

**SOCIO-ECONOMIC FACTORS AND ACCESS TO HEALTH CARE SERVICES IN  
NORTHERN CITY DIVISION MBALE CITY**

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## **ABSTRACT**

The study concentrated on socio-economic factors and access to health care services in Northern City Division, Mbale City and it concentrated on the following research objectives: To identify socio-economic factors affecting access to health care services in Northern City Division, Mbale City, to examine the challenges affecting access to health care services in Northern City Division, Mbale City and to determine interventions for improving access to health care services in Northern City Division, Mbale City. The study used a cross sectional research design and it used both qualitative and quantitative research methodology where it considered a population of 100 respondents and a sample size of 80 respondents. Study findings revealed concluded that age is one of the factors affecting access to health care services in Northern City Division, findings also concluded that Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices, that lack of insurance often contributes to lack of access to health which is a far reaching challenge, Findings revealed that Financial needs and insufficient coverage to pay medical bills lead to skipping of necessary care, that receiving some financial support from philanthropy can work as a strategy to improve health care access, that that affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities, and lastly findings concluded that adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians thus improving access to health care provision. The study recommended that: There should be more investments by different Governments in a number of strategies to reduce on socio economic factors affecting access to health care services in Northern City Division Mbale City and that there is need for the community and societies to begin being part of the group that try solve the challenges affecting access to health care provision.

## DECLARATION


**I, Khalayi Aisha** 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 it has never been submitted to any other institution of higher learning for any academic award.

Sign: .....  ..... Date: 26-08-2024 .....

**Khalayi Aisha**

## 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, Mbale City” and it is now ready for submission as a partial fulfillment for the requirements of the award of bachelor’s degree of public administration and management of Uganda Christian University.

Signature: .....  ..... Date: ..... *30<sup>th</sup> - 8 - 2024* .....

MR. NABENDE WAMAKOTE DANNY

**Supervisor**

## **LIST OF ACRONYMS**

MOH	Ministry of Health
WHO	World Health Organization
US	United States
ICU	Intensive Care Unit

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## 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 other physical and mental impairments in people. Health care is delivered by health professionals and allied health fields. Medicine, dentistry, pharmacy, 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 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, the state of provision of health care services in Northern City Division despite several measures put in place. This is indicated by very few people who try to access to health care services which are attributed to income levels, levels of Education, perceptions, gender among others. People of Northern City Division as of today are known to be having sickness yet the provision of health care within the City Division is insufficient, they don't have balanced diets, with majority having no access to quality health care. Mbale District hospital report (2023) notes that the male gender do not often go for health care services like the female gender. Lack of access to health care service skills 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 experience of severe outbreak of communicable and non-communicable diseases for the last 6 years. It is upon this background that the researcher wants to conduct a research study on socio-economic factors and access to health care services in Northern City Division Mbale City.

### **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 identify socio-economic factors affecting access to health care services in Northern City Division, Mbale City.
- II. To examine the challenges affecting access to health care services in Northern City Division, Mbale City.
- III. To determine interventions for improving access to health care services in Northern City Division, Mbale City.

### **1.5 Research questions**

- I. What are the socio-economic factors affecting access to health care services in Northern City Division, Mbale City ?
- II. What are the challenges affecting access to health care services in Northern City Division, Mbale City?
- III. What interventions can be implemented to improve 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.

### **1.6.2 Geographical scope**

The study was conducted in Northern City Division, Mbale City which is located within Eastern Uganda. Northern City Division is Boarded by Bungokho Division to the North, Industrial City Division to the south, to the East it is boarded by Namakwekwe and to the West by Wanale Division.

### **1.6.3 Time scope**

The research study considered a period between 2021-2024. This time 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).

## **1.7 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

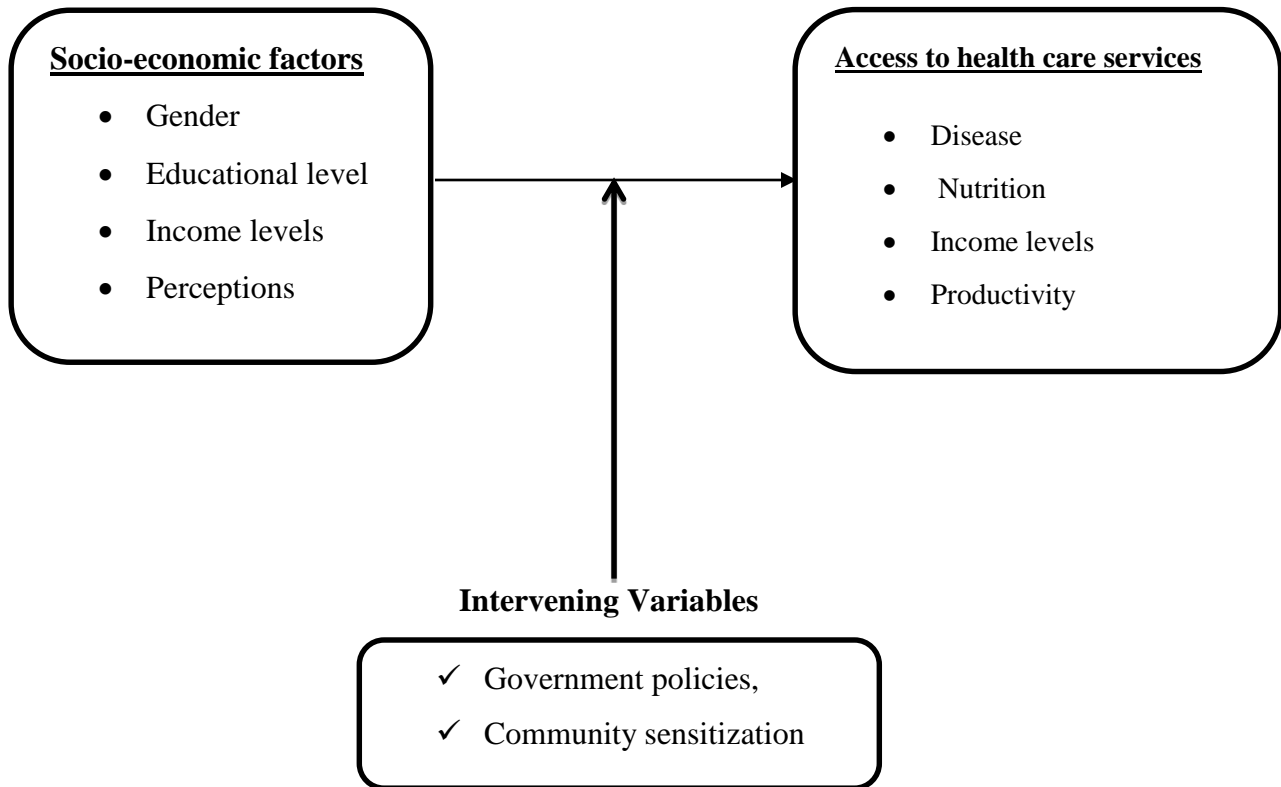
The findings of the study may provide useful and practical information to planners and decision makers that may inform policy thinking and practice as far as the elimination of socio-economic barriers is concerned so as to improve access to health care service

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

## 1.8 Conceptual Frame work

### Independent Variable

### Dependent Variable



*Source: researcher (2024)*

*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

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

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

#### **2.1 Social economic factors affecting access to health care services**

Globally statistics show that 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, nuptiality and mortality. Age is also a defining factor in many cultures in terms of social standing and economic security (Edvinsson & Broström, 2018). The research will investigate if age is one of the factors affecting access to health care services in Northern City Division Mbale City.

Differences in utilization of health care also highlight similarities among individuals within a certain age group. The study into aging and consumer decision making (Carpenter & Yoon, 2019) in West Africa confirms an interesting result in terms of understanding the cohort effect of age, and is particularly interesting for researchers. In Mbale City Northern City Division it is noted that people of young age don't utilize access to health care services well as they always do self-medication. In terms of this study, the researcher will find out whether the choice of health care and access differs by age and whether people in similar age groups could show a similar pattern in their choices in Northern City Division Mbale City.

In health research around the African Continent, much discussion has been generated around evidence found in the way men and women report on their state of health. Bash (2019) Similarly, their interaction with the health care system would also be influenced by gender. In a study focusing on men's health, utilization of health care services and core reasons for their non-participation, in East Africa where Countries Like Uganda, Kenya and Tanzania were considered, it was found out that men had a greater need for confidentiality and placed great value on trusting the expert knowledge of the health care provide Opio (2029). 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 (Ylispangar et al., 2018). This study which will be carried out in Northern Division of Mbale city will determine whether women access for care for themselves and their children is also unique. The study will further find out whether Northern Division of Mbale City, men through the control they have over resources, influence when and where women seek treatment for their health.

Marital status can be viewed as a proximate determinant in an individual's ability to access and use resources within a society due to its reflection of social support (Choi & Marks, 2019). Furthermore, studies into adult mortality have focused on linkages between race/ethnicity, gender, socio-economic status and marital status leading to a growing interest in the social issues that drive demographic processes. Distinct differences have been observed between the mortality patterns of never-married and married persons. Differences have also been observed as one changes marital status e.g. from single to married; and married to divorced or widowed (Choi & Marks, 2022). Socio-demographic studies have brought into question the origins of these differences in mortality, and given cause to consider that these differences are not necessarily biological but social. And these social differences speak to inequalities within the society in terms of accessing and using resources for health. This study will therefore investigate this phenomenon in Northern Division of Mbale city.

The influence of the social support provided by having a partner is more notable in particular for men in terms of utilizing health care. In a study on the health seeking behaviour of men diagnosed with tuberculosis it was found that men first consulted with a health practitioner due to the persistence of their spouses or someone else in the household (Auer et al., 2022). Family structure is seen to have a significant effect on health outcomes and health utilizations in terms of the impact this has on accessing the resources required to interact with the health care system (Hermeto & Caetano, 2019; Kanata & Banks, 2023). Hermeto and Caetano in reviewing the challenges faced by women who are single parents in Japan and Britain note the critical role played by social policies in assisting such families and this study will also find whether this is applicable in Northern Division of Mbale City.

Race is a multi-dimensional concept which is a combination of various factors such as biology, culture, economics, politics, geographic origins and racism. It is essentially a social construct that sets out varying degrees of racial superiority created by institutional and ideological forces

(Glasgow, 2007). One of the effects of racism has been segregated residential areas based on race. Although the institutional forces of racism have been eliminated segregated living based on race still exists. Racial discrimination affects the quality of health care available across race groups therefore; the concept of race cannot be investigated without evaluating the impact of other co-founding factors which affect how an individual experiences the health care system, with regard to goods and services, as well as the ultimate effect on health status (Haywood et al., 2020). This study will assess whether racial discrimination affects the quality of health care available across race groups in Northern Division of Mbale City.

In a similar study exploring race, gender and language concordance, the most significant results were observed for language concordance. The study found that in terms of contact, race and language showed significant results in terms of choice of health care provider. Race was found to be a significant predictor in whether the patient chose a primary care provider or a specialist care provider. From the language results it can be hypothesized that patients will be more likely to utilize the services of a health care provider who was proficient in their home language. In the study, language concordance showed patients who speak a similar language as the provider, reported less difficulty in telephonically contacting their health care provider and were not hesitant to contact them after hours (Martin et al., 2019). This study will investigate whether in Northern Division of Mbale City, race and language showed significant results in terms of choice of health care provider.

Health literacy defines the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Sudore et al., 2019). 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 and this study will investigate this phenomenon in Northern Division of Mbale City.

A significant relationship was found between low levels of health literacy and access to health care (Sudore et al., 2022). 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 utilization cannot be looked at in isolation. Consequently, Sudore and colleagues (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. 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, this study will examine whether the education levels of the patients in Northern Division of Mbale City have also been found to have an impact on the treatment received or how health care providers relate to such patients

The decision-making process in choosing health care is a complex phenomenon as even in instances where health care is covered by some form of insurance, health care choices are also influenced by individual and family factors (Dong et al., 2020). This is particularly true when looking at the influence of income in the health decision-making process as this variable acts both on the individual and household level. The effect of the household income on health decision-making is more evident in the African context due to the influence the head of the household yields. It is often the household head who decides how resources are distributed and as a result this household allocation impacts whether or not an individual may seek treatment for health-related matters. Therefore, this study will find out whether the utilization of health care services in Northern Division of Mbale City can be linked to the high cost of health care in relation to household income.

## **2.2 Challenges affecting access to health care services**

### **Insufficient insurance coverage**

According to Dong et al., (2020), a lack of insurance often contributes to a lack of healthcare. This challenge is dire and far-reaching: Financial need and insufficient coverage to pay medical bills can lead people to skip necessary care for themselves and their families, including preventive screenings, dental care and pediatric visits that track important childhood health

milestones. The lifetime health consequences of missing these appointments have prompted many health systems to launch initiatives that provide services to uninsured or underinsured patients. This study will find out whether in Northern City Division of Mbale City, financial need and insufficient coverage to pay medical bills can lead people to skip necessary care for themselves and their families, including preventive screenings, dental care and pediatric visits that track important childhood health milestones hinder access to healthcare services.

### **Healthcare staffing shortages**

By 2034, The Association of American Medical Colleges (2019) estimates that the American healthcare system could be up to 124,000 doctors short, with roughly a third of those deficits in primary medicine (WHO, 2022). But it's not just physicians that will be lacking nurses, technologists and other roles have predicted shortfalls as well. These gaps affect everyone, but particularly patients already in "healthcare deserts" such as rural areas. In response, many experts have called for expanded technology uptake from health to patient engagement to increase providers' capacity and address the gaps. This study will find out whether in Northern City Division of Mbale City, healthcare staffing shortages hinder access to healthcare services.

### **Stigma and bias among the medical community**

Stigma and bias exist across the medical community, including discrimination based on race, immigration status, sex, gender and sexual orientation. A 2020 paper from the American College of Physicians (2022) outlines how stigma hampers access to care, affecting patients' willingness and ability to seek specialized support such as mental healthcare services or hormone replacement therapy. Even unintentional bias from clinicians and staff from outdated medical materials makes patients feel unwelcome and reluctant to return. Health leaders are using clinician education to fight back, making inclusion an emerging topic in continuing medical education offerings and other resources. This study will find out whether in Northern City Division of Mbale City, stigma and bias among the medical community barriers hinder access to healthcare services.

### **Transportation and work-related barriers**

Dong et al. (2019), found that the same paper that discusses stigma and bias, the American College of Physicians cites transportation and work-related concerns as a key limit on patients' ability to access preventive care and treatment. Specific obstacles include an inability to travel

into city centers or take the required time off. Where clinically possible, telemedicine can help alleviate these concerns. Some health systems have also developed shuttle systems and after-hours services to expand access. Therefore, this study will find out whether in Northern City Division of Mbale City Transportation and work-related barriers hinder access to healthcare services.

### **Patient language barriers**

According to Sudore et al. (2020), in US households speaks a language other than English at home; meeting patients' language needs is a growing concern for health systems. When patients and clinicians don't speak the same language, it can impact the quality of care individuals receive, especially in hospital settings. While many patients involve family members as their interpreters, doing so can risk miscommunication and mistranslation. Instead, a Nursing Management paper suggests involving professional medical interpretation services and using multilingual patient education to better support patients. The challenges highlighted above call for new roles and new approaches on the part of health professionals (Obingar et al., 2018). For one thing, this study will find out in Northern City Division of Mbale City whether to care effectively for patients, the successful health professional in this century will need to master information technology, using its capabilities to manage information and access the latest evidence.

## **2.3 Interventions for improving access to health care services**

### **Adopt mobile health care**

According to WHO (2020), some healthcare professionals have studied how mobile health clinics can improve access to health care, including methods that would specifically improve health care in rural communities. These "clinics on wheels" can help solve the issue of transportation many rural citizens face. Mobile health clinics are also significantly less expensive for both patients and providers as the infrastructure costs are dramatically reduced. While offering potential cost savings to patients and insurers, mobile clinics can also assist in building relationships and increasing health literacy in rural areas for women and minorities. A study published in the *International Journal of Equity in Health* conducted in 2020, which reviewed several mobile healthcare initiatives, found that over half of mobile healthcare clients are women (55 percent) and racial/ethnic minorities (59 percent). Most of

those who received care were either uninsured or had some form of public insurance. The majority of these mobile clinics received some form of financial support from philanthropy, an issue that constituted part of the investigation for this study in Northern City Division of Mbale City.

### **Collaborating with Larger Healthcare Networks**

Mwiti (2020) and WHO (2021) argued that by affiliating with larger healthcare systems in more urban settings, rural healthcare facilities can improve health care in rural communities by offering their patients improved infrastructure and resources that are more financially viable. Collaborating with larger healthcare organizations can also bring more specialized and expansive healthcare services to rural areas. A report published by the RUPRI Center for Rural Health Policy (2019) notes a trend of rural hospitals increasing their affiliation with other hospital systems. The report offers several benefits rural hospitals can receive by collaborating with other hospital systems, such as improved technology and larger recruiting and retention efforts for staff. Through collaboration with larger legacy institutions, smaller healthcare facilities can lower their costs and increase their reach in rural communities and this issue formed a central focus of this study in Northern City Division of Mbale City.

### **Adopt a diverse and inclusive hiring policy**

A diverse and inclusive workforce not only reflects the broad range of patients you serve but also introduces different perspectives and experiences that can help improve the quality of care you provide. Encourage greater ethnic, gender, and socio-economic diversity in your workforce by implementing comprehensive diversity and inclusion hiring policies. From hosting bias awareness training for your hiring staff to writing more inclusive job descriptions, there are a variety of ways to remove bias from your hiring process and focus solely on the candidate skills that can enrich your practice. There is also need for hiring lower-cost physician extenders such as nurse practitioners, physician assistants, and other allied healthcare professionals to help close the gap in healthcare access. This study found out Northern City Division of Mbale City whether healthcare extenders can provide many of the same services as physicians, including diagnosing and treating illnesses, prescribing medications, and providing preventative care all at a more affordable cost for patients.

## **Collaborate with Community Organizations**

According to MoH (2022), to better understand and address the unique needs of different patient populations, form partnerships with local community organizations that represent and advocate for marginalized groups. These collaborations can help you tailor your products and services to meet the unique needs of specific communities more effectively. Mande et al., (2020) further argued that mobile health units are a great example of a solution you can support to help increase access to care in underserved communities. Mobile health units are staffed with healthcare professionals who can provide preventative, diagnostic, and treatment services to members of their local community. This study found out whether health care providers in Northern City Division of Mbale City often travel to rural or urban locations that lack access to traditional healthcare facilities in order to deliver much-needed care for otherwise marginalized or underserved populations.

## **Educate Clinical Staff on Healthcare Disparities**

Onyango et al., (2022) found that training and education are essential components of increasing access to care. Conduct regular workshops and training sessions to educate your clinical staff about the various social, economic, and environmental factors that contribute to healthcare disparities. The researcher will therefore found out whether in Northern City Division of Mbale City, clinical staffs are encouraged to become advocates for improving access to care and provide them with the tools and resources necessary to effect change.

## **Increase Flexibility for Patients**

According to WHO (2022) and MoH (2022), one way to increase access to care is simply by breaking down barriers that make it hard for patients to receive essential care. This starts with offering a variety of scheduling methods. Online scheduling can be a convenient option for patients who cannot make appointments during regular business hours. After-hours appointments can also be a great solution for those who work and cannot leave during the day. Open scheduling, which permits patients to walk in without an appointment, can provide those in crisis with immediate care. By offering these different scheduling methods, you can accommodate a wide range of patient needs. Another way to increase access is by offering flexible payment options. This study found out whether in Northern City Division of Mbale City, health care providers work with patients to develop payment plans that better suit their

financial situation. The researcher will also investigate Northern City Division of Mbale City whether health care providers set up recurring payments to ensure that patients are not hit with large bills all at once.

### **Using Data to Drive Decisions and Improvements**

By monitoring the data you collect on your patients and their health outcomes, you can identify disparities and barriers to accessing care. Use this data to address these barriers, allocate resources, adjust your strategies, and measure their effectiveness. Data-driven decision-making can help ensure that all patients receive the care they need, regardless of their background, location, or economic status. For example, during the early stages of the coronavirus pandemic, in an attempt to improve diversity, equity, and inclusion in their response to the pandemic, Brigham Health (Onyaiti et al., 2018) used data science to inform their incident command response. They utilized data regarding race, ethnicity, language, gender, and insurance status to help ensure equitable access to scarce resources such as ventilators and ICU beds, a phenomenon this study will investigate in Northern City Division of Mbale City.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.0 Introduction**

This chapter describes the methodology that was used in the study and some of the areas that will be covered include: Research design, area and population of the study, sample size, sampling techniques, research instruments, data quality control, data analysis as and ethical issues in the study.

#### **3.1 Research Design**

The research study used a cross-sectional research design using both qualitative and quantitative research approaches to analyze the relationship between socio-economic factors and access to health care services in Northern City 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 Sample size**

The total population (N) was 100 people and therefore the sample population of 80 persons was arrived at using Morgon table (1973) methods of determining a sample size from the population.

**Table 3.1:** Summary of the Sample Size and Sampling Technique

**Sample selection**

<b>Participants</b>	<b>Population (N)</b>	<b>Sample Size (n)</b>	<b>Sampling Technique</b>
Local leaders	10	8	Purposive sampling
Health workers	20	16	Simple random sampling
Intern workers	20	16	Simple random sampling
Residents of Northern City	25	20	Simple random sampling
Care takers	25	20	Simple random sampling
<b>Total</b>	<b>100</b>	<b>80</b>	

*Source: CDO's Office (2024)*

### **3.3 Sampling Techniques**

The researcher used the following sampling techniques:

#### **3.3.1 Simple random sampling**

The researcher used simple random sampling to select health workers, intern workers residents of Northern City, care takers and purposive sampling was used on local leaders. 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 were included in the sample. Simple random sampling enabled the researcher to get a representative sample for the research study and it allowed generalizability to a larger population with a margin of error that was statistically determinable.

#### **3.3.2. Purposive sampling**

Purposive sampling was used on school local leaders such persons had in detail information about the topic under study.

### **3.4 Research instruments**

The researcher used both questionnaires and interview guide.

#### **3.4.1 Questionnaire**

The researcher used a self-administered questionnaire as a research tool to collect data from the care takers, intern students and local leaders' category. The questionnaire had three sections:

Section A included respondents' demographic information, Section B, C and D focused on general close ended statements which were in accordance with the objectives of the study. The researcher got a list of local leaders and these were selected through purposive.

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 Likert scale of measurement on close ended questions based on a scale of strongly agree (5), agree (4), unsure (3), disagree (2), strongly disagree (1) were used because they allowed respondents to provide firsthand information which was free of bias and easy to use.

### **3.4.2 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). These instruments contained mostly open-ended questions. The interview guide was used on health workers and local leaders because this category of study respondents had more knowledge that could not fully be captured using questionnaires.

## **3.5 Data Analysis**

### **3.5.1 Quantitative data analysis**

Data processing was done through editing of the data which was coded for further data analysis. 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 socio-economic factors and access to health care services in Northern City Division, Mbale City. This is because data presentation requires clear portrayal of the findings presented, and the listed method above clearly fulfilled that purpose.

### **3.5.2 Pearson Correlations and Regression Analysis**

Pearson Correlations and regression analysis were used to establish the effect of socio-economic factors and access to health care services in Northern City Division, Mbale City. This type of inferential statistics is easy to compute and interpret and it which helped in

making conclusions. Descriptive statistical techniques (frequencies and percentages) were used to analyze field data from questionnaires which assisted in the interpretation of data.

### **3.5.3 Qualitative data analysis**

On the other hand, qualitative data gathered from open-ended questions in the interview guide were 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.

## **3.6 Research procedure**

The researcher presented a research topic to the department of social sciences 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.

## **3.7 Ethical considerations**

### **3.7.1 Consent**

The researcher got approved consent from the respondents. Respondents willingly 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 data collection. However, the prepared instruments helped the researcher to collect objective information hence fears of personal views were reduced.

### **3.7.2 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 on respondents' willingness to participate in the study.

### **3.7.3 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 was picked from another source, the author (copy right owner) was acknowledged.

## **3.8 Validity and reliability**

### **3.8.1 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 was 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 instrument that yielded content – valid data by first specifying the domain of indicators that were relevant to the concept being measured. A content-valid data measure contained all possible items that were used in measuring socio-economic factors and access to health care services in Northern City Division, Mbale City.

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

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

### **3.8.2 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 will be above 0.7 which shows that there is reliability.

## CHAPTER FOUR

### DATA PRESENTATION, ANALYSIS AND INTERPRETATION

#### 4.1 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 that are presented 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 who participated in the study.

**Table 4.1:** Age in years

		<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
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
	<b>Total</b>	<b>80</b>	<b>100.0</b>	<b>100.0</b>	

*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% were the majority and in the age bracket of 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 argues 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 before responding thus indicating that respondents give trustable information in line with the topic under study.

#### 4.2.2 Gender of Respondents

The respondents were asked to reveal their gender by ticking the appropriate column they belonged. The purpose was to find out the number of males and females who actually participated in the study as illustrated in table 4.2 below.

**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
	<b>Total</b>	<b>110</b>	<b>100.0</b>	<b>100.0</b>	

*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 finding indicates that there were 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, 2018)

#### 4.1.3 Marital status of the respondents

Table 4.3 depicts the marital status of respondents who participated in the study. The purpose was to find out the status of persons who participated in the study in relation to socio-economic factors and access to health care services in Northern City Division, Mbale City. As these persons were assumed to have a lot of responsibilities and know the economic burdens they face in feeding families as well as paying for their health care.

**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
	<b>Total</b>	<b>80</b>	<b>100.0</b>	<b>100.0</b>	

*Source: Primary Data (2024)*

Table 4.3 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 have experience in solving various socio-economic factors and access to health Care in Northern City Division.

#### 4.1.4 Educational level of the respondents

The level of education was used to demonstrate the knowledge of respondents in relation to socio-economic factors and access to health Care in Northern City Division.

**Table 4.4:** Levels of Education

	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
University	29	20.0	20.0	20.0
Tertiary	35	36.3	36.3	56.3
Secondary	16	43.8	43.8	100
<b>Total</b>	<b>80</b>	<b>100</b>	<b>100</b>	

*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 above 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 in Northern City Division were reliable. This was in line with Uma (2016) 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 questionnaires.

## 4.2. Objective one: Socio-economic factors affecting access to health care services

**Table 4. 5:** Descriptive Statistics

<b>Responses</b>	<b>N</b>	<b>1 (SD)</b>	<b>2 (D)</b>	<b>3 (U)</b>	<b>4 (A)</b>	<b>5 (SA)</b>	<b>Mean</b>	<b>Std. D</b>	<b>Comments</b>
Age is one of the factors affecting access to health care services in northern city division	80	5 (3.6%)	5 (3.6%)	10 (15.8%)	40 (50%)	20 (27%)	3.82	1.022	<b>High</b>
Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices	80	0 (0%)	2 (3.5%)	3 (7%)	60 (63.4%)	15 (26.1%)	3.96	0.815	<b>High</b>
Men with a lot of resources influence when and where women seek treatment for their health.	80	5 (5%)	5 (5%)	0 (0%)	50 (67.0%)	20 (23%)	4.14	0.600	<b>Very High</b>
Racial discrimination affects the quality of health care available across race groups.	80	10 (12.5%)	5 (4%)	5 (4%)	48 (51.1%)	32 (28.4%)	4.01	0.905	<b>High</b>
Literacy levels impact on how individuals interact with health workers and has an impact on health care access.	80	0 (0%)	0 (0%)	18 (10%)	64 (70.3%)	22 (18.2%)	3.93	0.745	<b>High</b>
Valid N (list wise)	80								
<b>Overall Mean &amp; Standard Deviation</b>							<b>4.00</b>	<b>0.824</b>	<b>High</b>

*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 Socio-economic factors affecting access to health care services. Below are responses in line with the first objective.

Respondents were asked to reveal if, age is one of the factors affecting access to health care services in Northern City Division where 27% of the respondents strongly agreed that Age is one of the factors affecting access to health care services in northern city Division, 50% of the respondents agreed, 15.8% of the respondents were undecided, 3.6% of the respondents disagreed and lastly 3.6% of the respondents strongly disagreed. A high mean of 3.82 indicated that age is one of the factors affecting access to health care services in Northern City Division. Respondents ADR assured that people in young age feel it is wastage of time to go for health care services yet the Elderly also face hardships as they could not easily move to such places for treatment.

Responses on if choice of health care and access differs by age and people in similar age groups show similar patterns in their choices 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 Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices. Respondents ADD2 and ADD3 proved that differs by age as the youth who have some money and energy always prefer private hospitals yet the elderly people go to government recognized institutions. This study finding was in line with Galal (2019) who conducted a study in Kenyan rural areas on health care provision and found out that age differences were one of the determinants of which place one went for health care provision.

Responses on if men with a lot of resources influence when and where women seek treatment for their health 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 men with a lot of resources influence when and where women seek treatment for their health. Respondents QQQT and RRRCT said that men with enough resources always prefer their women receiving quality health care services as compared to those with less resources who always take them to any available cheap health care service provider. This study finding was in line with Finan (2021) who conducted a research study in Kenya on poverty and health seeking and found out that most men with less resources preferred self-medication without seeking health care provision.

Responses on if racial discrimination affects the quality of health care available across race groups 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 racial discrimination affects the quality of health care available across race groups. Respondents KRC noted that that racial discrimination has greatly affected access to health care services. This finding was in line with the study conducted by Espejo (2019) from Tanzania and found out that in Government hospitals health workers that give equal attention as they prefer the ones with money where this discrimination has affected access to health care services.

Responses on if, literacy levels impact on how individuals interact with health workers and has an impact on health care access 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 Literacy levels impact on how individuals interact with health workers and has an impact on health care access. Respondents QNN1 said that people who have attained some level of education always quickly seek health care service provision as compared to the ones with no literacy levels who always think they have bewitched them.

A high overall mean of 4.00 indicated that socio-economic factors access to health care services in a number of illustrated above.

### 4.3 Objective two: Challenges affecting access to health care services

**Table 4. 6:** Descriptive Statistics

<b>Responses</b>	<b>N</b>	<b>1 (SD)</b>	<b>2 (D)</b>	<b>3 (U)</b>	<b>4 (A)</b>	<b>5 (SA)</b>	<b>Mea n</b>	<b>Std. D</b>	<b>Com ments</b>
Lack of insurance often contributes to lack of access to health which is a far reaching challenge	80	1 (2%)	0 (0%)	4 (6%)	25 (30%)	50 (62%)	4.46	1.072	<b>Very High</b>
Financial needs and insufficient coverage to pay medical bills leads to skipping of necessary care.	80	0 (0%)	5 (3%)	10 (7%)	45 (54%)	20 (36%)	4.22	0.668	<b>Very High</b>
Health care staffing shortages affects everyone but particularly patients already in healthcare.	80	0 (0%)	0 (0%)	5 (10.2%)	55 (67.0%)	20 (22.7%)	4.14	0.600	<b>Very High</b>
Stigma and bias among medical community including discrimination affect health care access.	80	2 (1%)	3 (3%)	0 (0%)	25 (38%)	50 (58%)	4.50	0.684	<b>Very High</b>
Transportation and work-related barriers hinder access to healthcare services	80	0 (0%)	0 (0%)	0 (0%)	25 (37%)	55 (63%)	4.58	0.509	<b>Very High</b>
Valid N (list wise)	80								
<b>Overall Mean &amp; Standard Deviation</b>							<b>4.34</b>	<b>0.732</b>	<b>Very High</b>

*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 about the challenges affecting access to health care services.

Respondents were asked to reveal if lack of insurance often contributes to lack of access to health which is a far reaching challenge and 62% of the respondents strongly agreed with this item, 30% agreed, 6% were undecided, none of the respondents disagreed and lastly 2% of the respondents strongly disagree. A very high mean of 4.46 indicated that lack of insurance often contributes to lack of access to health which is a far reaching challenge. This study finding was in line with Galloway (2019) who conducted a research study in Namibia and found out that that 85 percent of people in the country don't always go for insurance cover and this has continuously affected access to health care and it has far reaching challenges.

Respondents were also asked to reveal if financial needs and insufficient coverage to pay medical bills lead to skipping of necessary care and under this item, 36% of the respondents strongly agreed, 54% of the respondents agreed, 7% of the respondents were undecided and lastly none of the respondents strongly disagreed. A very high mean of 4.22 suggested that Financial needs and insufficient coverage to pay medical bills lead to skipping of necessary care. This study finding was similar to that of WHO (2020) which notes that the financial needs in health care have greatly affected provision of health care due to insufficient coverage of a number of areas.

Responses on if health care staffing shortages affects everyone but particularly patients already in healthcare showed that 22.7% of the respondents strongly agreed, 67% of the respondents agreed, none of the respondents were undecided, 3% of the respondents disagreed, and lastly 1% of the respondents strongly disagreed. A high mean of 4.14 indicated that Health care staffing shortages affect everyone but particularly patients already in healthcare. This was in line with a study conducted in Uganda by Opio et al, (2017) who found that many people who don't get access to proper health care have due to improper health staffing by Government that greatly affects patients who come for health care services.

Responses in line with if stigma and bias among medical community including discrimination affect health care access showed that 58% of the respondents strongly agreed, 38% of the respondents agreed, none of the respondents were undecided, 3% of the respondents disagreed and lastly 1% of the respondents strongly disagreed. Respondents ZZZZ assured that stigma

and bias among medical community including discrimination affect health care access. This finding was in line with a study conducted by Moris (2020) who conducted a study on health care provider bias and patient's wellbeing in Namibia and found out that health care provider care bias and discrimination have led to increasing death of patients and it has also discouraged people from seeking health care provision.

Responses on if transportation and work-related barriers hinder access to healthcare services showed that 63% of the respondents strongly agreed, 37% of the respondents agreed, none of the respondents were undecided, disagreed nor strongly disagreed a very high mean of 4.58 indicated that transportation and work-related barriers hinder access to healthcare services. This was in line with mark (2020), who conducted a research study in Kampala and found out that many health work providers always reach work late due to difficult in movement as a result of jam which in return has cost people their lives.

A very high overall mean of 4.34 indicated that transportation and work-related barriers hinder access to healthcare services

#### 4.4. Objective three: Interventions for improving access to health care services

Responses	N	SD	D	u	A	SA	Mean	Std. D	Comments
Receiving some form of financial support from philanthropy can work as a strategy to improve health care access	80	0 (0%)	0 (0%)	7 (3%)	28 (36%)	45 (60%)	4.46	0.694	<i>Very High</i>
Affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities.	80	3 (5%)	5 (7%)	0 (0%)	40 (60%)	32 (28%)	4.12	0.731	<i>Very High</i>
Collaboration with larger legacy institutions health facilities can lower their costs and increase reach in a number of areas.	80	0 (0%)	0 (0%)	9 (10.2%)	51 (67.0%)	20 (22.7%)	4.01	0.875	<i>High</i>
Adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians.	80	0 (0%)	0 (0%)	8 (6.8%)	22 (35%)	50 (58.2%)	4.47	0.647	<i>Very High</i>
Collaborating with community organizations may help in promoting areas that lack access to traditional healthcare facilities.	80	0 (0%)	0 (0%)	2 (4%)	20 (27%)	58 (69%)	4.56	0.562	<i>Very High</i>
Valid N (list wise)	80								
<b>Overall Mean &amp; Standard Deviation</b>							<b>4.34</b>	<b>0.677</b>	<i>Very High</i>

*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 third objective to the study was in line with interventions for improving access to health care services

Respondents were asked to reveal if, receiving some financial support from philanthropy can work as a strategy to improve health care access and 60% of the respondents strongly agreed, 36% of the respondents agreed, 3% of the respondents were undecided, none of the respondents neither disagreed nor strongly disagreed. A very high mean of 4.46 indicated that receiving some financial support from philanthropy can work as a strategy to improve health care access. This finding was in line with a study conducted by Roberts (2020) from Zimbabwe who found out that the improvement in provision of health care was as a result of receiving financial support from different donors.

Respondents were asked if affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities and 28% of the respondents strongly agreed, 60% of the respondents agreed, none of the respondents were undecided, 7% of the respondents disagreed and lastly 5% of the respondents strongly disagreed a very high mean of 4.12 indicated that affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities. This finding was in line with a study conducted by Anthony (2019) who conducted a research study and found out that there was much health provision improvement in places where affiliating with large healthcare systems in urban setting was the reason behind the improvement.

Respondents were asked to reveal if collaboration with larger legacy institutions health facilities can lower their costs and increase in reaching a number of areas and 22.7% of the respondents strongly agreed, 67% of the respondents agreed, 10.2% of the respondents were undecided, none of the respondents disagreed and lastly none of the respondents strongly disagreed a high mean of 4.01 indicated that Collaboration with larger legacy institutions health facilities can lower their costs and increase reaching in a number of areas. This finding was in line with a study conducted by Davis who revealed that collaboration with larger legacy institutions that have helped in provision of health care.

Respondents were asked to reveal if adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians and 58.2% of the respondents were in agreement with this, 35% of the respondents agreed, 6.85 of the respondents were undecided,

none of the respondents strongly disagreed nor disagreed. A very high mean of 4.47 indicated that adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians improving access to health care provision.

Respondents were also asked to reveal whether collaborating with community organizations may help in promoting areas that lack access to traditional healthcare facilities and 69% of the respondents strongly agreed, 27% of the respondents agreed, 4% of the respondents were undecided, none of the respondents disagreed nor strongly disagreed a very high mean of 4.56 indicated that collaborating with community organizations may help in promoting areas that lack access to traditional healthcare facilities. This was in line with a study conducted by Tomkins (2020) who conducted a study and found out in many communities where there was collaboration, the community has helped in providing land among others which have improved on provision of health care services.

## 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 City Division, Mbale City.

#### 5.1 Discussion of Findings

##### 5.1.1 Objective one: Socio economic factors affecting access to health care services

Findings revealed that age is one of the factors affecting access to health care services in Northern City Division. Respondents ADR assured that people in young age feel it is wastage of time to go for health care services yet the Elderly also face hardships as they could not easily move to such places for treatment.

Findings indicated that Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices. Respondents ADD2 and ADD3 proved that differs by age as the youth who have some money and energy always prefer private hospitals yet the elderly people go to government recognized institutions. This study finding was in line with Galal (2019) who conducted a study in Kenyan rural areas on health care provision and found out that age differences were one of the determinants of which place one went for health care provision.

Findings showed that men with enough resources always prefer their women receiving quality health care services as compared to those with less resources who always take them to any available cheap health care service provider. This study finding was in line with Finan (2021) who conducted a research study in Kenya on poverty and health seeking and found out that most men with less resources preferred self-medication without seeking health care provision.

Findings indicated that racial discrimination affects the quality of health care available across race groups. Respondents KRC noted that that racial discrimination has greatly affected access to health care services. This finding was in line with the study conducted by Espejo (2019) from Tanzania and found out that in Government hospitals health workers that give equal attention as they prefer the ones with money where this discrimination has affected access to health care services.

### **5.1.2. Objective two: Challenges affecting access to healthcare services**

Findings indicated that lack of insurance often contributes to lack of access to health which is a far reaching challenge. This study finding was in line with Galloway (2019) who conducted a research study in Namibia and found out that that 85 percent of people in the country don't always go for insurance cover and this has continuously affected access to health care and it has far reaching challenges.

Findings revealed that Financial needs and insufficient coverage to pay medical bills lead to skipping of necessary care. This study finding was similar to that of WHO (2020) which notes that the financial needs in health care have greatly affected provision of health care due to insufficient coverage of a number of areas.

Findings also revealed that Health care staffing shortages affect everyone but particularly patients already in healthcare. This was in line with a study conducted in Uganda by Opio et al, (2017) who found that many people who don't get access to proper health care have due to improper health staffing by Government that greatly affects patients who come for health care services.

Findings showed that stigma and bias among medical community including discrimination affect health care access. This finding was in line with a study conducted by Moris (2020) who conducted a study on health care provider bias and patient's wellbeing in Namibia and found out that health care provider care bias and discrimination have led to increasing death of patients and it has also discouraged people from seeking health care provision.

### **5.1.3 Objective three: Interventions for improving access to health care services**

Findings indicated that receiving some financial support from philanthropy can work as a strategy to improve health care access. This finding was in line with a study conducted by Roberts (2020) from Zimbabwe who found out that the improvement in provision of health care was as a result of receiving financial support from different donors.

Findings indicated that affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities. This finding was in line with a study conducted by Anthony (2019) who conducted a research study and found out that there was

much health provision improvement in places where affiliating with large healthcare systems in urban setting was the reason behind the improvement.

Findings indicated that Collaboration with larger legacy institutions health facilities can lower their costs and increase reaching in a number of areas. This finding was in line with a study conducted by Davis who revealed that collaboration with larger legacy institutions that have helped in provision of health care.

Findings indicated that adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians improving access to health care provision.

Findings indicated that collaborating with community organizations may help in promoting areas that lack access to traditional healthcare facilities. This was in line with a study conducted by Tomkins (2020) who conducted a study and found out that in many communities where there was collaboration, the community has helped in providing land among others which have improved on provision of health care services.

## **5.2 Conclusions**

### **5.2.1. Objective one: Socio economic factors affecting access to health care services**

Findings concluded that age is one of the factors affecting access to health care services in Northern City Division, findings also concluded that Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices and lastly findings concluded that men with enough resources always prefer their women receiving quality health care services as compared to those with less resources who always take them to any available cheap health care service provider.

### **5.2.2. Objective two: Challenges affecting access to healthcare services**

Findings concluded that lack of insurance often contributes to lack of access to health which is a far reaching challenge, Findings revealed that Financial needs and insufficient coverage to pay medical bills lead to skipping of necessary care, Findings concluded that Health care staffing shortages affect everyone but particularly patients already in healthcare and lastly findings concluded that stigma and bias among medical community including discrimination affect health care access.

### **5.2.3. Objective three: Interventions for improving access to health care services**

Findings concluded that receiving some financial support from philanthropy can work as a strategy to improve health care access, findings also concluded that that affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities, findings also concluded that Collaboration with larger legacy institutions health facilities can lower their costs and increase reaching in a number of areas and lastly findings concluded that adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians thus improving access to health care provision.

### **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 to reduce on socio economic factors affecting access to health care services in Northern City Division Mbale City.

There is need for the community and societies to begin being part of the group that try solve the challenges affecting access to health care provision.

### **5.4 Suggested areas for further research**

Role of Government in implementing proper access to health care services

Impact of health care infrastructure on provision of health care services

Role of the community in implementing health care provision

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**APPENDICES**

**APPENDIX I: CONSENT LETTER**

**Dear Respondents**

**RE. REQUEST TO COMPLETE RESEARCH QUESTIONNAIRE**

I am **KHALAYI AISHA** a student of Uganda Christian University pursuing Bachelor's Degree of Public Administration and Management am currently undertaking a research on a topic '**SOCIO ECONOMIC FACTORS AND ACCESSTO HEALTH CARE SERVICES IN NORTHERN CITYDIVISION, MBALE CITY**'. You are kindly requested to participate in this research and your selection to this effect has been based on random basis. Please feel free as you respond to the study questions because the information you are to give will only be used for academic purposes, will be kept confidential and finally will be held anonymous before any publication.

Thank you

.....

**(RESAERCHER)**

**APPENDIX II: QUESTIONNAIRE GUIDE FOR, HEALTH WORKERS, INTERN  
WORKERS AND LOCAL LEADERS**

**SECTION A: REpondent'S BIO – DATA**

**INSTRUCTIONS**

Please fill in the blank spaces or tick (✓) in the boxes provided where necessary.

1. Name: (optional)

.....

2. Age: 15 – 30  31 – 45  46 – 60  60 +

3. Sex: Male  Female

4. Marital status: Single  Married  Divorced  Separated  Widowed

5. Location:

Cell ..... Parish .....

Sub – county .....

6. Levels of education:

None  Primary  Secondary  Tertiary and above

Other (please specify)

.....  
.....

7. Religion: Protestant  Catholics  Muslims  Born again

Others (please specify).....

## RESPONSE SCALE

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

<b>SECTION B: Socio economic factors affecting access to health care services</b>						
1.	Age is one of the factors affecting access to health care services in northern city division	1	2	3	4	5
2.	Choice of health care and access differs by age and people in similar age groups show similar patterns in their choices	1	2	3	4	5
3.	Men with a lot of resources influence when and where women seek treatment for their health.	1	2	3	4	5
4.	Racial discrimination affects the quality of health care available across race groups.	1	2	3	4	5
5.	Literacy levels impact on how individuals interact with health workers and has an impact on health care access.	1	2	3	4	5
<b>SECTION C: Challenges affecting access to healthcare services</b>						
8.	Lack of insurance often contributes to lack of access to health which is a far reaching challenge	1	2	3	4	5
9.	Financial needs and insufficient coverage to pay medical bills leads to skipping of necessary care.	1	2	3	4	5
10.	Health care staffing shortages affects everyone but particularly patients already in healthcare.	1	2	3	4	5
11.	Stigma and bias among medical community including discrimination affect health care access.	1	2	3	4	5
12.	Transportation and work-related barriers hinder access to healthcare services	1	2	3	4	5
<b>SECTION D: Interventions for improving access to health care services</b>						
16.	Receiving some form of financial support from philanthropy can work as a strategy to improve health care access	1	2	3	4	5
17.	Affiliating with large healthcare systems in urban settings can help rural facilities improve on health care in rural communities.	1	2	3	4	5

18.	Collaboration with larger legacy institutions health facilities can lower their costs and increase reach in a number of areas.	1	2	3	4	5
19.	Adopting of a diverse and inclusive hiring policy may provide many of the same services as physicians.	1	2	3	4	5
20.	Collaborating with community organizations may help in promoting areas that lack access to traditional healthcare facilities.	1	2	3	4	5

### **APPENDICES III: INTERVIEW GUIDE**

- 1) What is your occupation?
- 2) What factors contribute to failure of access to health care?
- 3) Identify some of the challenges parents in accessing of health care.
- 4) What is the relationship between socio-economic factors and access to health care services?



# UGANDA CHRISTIAN UNIVERSITY

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MBALE UNIVERSITY COLLEGE.

Office of the Academic Registrar

To THE TOWN CLERK

NORTHERN CITY DIVISION  
MBALE CITY  
DATE 27/07/2024  
SIGN [Signature]

Dear Sir/Madam,

Re: Academic Research

Christian greetings!

We are honored to introduce to you Mr. Mrs./Miss KHALAYI ALISHA  
Of Registration Number J22/MUC/BPAM/021 pursuing a Masters'  
Degree/Postgraduate Diploma / Bachelor's Degree

Bachelor's degree

He/ she is required to carry out academic research on the topic  
Socio-economic factors and access to health care services  
in Northern city division, Mbale City.

and thereafter produce a well bound hard cover research report (MAROON) in color for  
undergraduate and three (BLACK) copies for Postgraduate students as a university  
requirement for the award of a degree/diploma in the academic discipline that he /  
she is pursuing.

We shall be grateful for the help you may offer to him or her accordingly.  
Thank you.

Yours faithfully,

[Signature]  
Mr. Akampurira Timothy  
Academic Registrar



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