SOCIO-ECONOMIC FACTORS AND ACCESS TO HEALTH CARE SERVICES IN NORTHERN DIVISION, MABLE CITY

SHARON TAAKA

M22/MUC//BSW/024

A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF BACHELOR OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF UGANDA CHRISTIAN UNIVERSITY

July, 2024

UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

DECLARATION

I, Taaka Sharon hereby declare that this research report entitled Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City is my original work and to the best of my knowledge has never been submitted to any other institution of higher learning for any academic award.

Sign: ..... Date: ……

Taaka Sharon

APPROVAL

This research report was carried out under my supervision on the topic "Socio-Economic Factors and Access to Health Care Services in Northern Division" and it is now ready for submission as a partial fulfillment for the requirements of the award of a bachelor's degree of social work and social administration of Uganda Christian University.

Signature: …… Date: ……

Mr. Kooba Vincent

Supervisor

DEDICATION

This research report is a special dedication to my beloved sister Wabule Annet for her financial support and guidance to me to this level. May the Almighty God bless the work of her hands.

ACKNOWLEDGEMENT

I acknowledge God the Alpha and Omega, for the precious gift of life, strength, knowledge and wisdom which have enabled me carry out this research report successfully.

I acknowledge my research supervisor Mr. Kooba Vincent for his tireless efforts and guidance till the completion of this research report may God the Alpha and Omega bless the work of his hands abundantly.

LIST OF ABBREVIATIONS

AIDS	:	Acquired Immune Deficiency Syndrome
DHS	:	Demographic Health Survey
HIV	:	Human Immune Virus
MoES	:	Ministry of Education and Sport
NGO	:	Non-Governmental Organization
STDs	:	Sexually Transmitted Diseases
UBOS	:	Uganda Bureau of Statistics
UDHS	:	Uganda Demographic health Surveys
UK	:	United Kingdom
UN	:	United Nations
WHO	:	World health organization
CDC	:	Centre for disease control
MOH	:	Ministry of health

TABLE OF CONTENTS

DECLARATION ii
APPROVAL iii
DEDICATION iv
ACKNOWLEDGEMENT v
LIST OF ABBREVIATIONS vi
TABLE OF CONTENTS vii
ABSTRACT x

CHAPTER ONE

INTRODUCTION

1.0 Introduction 1
1.1 Background to the Study 1
1.2 Problem statement 4
1.3 The Purpose of the Study 5
1.4 Specific Objectives of the study 5
1.5 Research questions 5
1.6 Scope of the study 6
1.6.1 Content scope 6
1.6.2 Geographical Scope 6
1.6.3 Time Scope 6
1.8 Significance of the study 6
1.9 Conceptual Frame work 7
1.10 Operational Definitions 8

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction 9
2.2. Gender and access to health care 9
2.3 Educational level and access to health care 11
2.4 Age and access to health services 13

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction 16
3.1 Research Design 16
3.2 Study Population 16
3.3 Sample size 16
3.4 Sampling Techniques 17
3.4.1 Simple random sampling 17
3.4.2 Purposive sampling 17
3.5 Research Instruments 17
3.5.1 Questionnaire 17
3.5.2 Interviews 18
3.6 Data quality control tools 18
3.6.1 Validity 18
3.6.2 Reliability 19
3.7 Data Processing and Analysis 19
3.7.1 Quantitative data analysis 19
3.7.2 Pearson Correlations and Regression Analysis 20
3.7.3 Qualitative data analysis 20
3.8 Data collection procedure 20
3.9 Ethical issues 20
3.9.1 Consent 20
3.9.2 Confidentiality 21
3.9.3 Fraud and plagiarism 21

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.2 Demographic characteristics of the respondents 22
4.2.1 Age of Respondents 22
4.2.2 Gender of Respondents 23
4.1.3 Marital status of the respondents 23
4.1.4 Educational level of the respondents 24
4.2. Gender and access to health care 26
4.3. Educational level and access to health care 28

4.4. Age and access to health care services 31

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction 35
5.1 Discussion of Findings 35
5.1.1 Gender and access to health care 35
5.1.2. Educational level and access to health care 35
5.1.3 Age and access to health care services 36
5.2 Conclusions 36
5.2.1. Gender and access to health care 36
5.2.2. Educational level and access to health care 36
5.2.3. Age and access to health care services 36
5.3 Recommendations 37
5.4 Suggested areas for further research 37
REFERENCES 38

APPENDICES

Appendix I – Consent Letter 39
Appendix II: Self-administered questionnaire for youth and local leaders 40
Appendix III: Interview guide for parents 42
Appendixes IV: Work Plan Schedule 43

ABSTRACT

This research study was guided by the topic Socio-Economic Factors and Access to Health Care Services in Northern Division. And it was guided by the following research objectives: To assess the effect of gender on access to health care services in Northern City Division Mbale City, to examine the effect of educational levels on access to health care services in Northern City Division Mbale City and lastly to investigate the effect of age on access to health care services in Northern City Division Mbale City. The study used both a quantitative and qualitative research design and it considered a population of 100 respondents with a sample size of 80 respondents. The study findings concluded that women and men health access is influenced by their gender interaction, that gender roles coupled with domestic expectations compromise health care access, that men with a more masculine gender orientation are less likely to go for health care counseling, that education levels affect access to health care services, that education attainment is an indication of literacy levels and impacts healthcare outcomes, that aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider, that if old people are constrained by levels of income, they end up not making right decisions and lastly that that health care is affected by age differences because older people have greater need for health care. The study findings concluded that: women and men health access is influenced by their gender interaction, that women access to health care is influenced by their gender due to community perceptions/societies they stay, that education levels affect access to health care services, that education attainment is an indication of literacy levels and impacts healthcare outcomes, that aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider, and lastly that if old people are constrained by levels of income, they end up not making right decisions.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter describes the background of the study, problem statement, purpose of the study, research objectives, research questions, scope of the study, significance of the study and the conceptual frame work.

1.1 Background to the Study

19th Century turned out to be a turning point in the healthcare industry. There were numerous advances in the technological, chemical and biological fields which gave the physicians an opportunity to learn more about diseases and better understanding to treat ailments. Healthcare industry started with home remedies. It began as a purely reactionary, medical practice in which people from diverse socio-economic backgrounds learnt about the medicinal properties of a plant through trial and error, documented it and passed on to others. The use of plants as healing agents is a long-standing practice (WHO, 2019). Healthcare eventually started as traditional healthcare where different cultures did a purposeful study on healthcare. One of the oldest examples comes from Mesopotamia known as "Treatise of Medical Diagnosis and Prognoses," where they made tablets based on rational observations of the body.

During the past 150 years, two factors have shaped the modern public health system: first, the growth of scientific knowledge about sources and means of controlling disease; second, the growth of public acceptance of disease control as both a possibility and a public responsibility. In earlier centuries, little was known about the causes of disease, society tended to regard illness with a degree of resignation, and few public actions were taken. As understanding of sources of contagion and means of controlling disease became more refined, more effective interventions against health threats were developed. Public organizations and agencies were formed to employ newly discovered interventions against health threats. As scientific knowledge grew, public authorities expanded to take on new tasks, including sanitation, immunization, regulation, health education, and personal health care. (Chave, 2020)

Globally, 50% of people are unable to access basic health services, as reported by the World Bank and the WHO in 2017.The link between science, the development of interventions, and organization of public authorities to employ interventions increased public understanding of social commitment to enhancing health. The growth of a public system for protecting health depended both on scientific discovery and social actions. Understanding of disease made public measures to alleviate pain and suffering possible, and social values about the worthiness of this goal made public measures feasible (Merchant and Jones et al., 2021). The history of the health care service system is a history of bringing knowledge and values together in the public arena to shape an approach to health problems. When the Great Depression hit in the '30s, healthcare became a more heated debate, most especially for the unemployed and elderly. Even though "The Blues" (Blue Cross and Blue Shield) were expanding across the world, the 32nd President of the United States, Franklin Delano Roosevelt (2017), knew healthcare would grow to be a substantial problem, so he got to work on a health insurance bill that included the "old age" benefits desperately needed at the time.

The term "health care services" means any services provided by a health care professional, or by any individual working under the supervision of a health care professional, that relate to (A) the diagnosis, prevention, or treatment of any human disease or impairment; or (B) the assessment or care of the health of human beings (WHO, 2019). Healthcare is the improvement of health via the prevention, diagnosis, treatment, amelioration or cure of disease, illness, injury and or her physical and mental impairments in people. Health care is delivered by health professionals and alliedhealthfields. Medicine, dentistry, ph armacy, midwifery, nursing, optometry, audiology, psychology, occupational therapy, physical therapy, athletic training, and other health professions all constitute health care (Merchant and Jones et al., 2021). The term includes work done in providing primary care, secondary care, and tertiary care, as well as in public health. Access to healthcare may vary across countries, communities, and individuals, influenced by social and economic conditions as well as health policies. Providing health care services means "the timely use of personal health services to achieve the best possible health outcomes. Socio-economic limitations to health care services affect negatively the use of medical services, the efficiency of treatments, and overall outcome (well-being, mortality rates) (Merchant and Jones et al., 2021).

More than 600 million people in Africa lack access to basic healthcare services, and overall health spending in Africa remains inadequate to meet increasing healthcare demands. Africa is home to over 16 percent of the world's population and shoulders 23 percent of the global

burden of disease, but it accounts for just one percent of annual Global health expenditures. Health is severely underfunded and careful spending is of even of greater importance (Merchant and Jones et al., 2021). Sub-Saharan Africans spend on average only $18 per capita on health care (excluding South Africa), compared to $3,641 in the developed world. This includes donor spending, which in some African Countries amounts to up to 50 percent of National budgets. With few exceptions African public healthcare systems border on dysfunctional (Ngobi et a., 2019). They lack the medical and administrative capacity to produce services efficiently and of adequate quality. A 1994 World Bank study found that 88 percent of every dollar of public expenditure on medication is lost to inefficiencies, with only 12 percent benefiting the consumer. The situation does not appear to have improved. Public systems lack transparency, making them subject to corruption and fraud and are not able to produce (actuarial) data on issues of Health Care Access.

Uganda has 135 Districts and 11 Cities, including Kampala, divided into 353 constituencies. A district has at least one constituency. These are further divided into 1,460 Sub-Counties and 7,467 villages (Republic of Uganda, 2018a, 2020a). In 2021, Uganda's population was estimated at 42.88 million people, with an Annual population growth of 3.0% (Republic of Uganda, 2019b, 2020a). The high population growth is partly attributed to the high fertility rate and declining child mortality levels estimated at six children per woman and 64 per 100,000 live births respectively (Republic of Uganda, 2017, 2019a, 2020c). The majority of the population (51%) is female, and 49% is male (Republic of Uganda, 2023b). Uganda has around 6,940 Health facilities, of which 45% are Government-owned, 15% are private not-for-profit, and 40% are private for profit. In 2019, the Health worker population ratio was 1.87 per 1,000 populations, which is still lower than the WHO ratio of 2.5 per 1,000 populations.

Health systems in Uganda have been criticized for being inequitable, with the poor receiving fewer services than needed, and the rich receiving more than needed but qualitative evidence has shown socio-economic factors a barrier both due to a facility being too far to travel to, as well as the economic opportunity costs associated with travel to the health facility. Similarly, restricted geographic access to health facilities influences poorer Ugandans to seek care at the nearest health facility or provider, even if the quality of care is lower (MoH, 2023). The interplay of poverty and health care access has been cited in numerous studies on health care utilization among Ugandans, leading to increased reliance on traditional, family, and community sources of health care instead of seeking professional care. However, the

relationship between socio-economic factors and health care access has not been modeled quantitatively on a country-wide basis.

In Northern City Division Mbale City, there is Namakwekwe Health Center III. According to the HSSP (2017), Namakwekwe Health Center III provides community-based preventive and promotes Health services. It serves a population of approximately 8,000 people. It offers outpatient care, antenatal care, immunization, and outreach plus maternity services, inpatient health services, and laboratory services. It is staffed by one clinical officer, one enrolled nurse, two enrolled midwives and one nursing assistant, one health assistant, one laboratory assistant, and a records officer (MoH, 2020). The health center is overcrowded by patients from diverse socio-economic backgrounds with limited facilities and staffs thus making access questionable.

Onyango and Sharone *et al* (2020) asserted that there are mountains of research on the identification of socio-economic factors and an equally large number of studies showing degrees of relationship between socio-economic factors and access to health services. However, Amoni (2021) and Nuwagaba (2021) had a different view noting that what is lacking in most cases since the previous decade is any convincing evidence that improving socio-economic factors is necessary in such a way as to produce significant improvements in measured achievement in access to health services. In fact, the entire vein of social and health research called “attribute-treatment interaction studies” is generally conceded to have been a failure and therefore this has warranted this study

1.2 Problem statement

Ideally, people are expected to participate actively in the development initiatives, engage in gain full employment and be in good health etc. The Government has ensured timely pay for health workers, supervision and facilitation of health centers as well as improving universal access to health services. However, what is happening in Northern City Division of Mbale City today is a case of worsening lack of access to health care services. People today are known of sickness, lacking balanced diets, with majority having no access to quality health care. Lack of access to health care services kills and disables many people of all ages as cancer and its toll on people’s health surpasses that of traffic accidents and malaria combined. Reports of Northern Division (2023) show that in Northern City Division Mbale City, there has been consistent experiencing of severe outbreak of communicable and non-communicable diseases for the last 6 years. In 2023, people who sought in-patient admission

at Namakwekwe health center III were only 174 of which 72% were from women and children from neighboring areas while (District Annual Health Sector Report, 2018)

Many health practitioners and stakeholders in the health system point to the issue of socio-economic factors as being crucial to the improvement of access to health care services; however, these factors are not well documented. Okiiria and Okiidi (2022) researched on health workers' training and health care services, and Okwalo's (2016) study on social factors and health care services, focused only on social factors that affect Health care services in Gulu District and no study about effect of socio-economic factors on access to health care services has ever been carried out in Northern City Division Mbale City. Therefore the lack of research in this area has led to distortions and lack of literature and this has given a research opportunity for this research study.

1.3 The Purpose of the Study

The aim of the study was to investigate the effect of Socio-Economic factors on access to health care services in Northern City division Mbale City.

1.4 Specific Objectives of the study

i) To assess the effect of gender on access to health care services in Northern City Division Mbale City.
ii) To examine the effect of educational levels on access to health care services in Northern City Division Mbale City.
iii) To investigate the effect of age on access to health care services in Northern City Division Mbale City.

1.5 Research questions

i) How does gender affect access to health care services in Northern City division Mbale City?
ii) What is the effect of educational levels on access to health care services in Northern City division Mbale City?
iii) In which ways does age affect access to health care services in Northern City division Mbale city?

1.6 Scope of the study

The study scope was categorized into geographical, content and time as follows:

1.6.1 Content scope

The study investigated the effect of socio-economic factors on access to health care services in Northern City division Mbale City. It specifically looked at the effect of gender and educational levels on access to health care services in Northern City division Mbale City. It also investigated the effect of age on access to health care services in Northern City division Mbale City. This scope was chosen because it enabled the researcher to get content valid data that addressed the research questions.

1.6.2 Geographical Scope

The study was conducted in Northern City division Mbale City of Mbale City. This study scope was chosen because there has been a lot of documented evidence of lack of access to health care services by the people (Division Report, 2023)

1.6.3 Time Scope

The research study considered a period between 2021-2024. This period was considered because it is during this time that access to health care services in Northern City division Mbale City fell to worst levels (UHDS 2023, Northern City Division Annual sector performance report, 2023).

1.8 Significance of the study

The results of the study may go a long way to help strengthen the provision of health care services In the City Division and the whole Nation at Large.

The study may help health care service providers in gaining insight into the effect of socio-economic factors on health care services

It may also help to form a basis for future planning and negotiations with various stakeholders on the socio-economic determinants of access to health care services

The findings of the study may provide useful and practical information to planners and decision makers that may inform policy thinking and practice as far as the elimination of socio-economic barriers is concerned so as to improve access to health care service

The study may contribute to the existing body of knowledge on the effect of effect socio-economic factors on health care services.

1.9 Conceptual Frame work

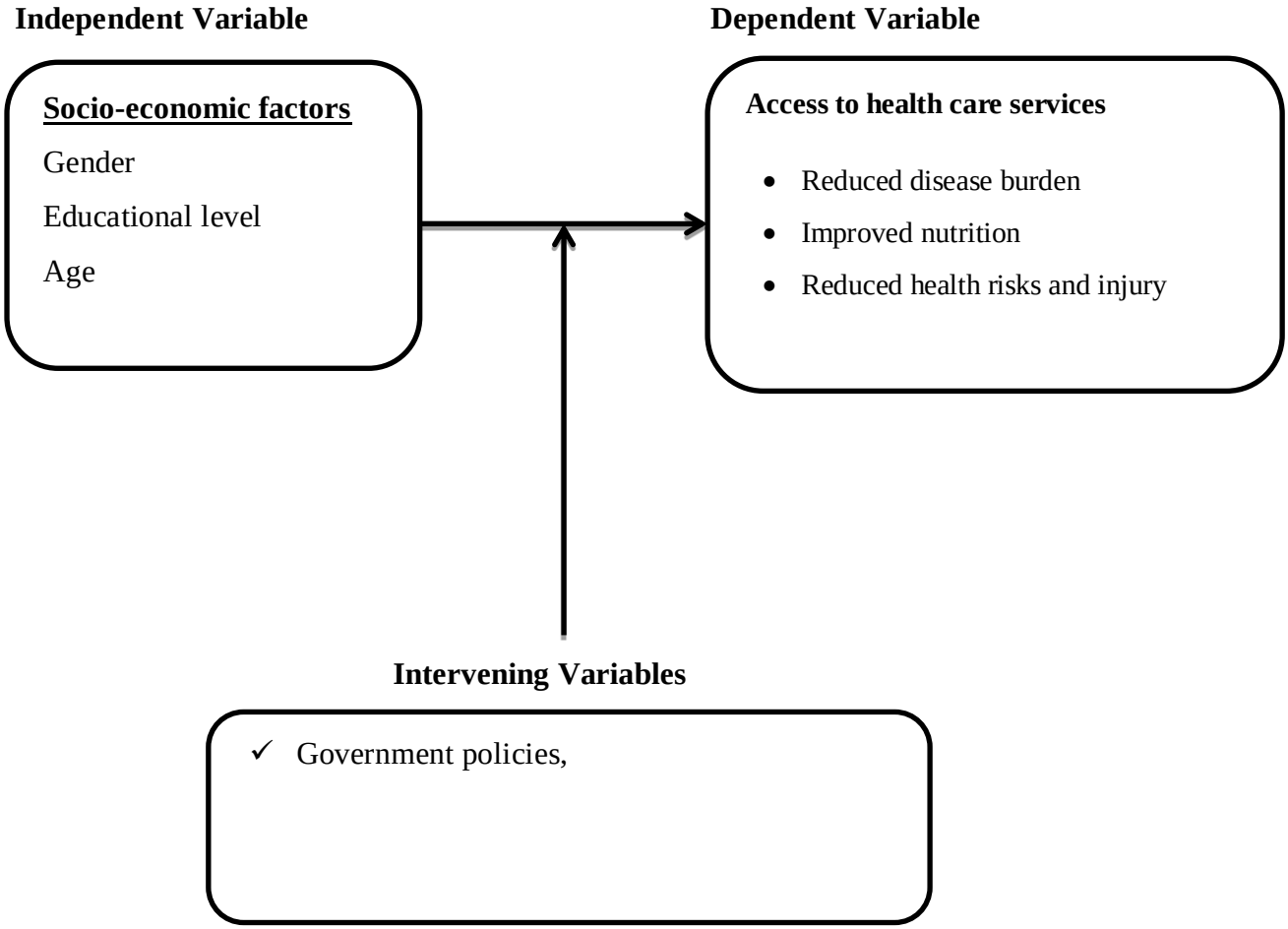

Figure 1.1: Conceptual Framework showing relationship between variables

Source: *Adopted from Miles &Huberman (2009, p. 18) and modified by the researcher 2024*

Form the above conceptual framework, socio-economic factors as an independent variable (IV) involves gender, educational level and age. The dependent variable in this case is access to health care services which includes the parameters of reduced disease burden, improved nutrition, reduced health risks and injury, reduced morbidity and mortality. The framework assumes that when drug abuse is controlled, it is likely to transform economic development of the people. Nevertheless, this may not be automatic as other factors may come into play.

These may include government policies; community sensitization and Wide spread provision of health care services. These factors have been dully coined as intervening variables by the study and are being isolated to avoid making wrong conclusions.

1.10 Operational Definitions

a) **Health care services** The term "health care services" means any services provided by a health care professional, or by any individual working under the supervision of a health care professional, that relate to (A) the diagnosis, prevention, or treatment of any human disease or impairment; or (B) the assessment or care of the health of human beings. (World Bank, 2018).

b) Socio-economic Factors: These are conditions present in communities and usually are beyond the control of an individual that determine the way, extent and quality of life (UNDP, 2017) as a process of enlarging people's choices by strengthening their capabilities and maximizing their use of those capabilities.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of the past literature related to the area under investigation. The review will be conducted according to objectives of the research study as seen below:

2.2. Gender and access to health care

Shaik & Hatcher (2018) found that in health research much discussion has been generated around evidence found in the way men and women report on their state of health. Similarly, their interaction with the health care system would also be influenced by gender. In a study focusing on men's access to health care services and core reasons for their non-participation, it was found that men had a greater need for confidentiality and placed great value on trusting the expert knowledge of the health care provider. The men reported being more specific in their health care choices and when seeking advice they would source a provider that they regard as being an expert in that area. It was also discovered that men's non-participation, in particular with free health services, had a great deal to do with time constraints and hence sought private health care (Spangar et al., 2008). Women access for care for themselves and their children is also unique. This is particularly evident in patriarchal societies where women's decision making is limited as in patriarchal societies, men through the control they have over resources, influence when and where women seek treatment for their health

Buor et al., (2017) argued that gender gap in health care access is compounded in developing countries where the burden of poverty further exasperates the plight of women. Women, especially those in rural areas, are expected to be involved in domestic duties and child care. Educating girl children is not a priority and coupled with the expectations of their domestic role this compromise their access of health care services. Time required to access health care services is non-prioritized as this takes women away from domestic duties. With illiteracy and limited formal education women face such challenges as unemployment, poverty, and low assessment of health needs, taboos about health and seeking treatment, self-medication, little or no health insurance and in some instances increased use of traditional medicine

Penderson & Vogel (2019) found that gender differences are typically defined by how individuals have been socialized as some societies have clear cut gender roles and stereotypes. Studies conducted into male gender roles and gender role conflict among men found that men who showed strong masculine gender orientation were distinctly different from men who showed more of a feminine gender orientation. This was particularly evident in studies focused on their help seeking behavior in terms of seeking out professional help from counselors. The findings show that men or those with a more masculine gender orientation are less likely to show interest in seeking counseling these findings are in line with two theoretical constructs that help to describe help seeking behavior in men-restrictive emotionality and interpersonal openness. These theoretical constructs are used to describe the difficulty or reluctance men have in sharing their feelings with other people. In terms of help seeking behavior these constructs both relate to one's willingness to be open with others and share concerns or request help (Good et al., 2020). These results were consistent against the men seeking help from a variety of sources including those sources outside of the medical fraternity such as a partner, friend, relative, parent, sibling etc.

When addressing health care service seeking behavior, Penderson & Vogel (2019) further found that that a strong link between masculine identity and seeking help. Men's access to psychological therapy services were greatly influenced by whether they viewed sharing their emotions with others as appropriate male behavior. Men who held strong beliefs regarding their masculine identity were more likely not to seek help for psychological conditions and have a negative view of men who accessed such health care services.

Gender stereotypes which shape the attitudes of men and women regarding health and seeking treatment indirectly would impact on use of services and choice of health care provider. In their study, Noone and Stephens (2008), note that respondents identified women as more frequent users of health care services. The study incorporated in-depth interviews with men and respondents had clear opinions regarding frequent use of health care services as typical behavior of women. Though the re importance of seeking treatment, it was clear that they felt that not all concerns needed medical attention. Seeking treatment from a medical practitioner for minor concerns such as influenza was considered not to be "masculine.

Similarly, Van der Hoeven et al., (2020) observed differences in health care seeking behavior in urban and rural settings in South Africa due to society's vi and health. They noted that the greater participation of women in their study could be linked to society viewing women as being in greater need of care, if not for themselves, then for those in their care

2.3 Educational level and access to health care

Health literacy defines the "degree to which and understand basic health information and services needed to make appropriate health decisions Ogang et al., (2020). Educational attainment or years of schooling are often an indication of literacy levels which can critically impact health outcomes. Literacy levels impact on how an individual interacts with the health care system and this relationship is summed up in the definition of health literacy. From the definition of health literacy, the decision regarding whether to seek care and where to seek care is influenced by the individuals understanding of the status of their health and the services available to them.

In a study looking at health literacy in older people it was found that those with low health literacy showed distinct difference in terms of access to health care. The health care access variables in this study were access to a regular doctor or place of care; having had an influenza vaccination in the last 12 months or having medical insurance to cover the costs of medication. A significant relationship was found between low levels of health literacy and access to health care (Sudore et al., 2017). This indicates that education influences how someone interacts with the health care system. In a South African society plagued by inequality, the interconnection of socio-economic factors is more evident. Hence, the impact of socio-economic variables on health care access cannot be looked at in isolation. Consequently, Sudore et al., (2019) defined the typical socio-demographic profile of individuals with low levels of health literacy as Black, male, low income and low levels of education.

Porterfield & Mcbride, (2017)and Kalichman et al., (2019) found that higher educational attainment has also been found to be a determining factor in treatment of disease and accessing health care. Individuals with limited education have been found to have a delayed response in seeking out specialized health care and have also shown to have greater difficulty in following treatment plans. Besides the impact on the individual and how they engage with the health care system; the education levels of the patients have also been found to have an impact on the treatment received or how health care providers relate to such patients.

In an investigation into the effect of poverty and the level of education of the care giver on perceived needs and access to health services amongst children with special health care needs, the, Porterfield & Mcbride, (2018) hypothesized that information about health needs plays a critical role in seeking specialized care. Their view is that parents who do not think their child needs specialized care will not seek access to available services. The ability of the parent to assimilate information and come to an understanding of the need for specialized care is directly related to their level of education. Previous studies which guided the authors towards this hypothesis showed that only half of the care givers that accompanied children with special needs to appointments with specialized physicians were able to provide a lay man's description of the medical diagnosis of the child. Another study showed low usage of specialized care by children with special needs. Such parents' children's had low income and low education, in spite of having medical insurance cover for specialty care.

Education can also be a barrier to accessing health care services which is particularly the case for individuals with low levels of education. In a study focusing on HIV sero-positive patients found that those with low levels of education were more likely to report a different adherence pattern than those with higher levels of education. The three main reasons cited by patients with low education levels was: how they perceived their treatment at the clinic, not wanting to be seen at the clinic and a distrust of the doctors (Kalichman et al., 2019).

Education levels can therefore influence the relationship between the health care provider and the patient which in turn impacts access of services and treatment literacy. Overcoming educational barriers to access of health care services cannot be done via a patient centered approach only. Patients levels of education and healthcare literacy does have an impact however the ability of the health care provider to adequately explain the diagnosis and treatment is just as important (Kalichaman et al., 2019). The doctor's ability different backgrounds is a major factor in the doctor-patient relationship. It is important for health care providers to have an understanding of their cultural beliefs and health beliefs (Betancourt et al., 2019). Hence it is been described as an asymmetrical problem in health research. In their other works, Porterfield and Mcbride (2021), hypothesize that asymmetry also occurs when health care providers perceive patients with low social standing, lower educated and low-income as less able to act on medical information. Similarly, they propose that more educated and higher income patients are able to access additional sources of medical information than less educated and low income

2.4 Age and access to health services

Age is an important indicator on the impact on many social aspects, as well act as indicator to measure certain life milestones. In demographic studies it describes a population but is critical when describing demographic processes of fertility, morbidity and mortality. Age is also a defining factor in many cultures in terms of social standing and economic security (Edvinsson & Broström, 2019).

Distinct patterns emerged when investigating differences in access of health care based on age. A study conducted into aging and consumer decision making found that differences between older individuals are related to the amount of trust they had in the service provider, their desire to have less control over processes and put more control into the hands of their physician, and in some instances the struggle to adapt to new information and new environments (Carpenter & Yoon, 2020). Carpenter and Yoon (2021) note that even though there is generally a cohort effect in terms of how older people make decisions, and this could be in many instances attributed to constraining factors such as income. Even for those who do want more control over health decisions they are often constrained by income and not having the necessary to make an informed decision due to lack of information, or their own inability to process information due to a decline in their thinking capacity as a result of aging (Carpenter & Yoon, 2021). These findings insinuate that older people base their choice of health care provider on the trust they have in the health care provider to provide the required treatment. It could also be interpreted as older people having difficulty assimilating health care information and processes.

Differences in access of health care also highlight similarities among individuals within a certain age group. The study into aging and consumer decision making (Carpenter & Yoon, 2021) confirms an interesting result in terms of understanding the cohort effect of age, and is particularly interesting for researchers undertaking research where age is an independent variable. In terms of the study into the investigation of socio-economic factors that determine health care access in South Africa, the choice then in health care could differ by age and people in similar age groups could show a similar pattern in their choices. Evidence of this cohort effect is also supported in the South African context from results from the National Demographic and Health Survey. In analysis of the access of traditional birth attendants, a decrease was recorded in assistance from traditional birth attendants during labour for women over 20 years of age over the period 1988 to 2003. In contrast women younger than 20 increased their access of traditional birth attendance over the same period (Peltzer, 2020).

Health care access has been found to be affected by age in terms of differences in need for health care across age groups. Older people generally are found to have a greater need for health care as a majority has been found to have a progressive decline in health particularly towards the end of their lives (Larsson et al., 2018). Patterns of access of health care services by elderly people can be in many instances attributed to mortality, or the process of dying which results in increased health problems as people age. It can be inferred that it is the process of dying that has a greater impact on health care access than aging (Larsson et al., 2018). Larsson et al., (2020) in their study into care access in the last years of life in relation to age and time to death found evidence of variation in the type of care used by older people. The care used varied between the use of professional care givers at home, institutions and hospitalizations. Results showed that older people seek out more expert care and specialist medical treatment in the years preceding death (Larsson et al., 2020). This would be consistent with the paradigm that health status and health beliefs are proximate determinants of health care access. Individuals' health status and health beliefs change with age and hence change and impact on health care access.

However, opting for specialist care is not the uniform choice amongst the elderly. In a report published by Statistics South Africa in 2013, their findings from the General Household Survey presented quite varied results of access based on age. Older people showed a distinct higher rate of reported poor health or injury in the month prior to the survey. Reports of illness increased dramatically from ages 45 years and older with the highest response of illness coming from those who were 65 years and older. The lowest percentage reports of illness or injury was from respondents in the 15-24 year age group (Statistics South Africa, 2019). However, when it came to seeking help for their illness respondents that reported not accessing health care because they felt it was not necessary or due to the high cost of health care also came from these age groups (Statistics South Africa, 2019). These results suggest that access or choice of health care is dependent on the state of health and barriers to health care. Age could therefore see varied preference and access of health care, not only based on age preferences but also barriers to health care that could be more evident at different ages. The effect observed of age on health care access could be viewed almost as a "life stage" effect.

The cohort effect of age can also influence health care access via access to social grants or benefits; or increase barriers to health care due to educational attainment or access to household resources; as well as influence access via the measure of social standing of the household e.g. car, telephone etc. (Grundy & Holt, 2001). Social policies also differ with age and this impacts on health care access in particular those policies that impact on income and health care costs (Lloyd-Sherlock & Agrawal, 2018). Benefits provided by the government vary through the life course and unless protected by universal health insurance coverage the population will benefit at certain ages or life stages; or be more vulnerable at other life stages, in terms of access to health care. In South Africa currently free health care is available to pregnant women and children under six years at public health care facilities. Primary Health Care (PHC) is also free at all public health care facilities for all South Africans. Rowland and Lyons (2019) described poverty and illness as being one of the greatest challenges faced in old age. Lloyd-Sherlock and Agrawal (2014) found that in South Africa there was an association between receiving a pension and health care access, but there was no relationship between receiving a pension and reported quality of life or control of chronic health conditions.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the methodology that were used in the study and some of the areas that were covered included research design, area and population of the study, sample size, sampling techniques, research instruments, data quality control and data analysis as well as ethical issues.

3.1 Research Design

The research study used cross-sectional design using both qualitative and quantitative research approaches to analyze the impact of Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City. This design helped the researcher to generate more sufficient data and relevant information that supported the variables and objectives of the research study.

3.2 Study Population

The population consisted of 40 residents of Northern City, 20 health workers, and 20 Government staffs. Residents of Northern City are chosen to participate in this study because they have enriched information on the topic under study while health workers are selected because of their interaction with people who come for health services and they have first-hand information regarding the impact of Socio-Economic Factors and Access to Health Care Services in Northern Division .Additionally, Government staffs were chosen because they had information given their experience in trying to put up better access to health services..

3.3 Sample size

The total population (N) is 100 people and therefore the sample population was 80 participants and this was arrived at using Krejcie and Morgan (1973) methods of determining sample size from the population.

Table 3.1 Summary of the Sample Size and Sampling Technique

Respondents	Study Population (N)	Sample Size (n)	Sampling Technique
Residents of Northern City	50	40	Simple random
Health workers	25	20	Purposive sampling
Government staffs	25	20	Purposive sampling
Total	**100**	**80**	

Primary data 2024

3.4 Sampling Techniques

The researcher used the following sampling techniques:

3.4.1 Simple random sampling

The researcher used simple random sampling to select residents of Northern City Division. This technique involved giving a number to every subject or member of the accessible population, placing the numbers in the container and then picking any number at random. The subject corresponding to the numbers was included in the sample.

3.4.2 Purposive sampling

purposive sampling was used to select Health workers and Government staffs because these people had the required information for the researcher to get a representative sample for the research study and allowed generalizability to a larger population with a law margin of error since the research managed to move from one to another in order to get the required sample size.

3.5 Research Instruments

The researcher used both questionnaires and interview guide.

3.5.1 Questionnaire

The researcher used self-administered questionnaire as a research tool to collect data from the health workers and government staffs. The questionnaire had three sections: Section A included respondents' demographic information, Section B, C and D focused on the general and closed ended statements which were in accordance with the objectives of the study.

According to Fisher (2004), a questionnaire is used because it is easy to administer, not so expensive, and helps to collect unbiased data. The nature of the questions were in form of structured and close ended questions where by a 5 Lakert scale of measurement was on close ended questions based on a scale of strongly agree (5), agree (4), unsure (3), disagree (2), strongly disagree (1). Questionnaires were used because they allowed respondents to provide firsthand information which was free from bias and it is was also easy to use .

Table 3.2 Likert Scale, Coding, and Interpretation

Scale	Coding	Mean	Interpretation
Strongly agree	5	4.20-5.00	Very high
Agree	4	3.40-4.19	High
Unsure	3	2.60-3.39	Moderate
Disagree	2	1.80-2.59	Low
Strongly disagree	1	1.00-1.79	Very low

Source: Primary Data 2024

3.5.2 Interviews

Other data was collected using interviews with the help of an interview guide. An interview guide is a research instrument that contains a set of questions on defined issues under study that are put to respondents on face to face basis (Saunders, et al, 2007). This instrument also contained mostly open-ended questions. The interview guide was used on residents of Northern City as respondents because this category of respondents had more knowledge that could not be fully captured using questionnaires.

3.6 Data quality control tools

3.6.1 Validity

The validity of an instrument is defined as the ability of an instrument to measure what it is intended to measure. To establish the validity of the instruments, the researcher used expert judgement as recommended by Gay (1997) as the best method for ensuring validity. Thus the researcher ensured that the instrument is clear, relevant, specific and logically arranged. The validity of the questionnaire was tested using the content validity test (CVI). To arrive at the relevancy of the questionnaire, the researcher designed the instruments that yielded content –

valid data by first specifying the domain of indictors that were relevant to the concept being measured. A content-valid data measure contained all possible items that were used in measuring the impact of Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City.

$$CVI = \frac{R}{R+N+IR}$$

Where, Relevant (R), Neutral (N), to Irrelevant (IR).

3.6.2 Reliability

The reliability of the instruments was tested using the test re-test method of reliability and Cron-bach alpha tests to determine the reliability index with the help of SPSS. Data was collected from 20 residents not among those in the sample. The principle of reliability as far as research instruments are concerned, is clearly put forward by Amin (2005), that an instrument is reliable if it produces the same results wherever it is repeatedly used to measure a trait or a concept from the same population and under similar circumstances. According to Nunnally (1978) the reliability coefficient Alpha is supposed to be above 0.7 to show that there is reliability.

3.7 Data Processing and Analysis

3.7.1 Quantitative data analysis

Data processing was edited, coded and analyzed. After data processing, quantitative data analysis was carried out by simple frequency tabulation using a Statistical Package for Social Science (SPSS). Data was then presented using different methods such as simple frequency tables which ultimately helped to measure the impact of Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City. This is because data presentation required clear portrayal of the findings presented, and the above listed method clearly fulfilled that purpose.

3.7.2 Pearson Correlations and Regression Analysis

Pearson Correlations and regression analysis was also used to establish impact of Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City. This type of inferential statistics was easy to compute and interpret and it also helped in making conclusions. Descriptive statistical techniques (frequencies and percentages) were used to analyze field data from questionnaires and assisted in the interpretation of data.

3.7.3 Qualitative data analysis

On the other hand, qualitative data gathered from open-ended questions in the interview guide was summarized. A style called content analysis was used to test the validity and authenticity. Then, data was categorized according to the sub-themes identified earlier.

3.8 Data collection procedure

The researcher selected and presented a research topic to the department of education which was approved. Thereafter the researcher developed a research proposal. After approval of the research proposal, the researcher obtained an introductory letter from the Head of department which was presented to the relevant authorities in the study area for data collection. Thereafter the researcher wrote a report which was presented to the department for further examination.

3.9 Ethical issues

3.9.1 Consent

The researcher got approved consent from the respondents. Respondents who were willing decided to participate in the study after the researcher explaining to them the purpose of the study which was purely academic. It was possible that the researcher's views could influence the way the study findings would be documented thus creating an ethical dilemma of failure to present exactly what the study subjects would reveal in the course of the data collection. However, the prepared instruments helped the researcher to collect objective information hence fears of personal views were reduced.

3.9.2 Confidentiality

Respondents were assured of confidentiality by keeping information given confidential. Respondents' identity was kept anonymous or pseudo names were used. This increased on disclosure of information as well as increasing respondents' willingness to participate in the study.

3.9.3 Fraud and plagiarism

Mugenda and Mugenda (2007) argued that fraud involves faking data. It also includes false presentation of research methodologies. On the other hand, plagiarism refers to owning another person's work by the researcher without acknowledging the author. According to copy rights law, in many countries including Uganda, both fraud and plagiarism are crime punishable by panel code. To avoid fraud and plagiarism, the researcher personally collected, analyzed and presented data and endeavored to present exactly what the study subject revealed. Where information is picked from another source, the author (copy right owner) was acknowledged.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents data analysis and interpretation based on the study objectives identified earlier. It begins with the analysis of the demographic data as seen below:

4.2 Demographic characteristics of the respondents

The first part of this chapter is a presentation and analysis of the preliminary data obtained from the study. It involves the background information of the respondents. The variables involved are age (years), gender of respondents, educational level and marital status**.** Data obtained has been presented in tables below.

4.2.1 Age of Respondents

Table 4.1 contains the age distribution of respondents who participated in the study. The purpose was to find out the average age of respondents in the study area.

Table 4.1: Age in years

		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	21-29	3	3.8	3.8	3.8
	30-39	34	42.5	42.5	46.3
	40-49	40	50.0	50.0	96.3
	50 above	3	3.8	3.8	100
	Total	**80**	**100.0**	**100.0**	

Source: Primary Data (2024)

A close look at the Table 4.1 shows that 3.8% of the respondents were 21-29 years of age, 42.5% were between 30-39 years of age, 50% who constituted the majority were 40-49 years and 3.8% of the respondents were 50 years and above.

The findings of the study imply that since majority of the respondents were 40 years above, this meant that they were mature enough and information acquired from them was reliable. The above view is in line with Amin (2005) who argued that the majority age of above 18 years adds value to the responses given that mature persons are more trustable as they take time to think about a particular aspect of life.

4.2.2 Gender of Respondents

The respondents were asked to indicate their gender by ticking the appropriate age column they belonged. The purpose was to find out the number of males and females who actually participated in the study.

Table 4.2: Gender of Respondents

		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	Female	29	36.3	36.3	36.3
	Male	51	63.8	63.8	100.0
	Total	**110**	**100.0**	**100.0**	

Source: Primary Data (2024)

Table 4.2 shows that out of the 80 respondents who participated in the study, majority 63.8% were males, while the remaining 36.3% were females. The findings meant that there are more males than females who participated in the study, naturally, males and females have different attitudes and views toward events and since females are home makers, they tend to remain at home and this explains their lower turn up rate in the study (Singer, 2004)

4.1.3 Marital status of the respondents

Table above depicts the marital status of respondents who participated in the study. The purpose was to find out the status persons who participated in the study in relation to socio-economic factors and access to health care services in Northern Division, Mbale City**.**

Table 4.3: Marital status of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	62	77.5	77.5	77.5
	Single	11	13.8	13.8	91.3
	Widower/ Widow	7	8.7	8.7	100
	Total	**80**	**100.0**	**100.0**	

Source: Primary Data (2024)

Table above shows that 13.8% of the respondents were single, 77.5% of the respondents were married, 8.7% were widows/widower .The data shows that majority of respondents were married (mature adults) and therefore their responses were trusted because they had experience in solving various social –economic factors and access to health care services in Northern Division, Mbale City.

4.1.4 Educational level of the respondents

The level of education was used to demonstrate the knowledge of respondents on vocational skilling and its effect on youth wellbeing.

Table 4.5 Levels of Education

	Frequency	Percent	Valid Percent	Cumulative Percent
University	29	20.0	20.0	20.0
Tertiary	35	36.3	36.3	56.3
Secondary	16	43.8	43.8	100
Total	**80**	**100**	**100**	

Source: Primary Data (2024)

From the research findings, 20% of the respondents had ended at University level of education, 43.8% had ended at secondary level and 36.3% had ended at tertiary level of education.

The data shows that majority of the respondents had attained some level of education whose opinions and views regarding socio economic factors and access to health care services in Northern Division, Mbale City. This is in line with Uma (2000) who argued that it is important in social investigation research to involve people that have attained an acceptable level of literacy and numeracy in order to be in position to understand and interpret content in the questionnaire.

4.2. Gender and access to health care

Table 4.6. : Descriptive Statistics

	N	1 (SD)	2 (D)	3 (U)	4 (A)	5 (SA)	Mean	Std. D	Comments
Women and men health access is influenced by their gender interaction.	80	5 (3.6%)	5 (3.6%)	10 (15.8%)	40 (50%)	20 (27%)	3.82	1.022	***High***
Women access to health care is influenced by their gender due to community perceptions/societies they stay.	80	0 (0%)	2 (3.5%)	3 (7%)	60 (63.4%)	15 (26.1%)	3.96	0.815	***High***
Gender gap affects access to health care in developing countries	80	5 (5%)	5 (5%)	0 (0%)	50 (67.0%)	20 (23%)	4.14	0.600	***Very High***
Gender roles coupled with domestic expectations compromise health care access	80	10 (12.5%)	5 (4%)	5 (4%)	48 (51.1%)	32 (28.4%)	4.01	0.905	***High***
Gender of men with a more masculine gender orientation is less likely to go for health care counseling.	80	0 (0%)	0 (0%)	18 (10%)	64 (70.3%)	22 (18.2%)	3.93	0.745	***High***
Valid N (list wise)	80								
Overall Mean & Standard Deviation							**4.00**	**0.824**	***High***

0.00-1.00 Very Low, 1.10-2.00 Low, 2.10-3.00 Moderate, 3.10-4.00 High, 4.10-5.00 Very High

The first objective of the study was about gender and access to health care

Respondents were asked to reveal if women and men health access is influenced by their gender interaction. Among the respondents in line with this item, 27% of the respondents strongly agreed that, 50% of the respondents agreed, 15.8% of the respondents were undecided, 3.6% of the respondents disagreed and strongly disagreed. A high mean of 3.82 indicated that women and men health access is influenced by their gender interaction. Respondents ADR assured that many women fear to interact freely to health care providers about their conditions.

Responses on if women access to health care is influenced by their gender due to community perceptions/societies they stay showed that 26.1% of the respondents strongly agreed, 63.4% of the respondents agreed, 7% of the respondents were undecided, 3.5% of the respondents disagreed, and lastly none of the respondents strongly disagreed. A high mean of 3.96 indicated that women access to health care is influenced by their gender due to community perceptions/societies they stay in.

Responses on if gender gap affects access to health care in developing countries showed that 23% of the respondents strongly agreed, 67% of the respondents agreed, none of the respondents were un decided, 5% of the respondents disagreed and strongly disagreed. A very high mean of 4.01 indicated that gender gap affects access to health care in developing countries.

Responses on if gender roles coupled with domestic expectations compromise health care access showed that 28.4% of the respondents strongly agreed, 51.1% of the respondents agreed, 4% of the respondents were undecided and disagreed, and lastly 12.5% of the respondents strongly disagreed. A high mean of 4.01 indicated that gender roles coupled with domestic expectations compromise health care access. Respondents KRC noted that gender roles coupled with domestic expectations are a major compromising factor to health care access.

Responses on if gender of men with a more masculine gender orientation are less likely to go for health care counseling, showed that 18.% of the respondents strongly agreed, 70.3% of the respondents agreed, 10% of the respondents were undecided, none of the respondents disagreed nor strongly disagreed. A high mean of 3.93 indicated that men with a more masculine gender orientation are less likely to go for health care counseling.

A high overall mean of 4.00 indicated that gender affects access to health care

4.3. Educational level and access to health care

Table 4.7: Descriptive Statistics

	N	1 (SD	2 (D)	3 (U)	4 (A)	5 (SA)	Mean	Std. D	Comments
Education levels affect access to health care services.	80	1 (2%)	0 (0%)	4 (6%)	25 (30%)	50 (62%)	4.46	1.072	***Very High***
Education attainment is an indication of literacy levels and impact health care outcomes.	80	0 (0%)	5 (3%)	10 (7%)	45 (54%)	20 (36**%)**	4.22	0.668	***Very High***
There is a significant relationship between low levels of health literacy and access to health care	80	0 (0%)	0 (0%)	5 (10.2%)	55 (67.0%)	20 (22.7%)	4.14	0.600	***Very High***
Individuals with limited education have delayed response in seeking specialized health care.	80	2 (1%)	3 (3%)	0 (0%)	25 (38%)	50 (58%)	4.50	0.684	***Very High***
People with low levels of education report a different adherence pattern than those with higher levels of education.	80	0 (0%)	0 (0%)	0 (0%)	25 (37%)	55 (63%)	4.58	0.509	***Very High***
Valid N (list wise)	80								
Overall Mean & Standard Deviation							**4.34**	**0.732**	***Very High***

0.00-1.00 Very Low, 1.10-2.00 Low, 2.10-3.00 Moderate, 3.10-4.00 High, 4.10-5.00 Very High

The second objective of the study was education level and access to health care. Below are the ways how the responses fared.

Respondents were asked to reveal if education levels affect access to health care services and 62% of the respondents strongly agreed, 30% of the respondents agreed, 6% of the respondents were not decided, none of the respondents disagreed and 2% of the respondents strongly disagreed. Respondent's ddd22d said that education impacts peoples understanding which makes them make better decisions regarding health care services. A very high mean of 4.46 indicated that education levels affect access to health care services. This was in line with a study conducted by Tomkins et al, (2019) from Kenya and found out that 75% of educated people take good health care about themselves as compared to 25% who have not any attained any level of education.

Participants were also asked in addition to the first point to reveal if education attainment is an indication of literacy levels and impacts healthcare outcomes. 36% of the respondents strongly agreed, 54% of the respondents agreed, 7% of the respondents were undecided, 3% of the respondents disagreed, and none of the respondents strongly disagreed. A very high mean of 4.22 indicated that education attainment is an indication of literacy levels and impacts healthcare outcomes. This was in line with a study conducted by Davis et al, (2020) that education is an indication of literacy levels and it impacts health care access and outcomes.

Furthermore respondents were asked to reveal if there is a significant relationship between low levels of health literacy and access to health care where 22.7% of the respondents strongly agreed, 67% of the respondents agreed, 10.2% of the respondents were undecided, a very high mean 4.14 indicated that there is a significant relationship between low levels of health literacy and access to health care. This finding was in line with a study conducted by Odiambo et al, (2019) from Nigeria and found out that there is a relationship between low levels of health literacy and access to health care.

In addition to this, respondents were asked to reveal if individuals with limited education have delayed response in seeking specialized health care and found out that individuals with limited education have delayed response in seeking specialized health care and 58% of the respondents strongly agreed, 38% of the respondents agreed, none of the respondents was undecided, 3% of the respondents disagreed, and lastly 1% of the respondents strongly disagreed. A very high mean of4.5 indicated that individuals with limited education have

delayed response in seeking specialized health care this was in line with a study conducted by James and Davis et al, (2020) who in their study in Rwanda found out that persons with limited education have less response to health care access. Respondent's GGQQD also were in agreement with their findings.

Respondents were asked if people with low levels of education report a different adherence pattern than those with higher levels of education and 63% of the respondents strongly agreed, 37% of the respondents agreed, none of the respondents was undecided, disagreed and strongly disagreed. This was proven with a very high overall mean of 4.3. This was in line with a study conducted by Morris et al, (2017) who conducted a study in Namibia and found out those low levels of education report different adherence patterns than those with higher levels of education.

4.4. Age and access to health care services

Table 4.8. : Descriptive Statistics

Responses	**N**	**SD**	**D**	**NS**	**A**	**SA**	**Mean**	**Std. D**	**Comments**
Age is a defining factor in many cultures in terms of social understanding and economic security.	80	0 (0%)	0 (0%)	7 (3%)	28 (36%)	45 (60%)	4.46	0.694	***Very High***
Aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider.	80	3 (5%)	5 (7%)	0 (0%)	40 (60%)	32 (28%)	4.12	0.731	***Very High***
Old people are constrained by levels of income not making right decisions	80	0 (0%)	0 (0%)	9 (10.2%)	51 (67.0%)	20 (22.7%)	4.01	0.875	***High***
Older people have difficult in assimilating health care information and process.	80	0 (0%)	0 (0%)	8 (6.8%)	22 (35%)	50 (58.2%)	4.47	0.647	***Very High***
Health care is affected by age differences because older people have greater need for health care.	80	0 (0%)	0 (0%)	2 (4%)	20 (27%)	58 (69%)	4.56	0.562	***Very High***
Valid N (list wise)	80								
Overall Mean & Standard Deviation							**4.34**	**0.677**	***Very High***

0.00-1.00 Very Low, 1.10-2.00 Low, 2.10-3.00 Moderate, 3.10-4.00 High, 4.10-5.00 Very High

The study objective of the study investigated whether age and access to health care services. Findings in relation to this objective are illustrated below:

Participants were asked to reveal if age is a defining factor in many cultures in terms of social understanding and economic sec unity and 60% of the respondents strongly agreed, 36% of the respondents agreed, 3% of the respondents were not sure, none of the respondents neither disagreed nor strongly disagreed.

Respondents were asked to reveal if aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider and findings showed that 28% of the respondents strongly agreed, 60% of the respondents agreed none of the respondents was neutral, 7% of the respondents disagreed and lastly 5% of the respondents strongly disagreed. A very high mean of 4.12 indicated that aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider.

Respondents were also asked to reveal if old people are constrained by levels of income not making right decisions where 22.7% of the respondents strongly agreed, 67% of the respondents agreed, 10.2% of the respondents were undecided and lastly neither of the respondents strongly disagreed nor disagreed. A high mean of 4.01 indicated that if old people are constrained by levels of income, they end up not making right decisions. This was in line with a study conducted by Davis and Davis 92020) who conducted a research study among house holders of the elderly and found out that their level of income would not allow them access better health care services.

Respondents were asked to reveal if older people have difficult in assimilating health care information and process and findings revealed that 58.2% of the respondents strongly agreed, 35% of the respondents agreed, 6.8% of the respondents were undecided and lastly none of the respondents disagreed nor strongly disagreed.

Respondents were also asked to reveal if health care is affected by age differences because older people have greater need for health care and findings revealed that 69% of the respondents strongly agreed, 27% of the respondents agreed, 4% of the respondents were undecided, none of the respondents neither disagreed nor strongly disagreed. A very high mean of 4.56 showed that health care is affected by age differences because older people have greater need for health care this was in line with a study conducted by Davidson et al, (2020) and found out that health care is affected by age differences because older people have greater need for health care.

INTERVIEW GUIDE RESPONSES

Respondents were asked to reveal if: gender affect access to health care services to show how it affects access to health care, whether Education levels affect people's access to health care services and how it does and lastly they were asked to reveal whether age affects access to health care and to show how it does. Below are their responses in line with this:

Respondent's revealed that gender affects access to health care where majority of the respondents said yes giving their reason that certain gender such as men have much responsibilities that they always have to go for work to make their families happy limiting their access to health care services. In addition to this other respondents who disagreed asserted that there is no way gender limits access to health care services though they had no reason.

Respondents were also asked through the interview guide if education levels affect people's access to health care services and 90 percent of the respondents agreed that education levels affect people's access to health care services because educated people are exposed which improves their access to health care service while 20 percent of the respondents didn't agree that education levels affect access to health care services though they didn't give a reason for their response.

Respondents were also asked to reveal if access to health care services is affected by age and majority of the respondents agreed that age affects aces to health care services because the elderly people find it hard to move long distances going to health care centers as compared to the young persons. Besides the elderly persons always don't have enough income to help facilitate their health care bills as responded by respondent KKRQ.

CHAPTER FIVE

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the discussion of study findings' conclusions and recommendations revealed about socio-economic factors and access to health care services in northern division, Mbale city.

5.1 Discussion of Findings

5.1.1 Gender and access to health care

Findings showed that women and men health access is influenced by their gender interaction. Respondents ADR assured that many women fear to interact freely to health care providers about their conditions, findings also indicated that women access to health care is influenced by their gender due to community perceptions/societies they stay in further findings indicated that gender roles coupled with domestic expectations compromise health care access and lastly finding indicated that men with a more masculine gender orientation are less likely to go for health care counseling.

5.1.2. Educational level and access to health care

Findings indicated that education levels affect access to health care services. This was in line with a study conducted by Tomkins et al, (2019) from Kenya who found out that 75% of educated people take good health care about themselves as compared to 25% who had not any attained any level of education, Findings also revealed that education attainment is an indication of literacy levels and impacts healthcare outcomes. In addition to this, Findings also revealed that there is a significant relationship between low levels of health literacy and access to health care.

5.1.3 Age and access to health care services

Findings here indicated that aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider, findings indicated that if old people are constrained by levels of income, they end up not making right decisions and lastly findings indicated that that health care is affected by age differences because older people have greater need for health care this was in line with a study conducted by Davidson et al, (2020).

5.2 Conclusions

5.2.1. Gender and access to health care

The study findings concluded that women and men health access is influenced by their gender interaction. Findings also concluded that women access to health care is influenced by their gender due to community perceptions/societies they stay in and lastly findings indicated that gender roles coupled with domestic expectations compromise health care access.

5.2.2. Educational level and access to health care

Study Findings concluded that education levels affect access to health care services; the study also concluded that education attainment is an indication of literacy levels and impacts healthcare outcomes and lastly the study findings concluded that there is a significant relationship between low levels of health literacy and access to health care.

5.2.3. Age and access to health care services

The study findings concluded that aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider, and lastly, findings concluded that if old people are constrained by levels of income, they end up not making right decisions.

5.3 Recommendations

Basing on the discussion of the study findings and conclusions of this report, the study recommends the following;

There should be more investments by different Governments in a number of strategies in order to help improve on health care services.

There is need for the government to sensitize the community in order to be aware of how to get proper health care services.

5.4 Suggested areas for further research

More research is need from the following fields

Role of Government in provision of health care services

Factors affecting provision of health care services

REFERENCES

Shalk (2018). Themes on health care services and Related Issues in Ethiopia. *Berchi,* 5: 1:11

Center for Educational Research, Training, and DevTech Systems, Inc. (2008) *The Safe health care Program: A Qualitative Study to Examine School Related Gender Based Violence in Malawi.*

Spangar (2018) challenges facing health care provision S. London: Africa Rights cited in 2005, *Unsafe Schools: A Literature Review of palliative care Developing Countries*, Wellesley Centers for Research on Women and DTS Consortium.

Buor (2017). Ethiopia: Demographic and Health Survey A.A: CSA

stephens (2016) *Sticks, Stones and Brutal Words: Health care for children***.** African Child Policy Forum and Save the Children Sweden.

Hoeven (2019) . An Investigative Study of health care provision. London: DFID.

MOH (2018) "challenges facing health care in rural areas: The Case of Machakel *Woreda,* Sostu Debir Shelel Peasant Association," Unpublished M.A. Thesis in Social Anthropology. AAU

Oganga (2020). Factors affecting provision of medication services: Conceptual Framework. A.A: AAU.

Kalichman (2019). Poverty and provision of health care services In Habtamu Wondimu (e.d.). Research Papers on the Situation of Children and Adolescents in Ethiopia A.A: AAU Printing Press.

Onyeka (2020). Health care Reports: children health care, Issues in World Health. Baltimore: (HANGF/USAID).

Larsson (2020). A Study on provision of health care in Selected Areas of Addis Ababa City Administration. A.A.: ANPPCAN.

Brosttrom (2015) "socio econic factors and access to palliative care in Ethiopian hospitals:." In Ohsako, T. (ed.). *Girls: Global Issues and Interventions.* Paris: International Bureau of Education, UNESCO.

APPENDICES

Appendix I – Consent Letter

UGANDA CHRISTIAN UNVERSITY

BSAWA -DEPARTMENT OF SOCIAL SCIENCES

Dear Respondents

Ref. Request to Complete Research Questionnaire

I am **Taaka Sharon** a student of Uganda Christian University pursuing a degree of Social Work and Social administration currently undertaking a research on a topic '**Socio-Economic Factors and Access to Health Care Services in Northern Division, Mbale City** and your selection was based on random sampling. Please feel free as you respond. The information you give will only be used for academic purposes, treated confidential and will be held anonymous before publication.

Thank you

……..

(Researcher)

TAAKA SHARON

Appendix II: Self-administered questionnaire for youth and local leaders

SECTION A: DEMOGRAPHIC DATA

Instruction

Please tick (√) where appropriate in the space provided

SECTION A

Personal Demographic Data

1. Age (years) 1) 21-29 ☐ 2) 30-39 ☐
   3) 40-49 ☐ 4) 50 above ☐

2. Gender 1) Male ☐ 2) Female ☐

3. Academic qualification 1) Grade III ☐ 2) Diploma ☐
   3) Degree ☐ 4) Masters ☐

SECTION B: QUESTIONNAIRE FOR SCHOOL TEACHERS AND LOCAL LEADERS

1	2	3	4	5
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

	Gender and access to health care	**Rating**				
1.	Women and men health access is influenced by their gender interaction.	1	2	3	4	5
2.	Women access to health care is influenced by their gender due to community perceptions/societies they stay.	1	2	3	4	5
3.	Gender gap affects access to health care in developing countries	1	2	3	4	5
4.	Gender roles coupled with domestic expectations compromise health care access	1	2	3	4	5
5.	Gender of men with a more masculine gender orientation is less likely to go for health care counseling.	1	2	3	4	5
	Educational level and access to health care					
1.	Education levels affect access to health care services.	1	2	3	4	5
2.	Education attainment is an indication of literacy levels and impact health care outcomes.	1	2	3	4	5
3.	There is a significant relationship between low levels of health literacy and access to health care	1	2	3	4	5
4.	Individuals with limited education have delayed response in seeking specialized health care.	1	2	3	4	5
5.	People with low levels of education report a different adherence pattern than those with higher levels of education.	1	2	3	4	5
	Age and access to health care services					
1.	Age is a defining factor in many cultures in terms of social understanding and economic security.	1	2	3	4	5
2.	Aging consumer decision making brings differences between older individuals in relation to the trust they have in the service provider.	1	2	3	4	5
3.	Old people are constrained by levels of income not making right decisions	1	2	3	4	5
4.	Older people have difficult in assimilating health care information and process.	1	2	3	4	5
5.	The choice of health care differs with age and people of similar groups.	1	2	3	4	5
6	Health care is affected by age differences because older people have greater need for health care.	1	2	3	4	5

THANK YOU FOR YOUR TIME

Appendix III: Interview guide for respondents

SECTION A: DEMOGRAPHIC DATA

Instruction

Please tick (√) where appropriate in the space provided

SECTION A

Personal Demographic Data

1. Age (years) 1) 21-29 ☐ 2) 30-39 ☐
   3) 40-49 ☐ 4) 50 above ☐

2 Gender 1) Male ☐ 2) Female ☐

3 Academic qualification 1) Grade III ☐ 2) Diploma ☐
   3) Degree ☐ 4) Masters ☐

Gender and access to health care

1. Does gender affect access to health care services?

   1. Yes 2. No.

If yes, explain how gender affects access to health care services?

……

Educational level and access to health care

Education levels affect people's access to health care services

   1. Yes 2. No

If yes, how do education levels affect access to health care services

……..

If No, explain how?

……

Age and access to health care services

What is the effect of age and access to health care services?

……..

Thank you

Appendixes IV: Work Plan Schedule

Duration / Activity	J	F	M	A	M	J	J	A	S	O	N	D
Developing Questionnaires												
Data collection												
Data processing and analysis												
Writing Draft and Final Report												
Submission of Report												