in the economy. This is because health services inequalities are considered to be systematic differences in the opportunities among difference groups of individuals to achieve optimal health care services, leading to unfair and avoidable differences in health care services outcomes. In the study, 106 households were the only ones in the upper class or the very wealthy people who could afford most specialized health care services in the Nairobi City County. The middle class accounted for 320households and they could have limited access to public health care. But the majority 640 households lacked access to public healthcare because they could afford the costs.

Poverty was found to be a very important variable that affected access to public healthcare. The lower class was disadvantaged because they could not access public health care due their inability to pay for the services. The upper class had better resources including monthly earnings and therefore could access full public healthcare. This allowed them to access a wide array of healthcare services from the public healthcare facilities.

Demographic factors were found to have important explanatory factors between the key variables. The study here considered age, gender and marital status. Ages between 15-29 comprised 426 households who could access public healthcare. Households above 65 years

could not also access public healthcare due to their elderly status and absence of health insurance among others. Other 480 households had limited access to public healthcare because of their ability to access resources necessary for purchasing healthcare services. Age therefore was an important variable that affected access to public healthcare.

Gender was another factor that was analyzed and was found to have impact on access to public healthcare. Of the 640 female respondents, 320 lacked access to public healthcare; 192 had limited access and only 128 had full access to public healthcare.

However, of the 426 male respondents, 170 lacked access to public healthcare, another 170 had limited access and 86 had full access. Gender was therefore an important intervening variable that explained the causal relationship between the key variables.

Marital status was yet another important intervening variable that had effect on access to public healthcare. The findings show that 640 respondents were married and lacked access to public healthcare; 320 were either married or single and had limited access to public healthcare. 106 households were either widowed or divorced and full access to healthcare.

Socio-cultural factors as intervening variables had important explanatory power between the key variables. This section discussed multiple factors including attitudes, communication, faith and social resources. All were found to have explanatory power on the relationship between social and access to public healthcare. This helped to confirm the positive relationship between the key variables. The correlation was positive as social class had important influence on access to public healthcare.

Effective patient communication enhances compliance, e.g. the way the recipient of care complies with both advice given as well as prescriptions. This is important in order to decrease the risk of mistakes in the treatment, or complaints over health care staff (Cacioppo, Petty, &

Crites, 1994; Leutar&Raic, 2008). A literate is a person who can be able to write and read in both languages, for example, English and Kiswahili; a semi-literate a person is one who can be able to only speak either English or Kiswahili; and the illiterate one is one who cannot write nor read either Kiswahili or English language.

Perceptions play an important role in shaping access to health care. This explains why several factors affect the perceptions of health seekers: shortage of staff and logistics, lack of supplies, training and insufficient supervision. Perceptions on all these affect access to healthcare.

Effective communication is vital in the provision of healthcare services. Patients communicate to the health care providers on how and where they are suffering from, failure to which may lead to communication barrier that effectively impacts on access to health care. Further, the health care providers are able to protect their patients' interests, minimize financial costs, and increase the efficiency in operations. It allows for proper record keeping and reduction of errors.

Faith is important and helps to get through situations. It gives strength in times of uncertainties. Without faith, many things cannot be resolved. Hence, faith is important in making healthcare decisions.

Cultural respect is critical to reducing healthcare disparities. They help improve access to healthcare. Healthcare should be responsive to the needs of all categories of patients. Hence, faith is important in dispensing healthcare matters.

Institutional factors were also found to be very important explanatory factors between social class and access to public healthcare. The study discussed the effect of health policies, leadership and governance, health infrastructure, health facilities, health workers and health financing.

107 respondents were upper class who found that health policies were not effective; 426 respondents were middle class who found that health policies were moderately effective; and 533 of the respondents were lower class who found that health policies were effective. This helped the majority to access public healthcare.

Leadership and governance was also found to be an important explanatory variable. In the study, 160 found that there was poor leadership in the health sector; 266 respondents found that there was average leadership and governance in the health sector; but 640 found that there was good leadership and governance in the health sector, hence, enjoyed full access to public healthcare.

Health workers were also found to be important explanatory factors. 106 respondents found that health workers evenly distributed and therefore enjoyed full access to public healthcare; 320 respondents noted that health workers were not evenly distributed and that affected their access to public healthcare. However, the majority 640 respondents confirmed that health workers were inadequate and therefore they could access public healthcare.

Health infrastructure was also found to be an important factor that helped explain the relationship between social class and access to public healthcare. 107 respondents found that there good infrastructure in Nairobi City County; 266 respondents found that there was fair health infrastructure in Nairobi City County; and the majority 693 found that there was poor infrastructure in the health sector. This category could not access public health due to lack of proper infrastructure. Health infrastructure was there important to enhance access to public healthcare.

Health was another important factor that was analyzed; the results showed that 213 respondents of high income earners found that there was good financing in the health sector in Nairobi City

County; 320 of middle income earners found that there was fair financing; and the majority lower income earners found that there was poor financing in the health sector of Nairobi City County. This category could not access public healthcare. Hence, health financing is an important factor on health matters.

8.3 Conclusion

This study enhances understanding on how access to public health care can be boosted by addressing various factors which influence the accessibility of health care services geared towards adding value on various disciplines including management benefits, knowledge for future application, theory and policy with respect to access to public health as a result of social class as well as socio-cultural and demographic factors.

This study has been key to knowledge generation as occasioned by the findings on the effect of social class, socio-cultural, demographic and institutional factors on access to health care in Kenya. Earlier studies on access to health care were carried out using single factor model. This study provides literature on relevance of social class, socio-cultural, demographic and institutional factors on access to health care services in Nairobi City County, Kenya.

8.4 Recommendations

This section outlined recommendation to policy makers, managerial practice, and other users of public health care services.

8.4.1 Policy Recommendations

In light of the above, the research wishes to make some recommendations, which if taken in consideration might bring some positive changes in increasing access to public healthcare in Nairobi City County.

Income, education at all levels and employment opportunities should be available at uniform rates for all the households. Income should be determined by known criteria that takes account of all social classes.

All households should have primary, secondary and university education despite social class differences. This means that education should be universal and compulsory for all social classes.

All forms of employment should be made available and based on merit and on known criteria applicable to all social classes. All jobs should be advertised in all media outlets and in some cases posted at public places like markets, schools and churches.

All households living in all residential areas should have equal access to public healthcare resources. Socio-economic resources should be given to all households irrespective of their residential locations. No households should be disadvantaged on the basis of residential location.

Poverty has robust relations with access to public healthcare and should therefore be eliminated at all costs irrespective of social class.

In that regard, wealth in terms of assets and investments should be equitably distributed to reach all irrespective of social class hierarchies. Opportunities should be spread along all social class lines to avoid discrimination or deprivation based on social class.

All ages of the households should access public healthcare in the same proportions. No discrimination in the provision of resources to access healthcare should be based on age structures. Households between 15-29 and even 65 years and above should have adequate resources to procure access to public healthcare.

In order access public healthcare, socio-economic opportunities should be availed to both genders (male and female) of all genders in equal proportions inNairobi City County.

Both married and unmarried or divorced or separated households should have equal socio-economic opportunities to access to public healthcare. Resources should not be portioned according to marital status. Wages and salaries should be fairly distributed according to known criteria for all.

Negative attitudes should be addressed promptly to avoid stress and other negative scenarios. Good perceptions should be enhanced among all the households by being given fair opportunities.

Social resources including people's social networks, the social support systems, social capital and social cohesion should be nurtured and supported for all social classes among the households. Efforts should be put in place to provide and show affection and other non-material resources that are necessary for growth and development.

The County should strengthen communication strategies so as to ensure that all citizens get information on delivery, planning and budgeting. All information should be published and widely disseminated to ensure accountability. The County should build the capacity of the officials on how to productively facilitate public participation.

Health public policies should be restructured to include the interest of the majority lower class in the county. Such policies should focus on distribution and supply of drugs to all health facilities.

Health workers should be adequately trained and redistributed fairly among the health facilities. They should be adequately remunerated so as to continue offering services in challenging

healthcare risk environments. Salaries and other allowances should be pecked on other categories like administration.

All health workers should be made to operate on safe, conducive and healthy environments to their routine duties. The County should improve workers environment and employee conditions through provision of adequate housing, transport, continuous education and training, regular communication with other upper health facilities. Allowances should be improved to include even their children.

They should be equipped with necessary resources to motivate their performance. These include decent housing both in work place and residence.

Health infrastructure is fundamental to the provision and execution of health services. Health infrastructure allows for and supports the key goals of health, creation of environment that promotes health delivery. Health infrastructure inputs are aimed at efficiency, effectiveness and sustainability. The WHO recommends norms such a: 15 health centers per 30,000 people, 45 dispensaries per 10,000 people; each person live 5km radius of a health facility to ensure access to public healthcare among others.

Improve health infrastructure especially with regard to provision of specialized equipment. Specialized infrastructure such as x-rays, renal and Ear, Nose and Throat services (ENT), digital mammography and Ultra-sound.Facilities should access enough water, sanitation and constant power supply of energy supply. This helps to maintain refrigeration and storage of vaccines and medicines.

The County should also develop regulation related to waste incineration from health facilities to reduce risks that health workers and patients are exposed to. This should be in accordance with the WHO regulation on best practices for incineration.

Distances to health facilities should conform to the guidelines given: health facilities should be within 5 kilometers away.

Health equipment like fridges for storage of some drugs and vaccines should be readily available. Essential medicines for basic ailments like malaria should be readily available.

Distribution and procurement of drugs across all health facilities should be prompt.

All health facilities should be adequately equipped with refrigeration facilities.

Transport especially ambulances should be readily available in all health outlets.

Heath financing has increased but should be pecked on 15% as recommended by African Union. The County should provide adequate financial resources according to budgets presented. This would help increase efficiency.

Both the County and the National government should stop delays in disbursements of financial allocations to the health sector. But the sector should also stop wastages. This means increasing the capacity of medical staff in charge of financial management.

The county should strengthen financial management by conforming to the existing practices.

National government should increase disbursements of health commodities.

Health insurance should be spread to include all households in all social classes. It should be prioritized in reducing financing burden at household level. The County should provide innovative financing options including private sector insurance support health financing indicatives. This means enacting appropriate legislation frameworks. Further, County should take registration for social health insurance mandatory at an early age in life.

8.4.2 Suggested Further Research

There is still a need for further research to determine why health inequalities persist despite concerted efforts to either reduce or eliminate them completely. Specifically, further research should focus on: why the distribution of social goods such as disposable income, access to education, employment opportunities and wealth are lopsided in favor of the upper and middle classes despite government intervention to redistribute them fairly among the households in the County.

Further, there is an urgent need to investigate why poverty persists and yet resources have been increased to address the problem.

There is need for a further research to investigate why discrimination especially against the poor and the vulnerable groups continues despite policy changes and additional resources to the sector.

There is an urgent need for a further research to investigate why inequality in access to public healthcare persists. It is imperative to establish why policies continue to be defective despite continuous reforms. It is important to establish why corruption (lack of transparency and accountability) persists in the leadership and governance system in-spite of the fact that reforms have been ongoing for a long time.

Further, there is need to understand why health infrastructure, facilities and health workers continue to decline despite increased financial resources to the sector.

Finally, a further research is imperative to understand why budgetary allocations continue to be deficient and yet donor support and out-of- pocket resources have continued to be supplemented.

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Appendix 1: Demographic data of Households

1. **What is your gender please?**

   Male ☐ Female ☐

2. **How old are you please?**

   Age

   15-24 years ☐

   25-34 years. ☐

   35-44 years ☐

   45-54 years ☐

   55-64 years ☐

   Over 60+ years ☐

3. **What is your marital status?**

   Single ☐ Married ☐

   Widowed ☐ Divorced ☐

   Separated ☐

4. **How many children do you have?**

   0-1 Children ☐

   1-2 children ☐

2-3 children ☐

3-above children ☐

5. **What is your religion?**

Protestant ☐ Catholic ☐

Islam ☐ Other (specify) ☐

Appendix 2: Questionnaire: Households Heads

Who heads this house hold?

1. Male ☐
2. Female ☐

How many members are in this household?

1. 1-3 ☐
2. 4-6 ☐
3. 7+ ☐

How many households are headed by females?

1. More than 200 of the total sample ☐
2. Less than 200 of the total sample ☐
3. None ☐

How many households are headed by males?

1. More than 200 of the total sample ☐

2. Less than 200 of the total sample
3. None
4. How many children are in each house hold?

Appendix 3: Household by residence

Where do you live in the city?

1. Low density areas
2. Medium density areas
3. High density areas
4. Very high density areas

What is the level of your income?

1. High
2. Medium
3. Low
4. Very low
5. None

Appendix 4: Education

What is your highest level of education?

1. Never attended school
2. Primary
3. Secondary
4. Vocational training
5. University or higher

Appendix 5: Occupation/Employment

What is your occupation/employment?

1. Business/Trader
2. Casual laborer
3. Public service/Civil servant
4. Seeking employment
5. Homemakers

Appendix 6: Self health assessment

What is your overall health status?

1. Very good
2. Good
3. Satisfactory
4. Poor
5. Don't know

Appendix 7: Access to healthcare services

How often do you report illness?

1. Daily
2. When sick only
3. Once in a week
4. None

Do you get your healthcare needs?

1. Yes
2. Sometimes
3. None

Why don't you report your illness?

1. High costs of care
2. Have self-medication
3. Long distances to the healthcare facility
4. Illness not serious
5. Poor quality services
6. Religious/cultural reasons
7. Fear of discovery of serious illness
8. Don't know

Where do you seek healthcare services?

1. Public health centers/dispensaries
2. Public hospitals
3. Chemists/pharmacy shops
4. Private hospital
5. Mission health centers/dispensary
6. Mission hospital
7. None

How far are healthcare facilities from your residence?

1. Less than 1 km
2. 1-3
3. 4-5
4. 6-9
5. 10+

Why do you choose a particular health facility?

1. Medicine is available
2. Staff are unqualified
3. More expensive services
4. Long waiting time
5. Was referred
6. Unfriendly staff
7. Would have paid
8. No privacy
9. I don't know

Why do you seek hospitalization/admission?

1. Malaria/fever
2. Normal delivery
3. Accidents and injuries
4. Hypertension
5. Diarrhea
6. Diabetes
7. Treatment
8. Delivery complications
9. Surgery
10. Routine checking

Which health facility do you visit when you are ill?

1. Public hospital
2. Private hospital
3. Mission hospital
4. Public health center
5. Mission health center
6. Nursing health center/Maternity homes
7. All others

Are you insured?

1. Insured
2. Uninsured
3. How do you pay for your healthcare?

How do you cope with ill health?

1. Donations
2. Borrowing
3. Contributions
4. Friends
5. Relatives

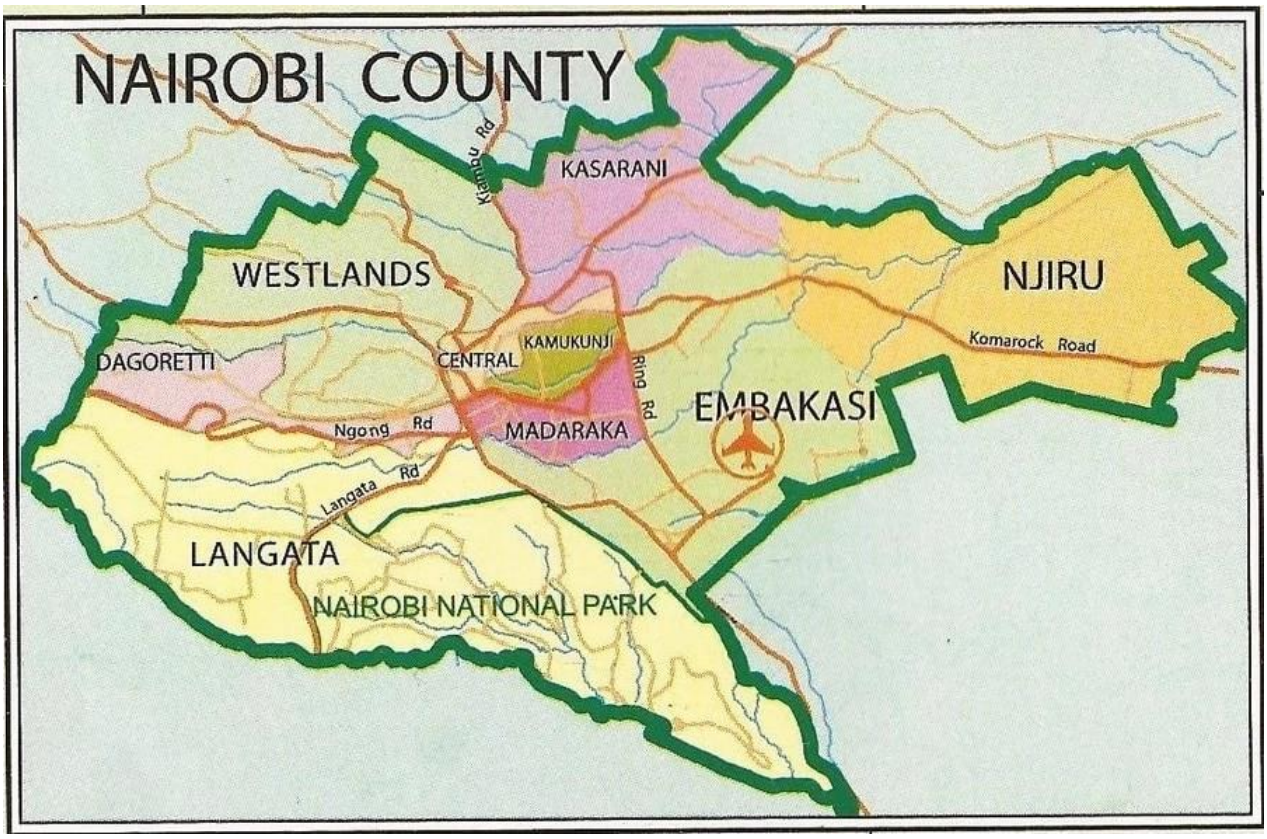
Appendix 8-Discussion guide for the wealth ranking meetings

The main questions that guided discussion on wealth ranking focused on perceptions of differentiating socioeconomic characteristics. These are summarized below:

1. When we look at ourselves in this meeting, are we all the same?
2. What makes us different from one another?

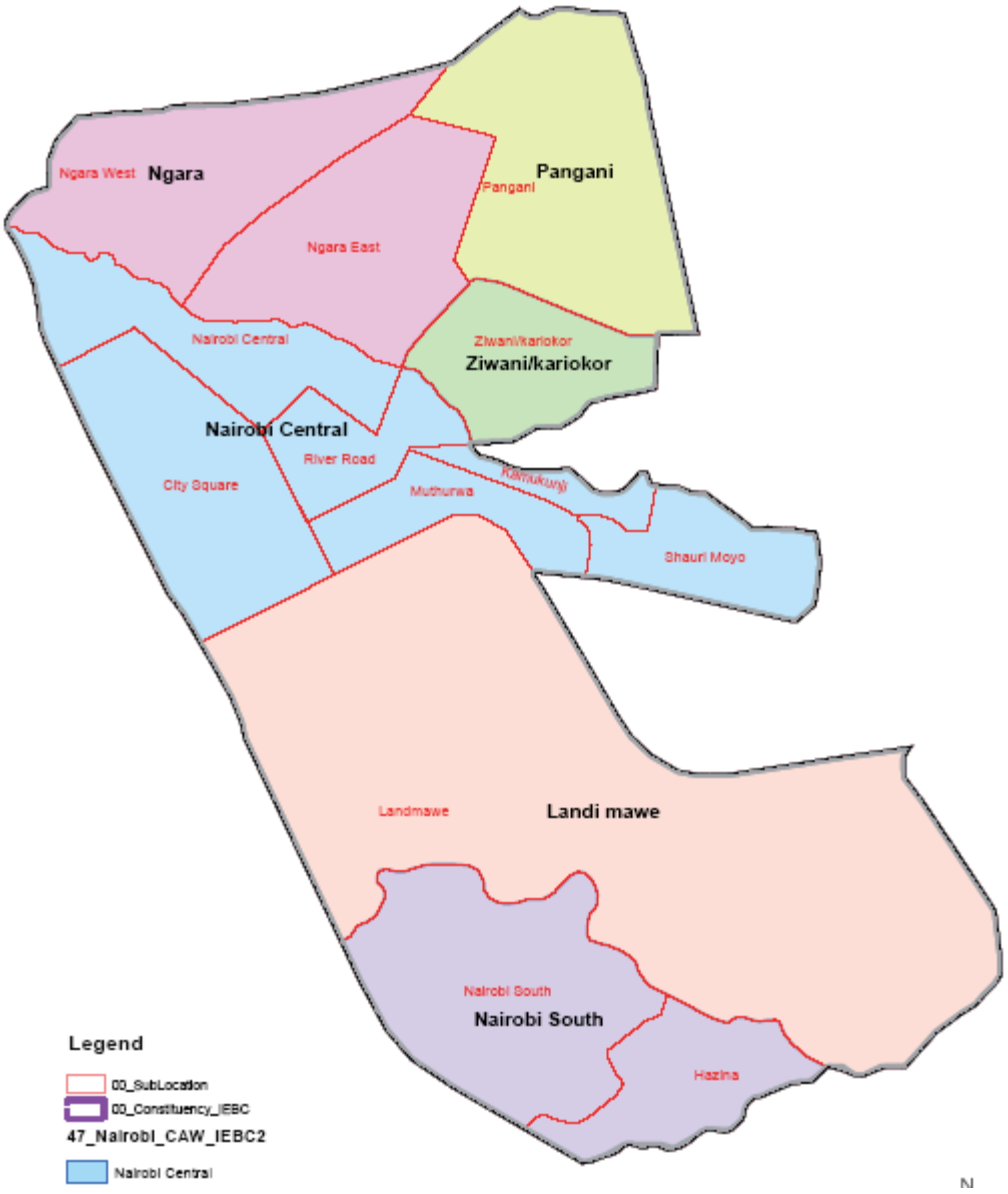
3. What are the different livelihood activities in this community that differentiate us from one another?

Political units of Nairobi County

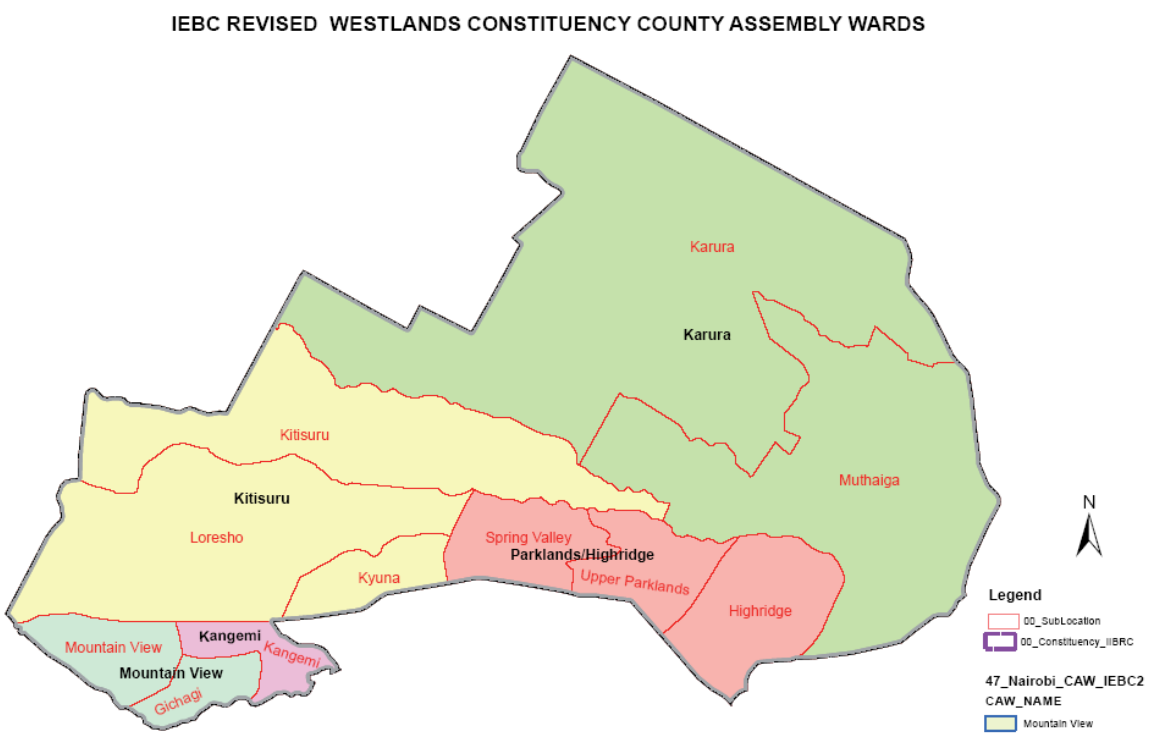


Source: Kenya National Bureau of Statistics 2010

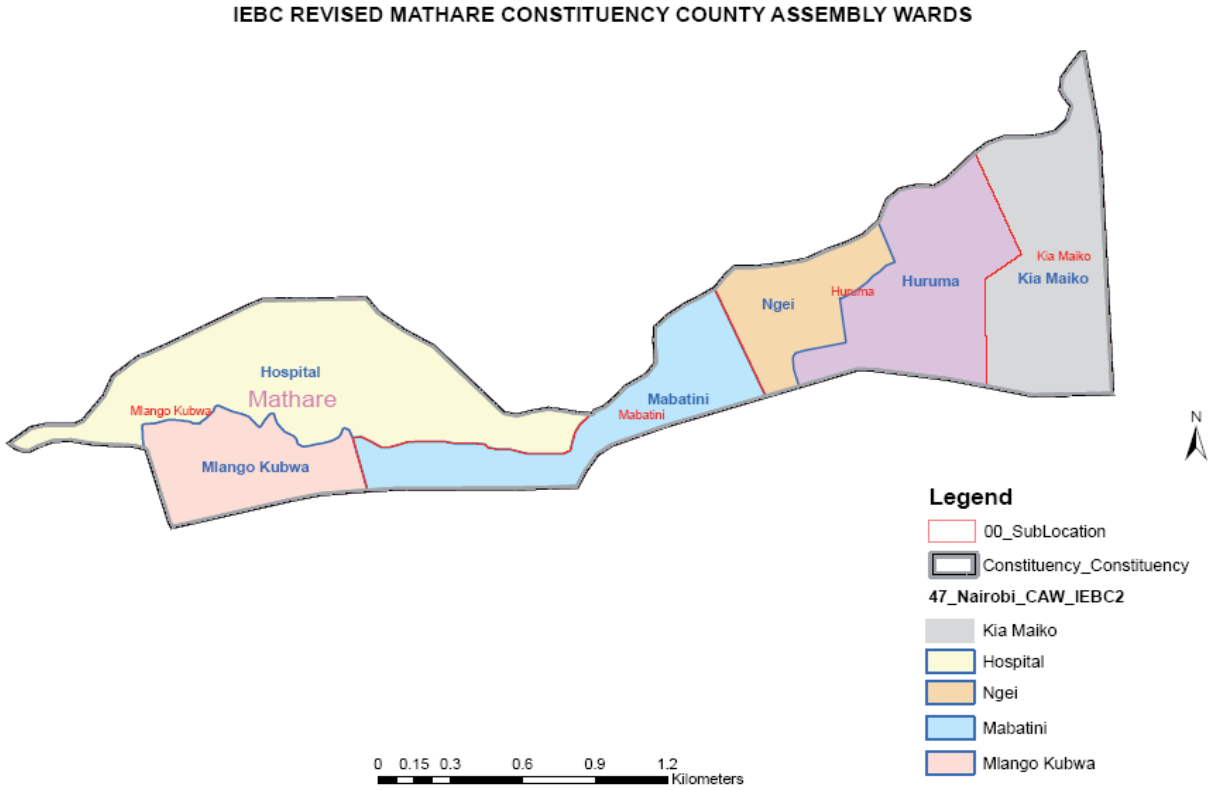
Appendix 10: Starehe Constituency Map



Appendix 11: Westlands Constituency Map



Appendix 12: Mathare Constituency Map



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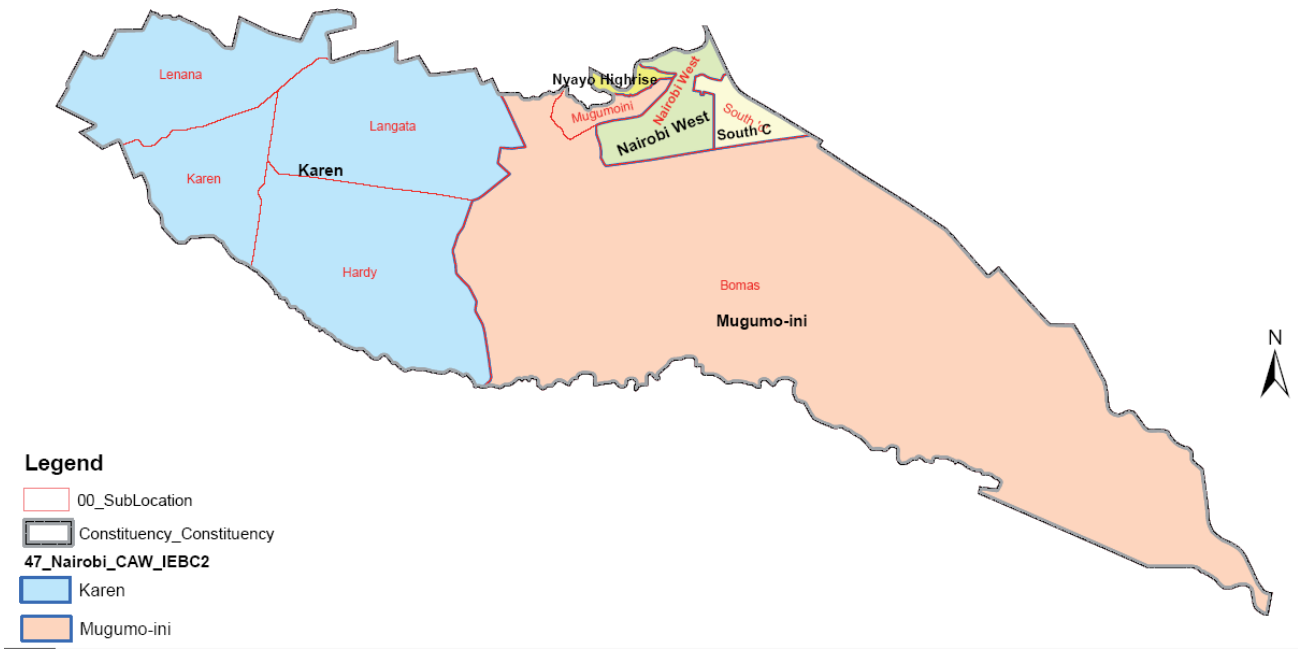
Appendix 13: Langata Constituency Map


Lenana
Langata
Karen
Karen
Hardy
Nyayo Highrise
Mugumoini
Nairobi West
Nairobi West
South C
South C
Bomas
Mugumo-ini
N
Legend
00_SubLocation
Constituency_Constituency
47_Nairobi_CAW_IEBC2
Karen
Mugumo-ini