



MAKERERE UNIVERSITY



**Karolinska
Institutet**

Department of Health Policy, Planning and Management, School of Public Health, Makerere
University College of Health Sciences

and

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ACADEMIC THESIS

The public defence for the degree of Doctor of Philosophy at Karolinska Institutet and Makerere
University will be held at Karolinska Institutet/ Aulan, Norrbacka, Thursday **9th June, 2011, 09.00**

AKADEMISK AVHANDLING

som för avläggande av gemensam medicine doktorsexamen (*Doctor of Philosophy, faculty of
medicine, PhD*) vid Karolinska Institutet och Makerere University offentligen försvaras på det
engelska språket i Föreläsningssal Aulan på Norrbacka, den 9:e juni 2011, kl 9.00

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Abstract

Background: Social determinants of health care use individually and synergistically contribute to substantial disparities that exist among children. Whilst many of the determinants that influence children's effective health care use are well defined, social capital as a potential enabling factor is less well evidenced, particularly in low income countries.

Aim: To study socioeconomic determinants in utilization of health care services for children in Uganda aged less than five years and the role of social capital in modifying these differences.

Methods: The thesis includes four studies (I-IV). Study I used qualitative research methods. Initially, three community meetings were held to identify wealth ranking categories. Subsequently 9 focus group discussions categorised by wealth category, were held to explore what the community perceptions were on barriers and facilitating factors for health care use in general. Studies II, III and IV used both qualitative and quantitative data from the Iganga-Mayuge Health and Demographic Surveillance Site collected between 2006-2008. Statistical analyses in studies II, III and IV used logistic regression analyses. Study II compared how a comprehensive relative poverty ranking index based on information from the community consultation estimated differences in use of a public health facility by febrile children less than five years (n=936). In study III, the socio-demographic distribution of social capital among caregivers who had taken their children to a public health facility is established (n=2,582). Sub-study IV assessed the magnitude and direction of association for each of the social capital dimensions with health care use among the same sample of febrile children in study II.

Results: Three broad wealth categories: '*abaavu*' (poorest); '*abafuni*' (low income earners) and '*abagaiga*' (least poor) were identified in study I. Barriers to health care utilization existed during the health seeking process, within the health service delivery and by virtue of the ownership status of livelihood assets. Amongst other factors, social resources were important in enabling the use of health services but perceived utility varied by wealth category, increasing for the least poor (I). A comprehensive wealth ranking index that captured a wider poverty construct that included social capital was more sensitive (OR 0.57; 0.37-0.89) than a conventional material capital asset-based index (OR 1.00; 0.66-1.50) in discriminating differences in use of a public health facility (II). Female caregivers, living in higher quintile households were less likely to perceive high levels of social capital for three dimensions – trust (OR 0.67, 0.46-0.97); instrumental support (OR 0.74, 0.58-0.94); informational support (OR 0.57 0.43-0.75) compared to those living in lower quintile ones. Male caregivers, living in a higher quintile household were less likely to perceive high levels of reciprocity (OR 0.64, 0.44-0.92) compared to those in low quintile ones. Being older than 30 years old – (OR 1.94, 1.01-3.72) and having attained more than primary five school level (OR 1.94, 1.18-3.19) were both associated with a higher likelihood of perceiving high levels of informational support among male caregivers (III). Children's use of a public health facility was independently associated with social capital. Children living in villages with perceived high trust (OR 2.75, 1.50 to 5.02) and medium levels of informational support (OR 1.68, 1.12 to 2.50) had a higher likelihood of using a public health facility. In direct contrast, children living in villages with high levels of perceived reciprocity (OR 0.69, 0.49 to 0.97) had a lower likelihood of using a public health facility than those who lived in villages with perceived low reciprocity (IV).

Conclusion: Universal access to essential health care in Uganda continues to be constrained by multiple barriers that occur during the health seeking process, within the health service and by virtue of an individual's ownership status of livelihood assets. The distinction of these disparities in health care use is improved when a wider poverty construct that includes social capital is used. Disparities in health care use amongst Ugandan children can be independently explained by their caregivers' community level stocks and distribution of social capital.

Key words: Social determinants; social capital; children; Uganda; health care use