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The Influence of Socio-Cultural Factors in Access to Healthcare in Kenya: A Case of Nairobi County, Kenya

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Abstract
The study examined factors that determine access to healthcare among the households in Nairobi County. The problem of concern in this study was that access to healthcare challenges have persisted despite expansion in healthcare system in Nairobi County. Access to public healthcare in Nairobi County is unequal among social classes. Lower social classes have worse healthcare than either the upper or the middle classes. The study sought to find out why the disparity in access to healthcare in Nairobi County persists despite government efforts to address the issue. The study employed a qualitative design. The households living in Nairobi County provided the frame in which the population sample was drawn using multistage cluster random sampling to arrive at a sample size of 1066. Qualitative data was collected using observations, focus group discussions and in-depth interviews. Content analysis was used to analyze qualitative data. The results confirms robust positive correlations between independent intervening variables (explanatory variables: socio-cultural variables) and dependent variables (access to public healthcare). The independent intervening variables had significant influences on access to public healthcare. The P-value was statistically significant. The results were not due to random chance and that P- 0.01< 0.05 confirms a positive relationships between the variables. The study objective and question were achieved. The hypotheses were disconfirmed.

Keywords: Social class, Access to Public Healthcare and Socio-Economic Status

1. Introduction

Access to healthcare among the various social groups is unequal in both developed and developing countries. In the United States, access to healthcare is unequal among families with different socio-economic backgrounds. For example, low income families have less access to healthcare, and this explains why they have high infant mortality rates compared to families of high incomes (Kitagwa, E.et al.1973). Evidence also show that African Americans, Red Indians and Hispanics have less access to healthcare due to their racial backgrounds compared to the majority whites (ibid). Socio-economic and racial factors play a key role in the distribution of access to healthcare. In France, access to healthcare for manual workers is less compared to professional workers (Andersen R. 1979). Professional workers have better socio-economic resources, defined by income, occupation

and education, which positively influence access to healthcare. The manual workers have less of these socio-economic resources, hence, the reason for not having good access to healthcare. In this case, occupation or employment statuses have some influence on access to healthcare. In Canada, low income population has less access to healthcare compare to middle or high income population. As a result of this health differences, life expectancy is lower among the lower income households compared with the higher income households. Income in this case appears to have an important influence on access to healthcare. Households with high incomes can purchase healthcare services at private or specialized outlets. But those with less income have limited options and this limits their access to healthcare.

In another study, evidence show that Eskimos have less access to healthcare, due to their origin status, compared to the native Australians. Originality status appears to affect access to healthcare. In this study, the native Australians have better advantages over the non-population. The evidence suggests that the non-locals are discriminated against and do not access equal resources and opportunities like the locals. Origin and discrimination therefore appear to be important factors in this study.

In Britain, low income population has less access to public healthcare compared to the higher income populations (Donabedian A, 1980). Income includes wages, salaries, rents, pensions and gratuities among others affect access to public healthcare. Those with high incomes have better capacities to procure public healthcare. Those with less income have less opportunities or resources to access public healthcare. The studies above show that access to healthcare was unequal among social classes. Socio-economic and cultural factors are distributed unequally and the upper social hierarchies have better access to healthcare, compared to the lower social classes. Health inequality persists despite the fact that these are developed countries with advanced health system.

In some Sub-Saharan countries, access to healthcare is still common despite numerous research and policy interventions. The World Bank shows that 50% of African population has access to modern facilities, and more than 40% do not even access clean water and sanitation. Immunization has not covered the entire population. This has resulted in high levels of maternal and infant mortalities, despite adequate human and material resources at their disposal (World Bank, 2006). For example, access to healthcare among poor Tanzanians is poor compared to the wealthy. This is more pronounced in rural areas, where incomes, education, employment is low compared to the urban areas (Schellen, A. et al. 2003). In Uganda, access to healthcare is adversely affected because of poor health systems-poor hospitals, lack of equipment, low staff capacities leading to high infant mortality rates (Donabedian A. 1990). The low socio-economic class population has limited options compared to the upper and middle class who can afford health insurance cover and use of private facilities (Brawley M. 2000).

Like the developed world, selected Sub-Saharan African countries provide unequal access to public healthcare. Sub-Saharan Africa is endowed with many natural and human resources, and yet access to public healthcare is still unequal. Socio-cultural disparities play an important role in access to public healthcare. The above shows that there is an extensive literature considering association between socio-position and subsequent health outcomes (Gallo V. et al. 2012). Socio-position has been conceptualized and measured in different ways internationally as demonstrated in USA, France, U.K and Sub-Saharan countries.

Access to healthcare challenges have persisted despite expansion in healthcare system in the Country. While all social groups need available, timely, convenient and affordable healthcare (IOM, 1993), these are only available to the upper and lower middle class. These are gaps that require urgent further research and policy interventions that specifically focus on these disparities. Policy makers also need to address the capacity of healthcare systems in order to effectively focus on these disparities.

According to National Bureau of Statistics, NBS, only about 52% of Kenyans have access to healthcare within 5 km. Mortality and morbidity rates are high; use of skilled attendants is only at 46% during delivery; use of modern contraceptives stands at only 46% and fertility rates are high at 2.7%. Majority of Kenyans have limited

access to healthcare due to the following: poor of proximity to health facility; unavailability of essential and prescriptive drugs in the facilities; high costs for the available drugs; unaffordable insurance services; unfriendly, unprofessional health personnel.

Apart from the structural problems, Kenya has over the years suffered under ethnic political divisions that have determined distribution of resources (Holmquist and Githinji, 2009; Thomas-Slayter, 1991). Ultimately, certain regions that correspond to certain ethnic communities are relatively endowed with health facilities than others. While Nairobi County is multi-ethnic, certain informal settlements are highly populated by specific ethnic communities which suffer from the ethnic political dynamics reflected across the country.

Access to public healthcare is also lopsided in favor of the upper and middle class. These categories shun public healthcare facilities and opt for private health facilities which offer more specialized or better care compared to the public facilities. These private facilities that provide public healthcare but are private functionally include Nairobi hospital, Aghan, mater and Karen hospitals. It is only the upper and middle social classes who utilize these facilities because of their advantaged positions and lucrative social insurance packages. These facilities isolate the lower social classes from accessing specialized or better care.

2. Definitions of concepts

Social class----Independent variable

Multiple theories of social class have been articulated but such theories are interlinked and co-dependent. For example, social class has been defined as "….social groups arising from interdependent economic relationships among people. These relationships are determined by a society's forms of property, ownership labor and their connections through production, distribution and consumption of goods, services and information. Social class is thus premised upon people's structural location with the economy-as employees, employers, self-employed; and unemployed (in both formal and informal sector), and as owners or not of capital, land, or other forms of economic investments" (Krieger, N. 2001).

Another theory is associated with Max Weber (Weber, M. 1978). This theory suggests that class differences emerge through the process of "social closure", where some groups are prevented from accessing particular positions. This occurs through education (e.g limiting the availability of appropriate education; and then limiting the best paid and most interesting jobs to those who hold particular certificates of training/degrees; through ownership of capital (limiting the position of a company, housing, land ownership to those born into particular circumstances); through legal or cultural rules (e.g color, religious, marriage or gender. Any of these barriers act to deny most people access to favorable positions in the occupational structure and facilititates access to others. Capitalists are defined by private property rights in means of production; the middle class are defined by mechanisms relating to the acquisition of education and skills; and the working class is defined by exclusion from both higher education and capital.

And yet another aspect of class theory is in relation to the process of exploitation and domination. This conceptualization is closely aligned with that of Marxism (Muntataner,C., & Lynch, J. 1999). This one describes the process through which some social classes control the lives and activities of other classes (domination); the process through which the capitalists (the owners of the means of production) acquire economic benefits from the labor of others (exploitation).

Even when all these theories are synthesized, none explains social class in Kenya appropriately. However, the Kenya National Bureau of Statistics provides some clue that appears more useful for this study. According to the KNBS, the upper class comprises those who spend more than Shs. 200,000 per month (KNBS, 2020). The

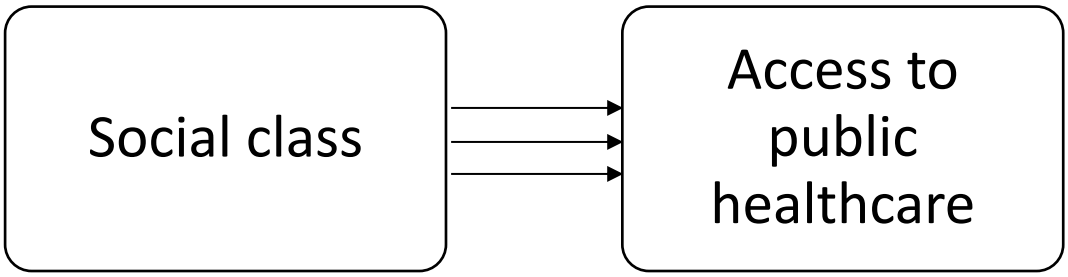
middle class consists of households who spent Shs. 24,000-Shs. 120,000 per month (NBS, 2020). Further, upper class earn 200,000 and above, middle class earn 23,670-199,999 and lower class earn below 23,670 (KNBS, 2019). In this study, therefore, monthly earnings are used to conceptualize social class.

Access to Public healthcare----------Dependent variable

At the theoretical level, access to health is defined as a way of approaching, reaching a place, opportunity to reach a health facility (Whitehead, M. et al. 1997). It has also been defined as access to a service, a provider, or an institution; access here is defined as the opportunity (Gulliford, et al. 2002). Access to healthcare means helping people to command appropriate healthcare resources in order to preserve or improve their health. This implies that services should be available and adequate to supply the services required. For Nairobi Residents, access to healthcare means; proximity to health facilities, availability of affordable insurance services, timeliness of care, availability of prescription drugs and readily available health personnel. However, it is only the upper class that has full access as opposed to the lower class that lack or have only limited access to public healthcare. The upper class and to some extent the lower class have health insurance and this helps to mitigate high costs especially in the private health facilities that also offer public healthcare services.

In this study, access to public healthcare is conceptualized using indicators like: lack of access, limited access, and full access to public healthcare. This relationship between the independent variable (social class) and the dependent variable (access to public healthcare) is explained using various socio-cultural variables as shown in figure 1.1 below:

Figure 1.1 Social class and access to public healthcare



In addition, high and middle classes have access to healthcare in private healthcare facilities like Aghan University hospital, Nairobi hospital, and Mater hospital including health clinics across the County. This is because they can afford given their socio-economic status. These classes have high earnings and in some instances they have healthcare insurances that they can use to purchase full or limited access to healthcare.

3. Methods

Site description

This study purposively selected Nairobi County, from the 47 Counties of Kenya. Following the adoption of the 2010 constitution, Kenya was divided into 47 Counties. Nairobi County has an area of 696.1 km^2 and is located between 36^0 45 ' east and 1^0 18' south latitudes. It lies at an altitude of 1,798 meters. The County also offers a mix of rural and urban economic systems; it depicts a traditional and modern ways of living. The County Houses University of Nairobi where the study was taking place. The County also houses other institutions like Parliament, Ministry of Health and Education whose members had been identified as useful sources of data.

It has a combined population of about 4 million people drawn from all parts of Kenya and beyond. The County has both urban and informal settlements. 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 labour 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 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.

Population

The population was chosen from among households in Nairobi County. The participant characteristics in this study included: age structure, gender, income, employment/occupation, marital status, wealth and place of residence.

Sampling technique

The study used multi-stage cluster sampling to determine the study sample. This is a form of cluster that involved several cycles of sampling from the groups. The population was divided into clusters then samples were taken. The selected clusters were further divided into smaller clusters and re-sampled again. This processed was repeated several times until the ultimate sampling units were selected at the last of the hierarchical levels.
Nairobi County…….cluster 1…..random selection
Constituencies……..cluster 2…..random selection
Wards……cluster 3…..random selection
Sub-locations……..cluster 4……random sampling
Village units…….cluster 5……..random sampling

Multistage cluster random sampling was used to select the population study sample. This sample was 1066. This method allowed the researcher to apply cluster or random sampling after deterring the groups for selection. This allows the population to be divided into groups without restrictions. It also allows for flexibility to choose the sample carefully. It is also useful when collecting primary data from a geographically dispersed population such as the one in Nairobi County.

Data collection instruments

Data for the qualitative design was collected using the following instruments: in-depth interviews and focus group. The data was analyzed using content analysis. Content analysis is used to determine the presence of certain themes or concepts within the qualitative data. Content analysis helps to quantify and analyze the presence of meanings and relationships between the variables. Such robust associations helped to determine if the study questions and objectives were achieved. They also assisted to confirm or de-confirm the study hypotheses. The results were used to make recommendations.

Data Analysis

Qualitative data was collected for objective two using individual, in-depth and focus group discussions. These were the socio- cultural factors which included culture, language, social capital, poverty, race, ethnicity, migrant status, habits, values and others.

The responses defined households' perceptions, opinions, and feelings about the phenomena. The study made discovery of various themes from common sense, constructs, researcher's values, and personal experience with the subject matter. This is what ground theorists call open coding, and what content analysts call qualitative analysis or latent coding (Gibbs, 2002).

The transcripts were analyzed using content analysis and analytical phases included becoming familiar with the data, generating new codes, searching for and review for themes and patterns. The assistant researchers read each transcript a number of times in order to familiarize them with the content and thereafter generated initial codes (Patton MQ. 2002). Items describing similar ideas were grouped, coded manually, and sorted to capture common themes (Pope C. et al. 2000). The team conducted all analyses and resolved discrepancies through discussions. The objective here was to measure the relationship between socio-cultural factors and access to healthcare.

4. Ethical consideration

The National Commission for Science, Technology and Innovation approved the study's research protocol on 14th July, 2015 for a period ending 18th December, 2015. Permit No. NACOSTI/P/15/7814/6977 was issued on 14th July. 2015. The Ministry of Health authorized the study to be carried out on its health facilities; The Ministry of education too authorized the study to be carried out; The County Government of Nairobi, Health Department authorized the study to be carried in the County.

Households in Nairobi County were eligible to participate in the study, 15+ years of age, and they live in Nairobi. Prior to participating, all individuals received a letter describing the study purpose and procedures, and that participation was voluntary. Oral and written consent was obtained from the participants before the interviews commenced. Al the data obtained was held confidential. The use of the data collected, the purpose and access to information as well as the role of the researcher was explained. The interviewers explained the usefulness of the study findings, which was to help plan improvements of access to public healthcare among various stakeholders.

5. Findings

The data collected was qualitative through focus group discussions and in-depth interviews. The study was designated to evaluate the influence of socio-cultural factors on access to public healthcare in Nairobi County. This was a qualitative study designed to explore perspectives and experiences in access public healthcare among the households in Nairobi County. The study explored how socio-cultural factors influenced public healthcare in Nairobi County. It conducted focus group discussions because they are important techniques for working in diverse cultural settings and provide rich and invaluable information. In-depth interviews were useful in providing detailed information about the respondent's thoughts and behaviors. This also helps to understand the underlying motivations, beliefs, attitudes, and feelings of the respondents on particular issues. Transcripts were analyzed using thematic/content analysis. Data was coded in phases to create meaningful patterns. Themes identified included new policies/regulations, culture, behaviors, attitudes, values, poverty, deprivations, social resources, social capital, communication, discrimination and so on.

Attitudes

The majority did not like nor understood the new regulations. According to them, these new regulations were a preserve of households of upper and middle class hierarchies. This failure to appreciate the regulations further alienated them from access public healthcare.

However, the minority understood and followed the new regulations. The new regulations increased access among 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. We therefore conclude that attitudes (explanatory variable) have significant influence on access to healthcare. This positive relationship confirms the questions and the objective of the study. The null hypothesis is nullified and the alternate hypothesis is upheld.

Perceptions and perspectives towards services provided

The majority of the respondents were not satisfied with the services provided by the county health systems. The healthcare delivery systems did not satisfy their needs as they are not treated well by the healthcare personnel. All kinds of treatments were quite unsatisfactory, and this limited their access to healthcare.

On the other hand, a few households, mainly the middle class, expressed satisfaction with healthcare services. The services were not readily available but they were satisfied with what was available. This is so because this category had additional opportunities that gave them access to healthcare in private facilities. They had alternative options compared to the lower class.

But the minority had poor perceptions and perspectives but they did not care about services given. This category of social class had better socio-economic resources that gave them many options to access private healthcare. Whether services were available or not, was of less significance given the opportunities before them.

This means that perceptions and perspectives (intervening variable) have a potential association with access to public healthcare. Perceptions and perspectives had a positive relationship with access to public healthcare. This relationship confirms the objective and the question of the study. The relationship also nullifies the null hypotheis and upholds the alternate hypothesis.

Access to public healthcare services

The minority did not appreciate access to public healthcare services. This is because they were not using public facilities much. Their healthcare was mainly in private health facilities, given that they had better opportunities to purchase private healthcare services.

On the other hand, the middle class care somehow appreciated access to healthcare services. They partly used public facilities and therefore accessibility was to some extend important. This was because they had some socio-economic packages that gave them some options to use private healthcare.

However, the majority of the lower class viewed access to healthcare as a very important component of their healthcare. They entirely depend on public health services and any delays or otherwise seriously affected them. This is so because they entirely depend on public facilities to access healthcare. They have no opportunities, given their deprived status to access healthcare.

Perceptions were therefore found to have a social relationship with access to public healthcare. This potential association influenced access to public healthcare. This association nullified the null hypothesis and affirmed the objective and questions of the study.

Communication

The findings show that majority of the lower class did not understand English or Kiswahili. They could only communicate in their local languages. The health facilities lacked interpreters to help them communicate with health providers. This affects their ability to access public healthcare.

The middle class had fairly good communication skills and could communicate with health providers well. They could communicate in English and Kiswahili. This medium communication increased their access to healthcare. This advantage was due to their advantaged socio-economic status.

However, the minority upper class had very good communication with the health providers. They communicate easily with health providers, and this increases their access to healthcare. This is partly due to their socio-economic status. Consequently, ability to communicate had a positive association with access to healthcare. The potential association influenced access to public healthcare. This explanatory intervening variable was an important factor in access to healthcare. It influenced access to public healthcare, and this nullified the null hypothesis and affirmed the alternate hypothesis. The causal effect confirmed the objective and the question of the study.

Lack of faith in public facilities

The findings show that minority upper class had no faith in health facilities. These facilities were dilapidated, old and needed repairs urgently. They lacked efficient health workers. In addition, health facilities lacked clean water and sanitation. They shied away from using them in preference to private health facilities.

On the other hand, the middle class had some limited faith in public health facilities. They used them partly to supplement their use in private facilities. This was so because they had limited access to socio-economic opportunities compared to the upper class.

However, majority lower class had faith in public facilities despite lack of essential facilities like laboratories, clean water and sanitation and few health personnel. Even without faith, lower class entirely relies on public facilities for healthcare. They lack socio-economic resources and cannot afford private healthcare.

Lack of faith in public resources had a causal relationship with access to public healthcare. This positive relationship influenced access to public healthcare. The relationship nullified the null hypothesis and affirmed the alternate hypothesis. The relationship also confirmed the objective and the question posed in the study.

Cultural factors

The majority lower social class respect culture/ because it affects perceptions of health, illness and death. They value customs, values, language and traditions as they make it easy to communicate freely and honestly. In this way, they can reduce disparities and improve health outcomes.

On the other, middle class have some respect of cultural components because their socio-economic positions have added considerable challenges to culture and traditions. They consider culture and traditions as somehow outdated and they prefer modern western culture. Cultural factors therefore have limited effect on access to healthcare.

However, minority upper households have limited respect to culture and related traditions. They consider culture outdated and outrageous and therefore try their best to discard in preference to modern culture. Most of these households have high opportunities occasioned by their access to socio-economic assets—high income, education and occupations. These factors have profoundly changed their life styles and now only prefer to use modern medicine. They shun culture because it makes them look backward and primitive.

Culture had a significant association with access to public healthcare. The association was positive and this correlation nullified the null hypothesis and confirmed the alternate hypothesis. The objective and the study question were also confirmed.

Perceptions towards health workers

The majority of the lower class experienced hostile receptions; the workers were rude and lacked cultural appreciation. Despite these negative attitudes, they still seek healthcare in public places, due to limited options arising from their socio-economic deprivations. These attitudes seriously affect access to healthcare.

On the other hand, the middle class had some negative attitudes towards health workers. This forced them to seek healthcare in private facilities, where staff are respectable. They are able to do so because they have better access to socio-economic resources. These opportunities give them alternative options.

However, the upper class had very negative attitudes and cared less because they had alternatives. They were of high socio-economic status–high incomes, education, and employment and therefore they do not rely so much on public health facilities for their health needs.

Perceptions towards health workers have potential associations with access to public healthcare. These explanatory intervening variables have a positive relationship with access to public healthcare. These positive correlations nullified the null hypothesis and confirmed the alternate one. Both the objective and question were confirmed.

Poverty

The minority upper class is above poverty lines and therefore poverty does not concern them. They have high incomes, way above 200,000 as per the (NBS, 2019) records and therefore access to public and private healthcare is not a challenge. They can access full healthcare at both private government wing and the private sector.
The middle class too have some middle level incomes between 3,670-199,999 and therefore can access both public and private healthcare facilities. They have medium social insurance covers and this mitigates high healthcare costs. They can therefore access some limited access to healthcare.

However, the majority lower class has no resources and therefore cannot access public healthcare. Their earnings are below 23,670 and this cuts them off from accessing public healthcare. They live in deplorable conditions which in themselves increase poor health.

Poverty therefore has robust relations with access to public healthcare. Poverty has a positive relation with access to public healthcare. This correlation influences access to public healthcare at all stages-infancy, adulthood and old age. It is therefore an independent variable (intervening variable/explanatory variable) that has significant influence on access to public healthcare.

Social resources

Social resources include tangible items like money, information, goods and services. Love and affection fall in this category. Social position in society is part of social resources.

On the other hand, middle class have fair respect or value to social resources. They too have some fairly moderate social goods. They have fairly good incomes, education and employment opportunities. These factors influence their access to healthcare.

However, the majority lower class value social resources as they have considerable influence on access to healthcare. These factors frame behavioral choices including decisions affecting health.

Social resources (explanatory variable) therefore have a causal relationship with access to public healthcare. This association influence access to healthcare, and hence, nullifies the null hypothesis and accepts the alternate hypothesis. The correlation upholds the objective and the research question.

Social networks

Social networks are defined as the web of person-centered social ties. They include social relationships, size, density, blondness, homogeneity, frequency of contacts, extent of reprocity and duration. Other factors include secure attachments necessary to access food, warmth and other natural resources. They provide love, security and other non-material resources that are necessary for human development.

The majority lower class values these resources but the upper and middle class are somewhat reserved. They have enough socio-economic resources and therefore do not rely on social networks.

Social variable potentially affect access to public healthcare. This association determines the extent, strength and the quality of social connections with others. The correlation is positive and therefore nullifies the null hypothesis and upholds the alternate hypothesis.

Social capital

These are resources that available to households. Social capital includes dimensions like economic resources gained from being part of networks of social relationships, trust, trustworthiness, and civil norms, association of membership, voluntary associations, and homogeneity. Social networks, social support, social networks and social connections are valuable to households and allow access to healthcare resources. They sometimes provide job opportunities and help enhance skills.

The minority do not value social capital because they are insulated by high socio-economic resources. They have high incomes, education and employment opportunities and these resources promote their health needs.

On the other perspective, the middle class had some middle level value for social capital. This was because they sometimes benefit from social capital. This position they hold is because they also have some social goods like moderate incomes, education and employment opportunities that enable them access healthcare resources but in some limited way.

However, the majority of the lower class has considerable value for social capital. High level of social capital does influence access to healthcare through spread of health norms. Social capital increase knowledge and skills that affect access to healthcare. It also helps tackle health inequalities that result from social isolation, low levels of support and confidence. Social capital sometimes tries to reduce the gap between the poor and the rich. Furthermore, it helps to increase support opportunities for people and groups to form connections. Negative social capital can also pose restrictions of individual freedom and exclusion.

Social capital has potential association with access to public healthcare. It is an explanatory variable that shows a positive relationship with access to public healthcare. This correlation nullifies the null hypothesis and confirms the alternate hypothesis. The relevance and magnitude of the association has significant influence on access to public healthcare. The findings confirm the research question and the objective.

6. Discussion

Socio-cultural factors have been found to have significant influence on access to public healthcare. These factors include culture, attitudes, values, discrimination, stress, associations, and social capital among others. Stress for example has been found to affect access to healthcare in many instances: Stress has been associated to risk

behavior and chronic diseases and these are dominant causes of mortal (Brunner, 2000). Quite often, people do not take stress as important for their health let alone the fact that some do not even understand when stressed. This continues to be a killer disease albeit lack of specific policies to address the vice.

Other socio-cultural factors include lack of "social resources" among the lower socio-economic classes. These include character and intensity of social net works, associational social hierarchies (Hall and Taylor). These resources are important and they assist households' access resources that are adequate to meet their healthcare needs. It is important that these resources are nurtured and distributed evenly among the households.

Other factors related to the above are social relations, social net works, trust, secondary associations, marriages and friendships. All these constitute "social capital" that is critical for day –to -day living. Others include status hierarchies in society that create distinctions among social class, and assign individuals with prestige social positions (Ollivier, 2000). These factors (independent variables) have profound influence on access to public healthcare (dependent variable). Lack of them increases inequality in access to healthcare. The most affected are lower social class. These are gaps that need to be addressed.

Migrants all over the world have been found to lack adequate access to healthcare because of their citizenship status (Carmononce, R. 2014). Migrants have serious challenges especially in the US where access is healthcare is restricted among non-citizens. In Nairobi County, migrants are not restricted from having access to healthcare using public facilities. This is partly so because migrants have not been clearly defined as most neighboring counties flock into the city county in search of employment and other socio-economic benefits. However, they increase pressure on the limited health resources in the county, making difficult for the city population to access healthcare. Migrants therefore (independent variable) have significant influence on access to public healthcare (dependent variable).

The government has implemented many policies and programmes to address the plight of migrants and many of them access limited socio-economic benefits. In fact, because of the poor identification systems in the Country, many migrants simply melt into the city population. In that way, they access the social benefits provided by the state. However, these benefits as suggested earlier are inadequate and more needs to be done to increase social protection programs. These proceeds can increase their capabilities to access socio-economic resources that can meet their healthcare needs. The situation is worse in informal settlements where the majority live (GOK, 2012). These are the lower social class who live closely with what Karl Marx terms "*lumpenproletariat" (*Brown D. 2009).

According to Max Weber, households with prestige, honor and power have more opportunities to access healthcare compared with those who lack them. Prestige, honor and power are very important social assets that increase social inequality among social classes. The households with honor, prestige and power also have better socio-economic benefits and these only help to divide society further. Those with these combined assets have more opportunities to compete in a competitive market and therefore access more healthcare compared with those without.

Unfortunately, little is being done to augment these factors and these have increased stress leading to premature deaths. Some studies have shown that such people appear to be healthier (Kawachi, K. 2004). Such illusions have resulted into fatal health outcomes. It is imperative that government and other stokeholds address the need to have these factors so that they can enhance access to healthcare. Relevant departments of government should increase these among the people who need them most.

7. Conclusion

Access to public healthcare is influenced by many factors. In this study, socio-cultural factors are independent (intervening/explanatory variables) determinants of access to public healthcare. They indicate the extent,

strength and quality of social connections with others. They recognize the importance of such social connections. These are resources that available to households.

Attitudes impact on emotions, well-being, satisfaction with care, and access to healthcare services. They influence health outcomes. Positive attitudes increase satisfaction while negative ones create stress and can consequently reduce the life span of households.

Perceptions play an important role in shaping health outcomes. 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 important for healthcare. It makes providers protect their patients, save on costs, and increases day-to-day operating efficiency. It helps patients to access medical histories and hence reduces chances of medical 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.

Social resources include tangible items like money, information, goods and services. Love and affection fall in this category. Social position in society is part of social resources.

Social networks are defined as the web of person-centered social ties. They include social relationships, size, density, blondness, homogeneity, frequency of contacts, extent of reprocity and duration. Other factors include secure attachments necessary to access food, warmth and other natural resources. They provide love, security and other non-material resources that are necessary for human development

Social capital includes dimensions like economic resources gained from being part of networks of social relationships, trust, trustworthiness, and civil norms, association of membership, voluntary associations, and homogeneity. Social networks, social support, social networks and social connections are valuable to households and allow access to healthcare resources. They sometimes provide job opportunities and help enhance skills.

These social variables potentially affect access to public healthcare. The magnitudes of the associations are vast and have significant influence on access to public healthcare. The study questions and objectives were achieved. The hypothesis was de confirmed. The associations nullify null hypothesis and accept alternate hypothesis. The nullification confirms the study objective and question.

Healthcare is central to quality of life, yet many households in the County lack proper access to public healthcare. This study adds to the current literature on access to public healthcare. It provides new information on households' perspectives and experiences in accessing public healthcare. The study also identifies opportunities for improving access to public healthcare.

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Conflict of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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