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Assessment of the level of knowledge and awareness of women on sexual and reproductive health services (SRH) under decentralization in Kampala Uganda

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ABSTRACT

This is an assessment of the level of knowledge and awareness of women on sexual and reproductive health services under decentralization in Kampala Uganda. It examined knowledge and perceptions about SRH. Kyanja parish in Nakawa division which is located in Kampala district was purposively selected as the study area. A purposive and simple random sampling techniques were used in selecting 77 respondents from the 5 zones in the parish. The study was cross-sectional and it employed both qualitative and quantitative methods of data collection. The results of the study reveal that respondents understood SRH in different ways. Majority of the respondents believe that SRH is a general reproductive health care among women. However, some men think that women who seek for SRH are immoral something that limit most women from seeking for such services on time. There is need to address the existing gender and social cultural factors that limit women's liberation.
Keywords: Assessment, knowledge, awareness, women and sexual reproductive health (SRH).

INTRODUCTION

Sexual and Reproductive Health (SRH) is a state of complete physical, mental and social well-being and not merely the absence of diseases, in all matters relating to the reproductive system and to its functions and processes [1]. Thus SRH implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Sexual and Reproductive Health entails various services which includes; family planning, counseling, sexual health education, HIV testing, diagnosis and treatment of sexually transmitted illnesses as well as antenatal, delivery and postnatal care services [2]. According to [3], the right to SRH also means that everyone should be entitled to control their own health and body, including having access to sexual and reproductive information and services, free from violence and discrimination. Knowledge about Sexual and Reproductive Health amongst women and girls is an important step towards getting access to and utilization of related information and services in a timely and effective manner [4]. However knowledge and level of awareness among women and girls across the globe on specific areas of SRH information and its related services have varying levels based on a number of factors. According to [5]. These include; geographical area and surrounding environment, age, economic status among others. A study carried out on determinants of adolescents reproductive health service utilization in Ethiopia by [2] asserts that, unlike married women

who are often specifically interested in seeking for SRH information and services like family planning, antenatal, delivery and postnatal care services, adolescent girls below 18 years on the other hand are often interested in SRH services such as counseling, sexual health education and information of contraceptive. In line with the above, [6] adds on that knowledge on SRH also differs based on geographical location, where they contest that SRH knowledge seeking behavious between most developed countries differs dramatically from those women and girls in developing countries. Where the level of awareness and knowledge on SRH is often high in developed countries and low in developing countries especially those in Africa. This could be the reason why 90% which is approximately 10.8 million out of 12 million of unplanned pregnancy do happen among women and girls developing countries with highest prevalence being in sub-Saharan Africa, where out of these unintended pregnancies about 5.6 million are aborted with about 3.9 million using unsafe means due to lack of adequate knowledge on SRH [1]. Scholars such as [7]; [8]; [9]; [10]; [11] have given an account into the causes of low level of knowledge on SRH among women and girls, where a number of factors ranging from individual behavior, socio-cultural to religious as well as due to low socio-economic status and infrastructural development have been cited to be the leading causes of low levels of knowledge on SRH. However, government policies such as lack of formal and comprehensive sex education in schools in some countries where Uganda is inclusive has also been stated by [12]; [13] to be the contributors. On the other hand lack of parental involvement in the sexuality education of their children also plays a key role in limiting knowledge acquisition as they grow up [14]. With this parents are failing to be prominent socializing agents of sexuality for their children. This in turn adversely affects adolescents as they transits into adulthood [14]. In Uganda, despite policy actions and strategic efforts made to promote sexual and reproductive health service uptake among women and girls, its utilization remains very low. For instance, according to 2016 Uganda Demographic Health Survey, there is a dramatic knowledge gap among the youth on contraceptives, pregnancy related information and HIV/AIDS. Therefore, due to limited knowledge of contraceptive use coupled with poor access to sexual and reproductive health care services, young people engage in unprotected sex to satisfy their sexual desires and curiosity and at the end, they become victims of HIV and unwanted pregnancy. For instance, [15] statistics showed that one in 4 (25%) girls aged 15-19 have begun childbearing and also a high number of them have been affected by HIV/AIDs due to low knowledge on contraceptive and its use. Furthermore, by the fact that Uganda is a culturally rich nation with vast kingdoms, norms are still highly respected and the majority of women are confined in private sphere to perform domestic and agricultural based work, hence leaving them with little or no time to seek for SRH something that limit their knowledge on available services and SRH information [16]. For instance, according to [17], women and girls do the large majority of unpaid care work, typically 5 times more than men. The population especially in poor rural areas households spend least 5-6 hours per day on basic care needs of the household which limits their participation in productive or development work including seeking for SRH information and services that could enhance their health [17]. Due to such patriarchal practices most women have been denied their rights specially, the right to work, the right to have the number of children they desire to have and rights to seek for health including SRH in desired places. As such in most cases women have been forced to produce children to fulfil the man's desire making Uganda one of the country with highest fertility rate in the world with about 4.895 births per woman in 2019 though this had a 2.3% decline from 2018 which was 5.010 births per woman and a 2.98% decline

from 2017 [1]. According to [18], this has persistently declined from 7.1 children per woman in 2006 however, despite the above, the number of women attending antenatal clinics has been very low partially due to gender and social cultural factors. This could be one of the reasons why maternal mortality rate (MMR) in Uganda has remained high at 343 per 100,000 live births [19]. Approximately, 16 women die every day in Uganda as a result of pregnancy related complications due to inadequate knowledge, access and utilization of SRH [15].

Aim of the study

To assess the level of knowledge and awareness of women on sexual and reproductive health services under decentralization in Kampala district, Uganda.

Research Question

What is the level of knowledge and awareness of women on sexual and reproductive health services under decentralization?

METHODOLOGY

Research design

Given the nature of the study, a cross-sectional design was adopted. This design is normally used in situations where the population of study is large and is examined at a single point in time [20]. It also involves collection of data on more than one case at a single point in time in order to gather a body of quantifiable data in connection with two or more variables, which are then examined to detect their pattern of association [20]. Hence it is suitable for the proposed study. The study also employed a mixed approach of both qualitative and quantitative methods of data collection and analysis. The methods include, use of questionnaires and in-depth interviews which was developed in reference to the stated objectives. According to [21] mexed methods are compatible and can be used at the same time. Qualitative methods was used because some SRH challenges especially those that related with culture may not be not be quantified while quantitative methods was used for quantifiable information. Although the study focuses mainly on women in child bearing age, some male key informants particularly the doctors and local leaders will also be consulted for purposes of analyzing gender asymmetries without bias. This helped in bringing out a clear picture on gender factors.

Area of study

The study was carried out in Kyanja parish which is located in Nakawa division in Kampala district. Kyanja one of the 23 parishes that make up Nakawa division, one of the five administrative divisions that make up Kampala district. It is located approximately 8 km by road, North West of Kampala city center (Kampala Capital City Authority [22]. According to Uganda Bureau of Statistics, despite Kyanja parish being in a formal developed settlements, majority (about 15%) of households are located more than 5 km from the nearest health facility, whether public or private. Because of this reason, a good number of residents gets a challenge in seeking for health care, more so sexual and reproductive health care services. Apart from this, there are other factors such as cultural, social and economic factors that hinder access and utilization of SRH care services, though little has been done to investigate on this, hence the need to carry out a study for furtherinvestigation.

Source: Modified from:
http://www.mcgill.ca/mchg/projects/edible/kampala/kampalainfo/**Figure 1**: Map with administrative boundaries of Kampala districts showing the study area (Nakawa)

Study population

The target population in this study was comprised of 64 women who are in their reproductive age of 15-49 years. These included both the singles and those that are married. About 13 key informants will also be included. These groups of respondents will be selected by the help of research assistants, particularly the trained midwives from the area of study. Other groups included key informants such as; health officials, medical staff such as gynecologist and midwives, traditional birth attendants, TBA's and local leaders in the area.

Sampling methods

This study employ simple random and purposive sampling techniques to select the required number of respondents. Purposive sampling technique was used in selecting key informants in different villages within the parish. These included; health officials, medical staff especially, such as nurses and doctors as well as the traditional birth attendants and local leaders. In-depth interviews was used in gathering the required information from these key informants. On the other hand, random sampling technique was used in selecting women in child bearing age where information about the challenges they face with regard to access and utilization of SRH services were collected usingquestionnaires.

Sample Size

[23], defines a sample as a subset of predetermined size from a population of interest. According to the 2014 Uganda housing and population census, Nakawa division has a total population of 317,023 [24]. Therefore out of this number, 11.4% error margin was considered to select a sample size of 61 respondents. This was arrived at using Yamane (1967) formula shown below,

$$n = \frac{N}{1 + N(e)^2}$$

Where;
n= sample; N= Population = 317,023;
e= Error margin of 11.4%
n = 317,023/ 1+ 317,023 (0.1139^2)

n = 317,023/ 4,117.163
n = 77.00035
n=77 respondents
These participants were distributed accordingly based on [24] sampling tables as illustrated in the following proposed sample structure table;

Table 1: Sampling structure

Structure	Category	Method used	Target Number	Actual selection
Women	Child bearing age	Survey (questionnaires)	55	48
		1 FGD of 8 married women	8	8
		1 FGD of 8 women who were not in marriage	8	8
Key informants	Women (2 doctors, 2 TBAs and 2 nurses/midwives, 1 representatives from NGOs, 1 local leader)	In-depth interview	8	8
	Men (2 doctors, 2 opinion leaders, 1 local leader)	In-depth interview	5	5
Total			**84**	**77**

Research Instruments

The current study employed two research instruments. These include; key informant interview guides for key informants and questionnaire for women in childbearing age. The questionnaires were administered on a randomly selected sample of women in child bearing age who are the main target groups in this study. Using these tools, responses on various aspects influencing access to and utilization of SRH care services were gathered. The key informant guide was used during the consultations with the providers of health services for example, doctors such as gynecologists, medical assistants, nurses, midwives, TBA, opinion leaders and local leaders.

Validity and reliability of instruments

According to [25], validity is the best available approximation to the truth or falsity of a given inference, proposition or conclusion. While reliability measures the extent to which instruments produces consistent scores when the same group of individuals is repeatedly measured under the same conditions.

Validity testing

According to [25], validity is the best available approximation to the truth or falsity of a given inference, proposition or conclusion. Validity in the current study was measured through Content Validity Indices test (CVI). With this, instruments were revised based on the feedback from experts in the field of SRH as well as from the supervisor. For instance, a small group of experts were specifically requested to answer some questions from the draft questionnaire by indicate whether the items used in the study adequately addresses the study objectives or not. The CVI was arrived at using the followingformula.

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

Where CVI = Content Validity Index R = Number of respondents rating all items in the instruments as relevant

N = Total number of respondents participating in the pilot study (Those who rate all items as relevant (R) plus those that rate some as Irrelevant (IR). The tools were acceptable as valid if CVI from the calculations that was 0.70 or higher as recommended [26].

Reliability testing

Reliability refers to consistency or reproducibility of measurements. Reliability of instruments in the current study was determined using a test- retest method which was done within a time lapse of one week. According to [27], test-retest reliability can be used to measure the extent to which instruments are expected to produce consistent scores when the same group of individuals is repeatedly measured under the same conditions. The pilot was tested on few respondents and the results were not included in the final study. A Cronbach alpha reliability test was carried out and only the alpha coefficient of less than 0.5 (<0.5) would be accepted as a measure of reliability of tools as recommended by [26].

Data Sources

Both primary and secondary sources were used. For primary sources, data was collected through in-depth interviews with key informants and questionnaires from respondents in the field. While for secondary data, articles and literature reviews from different scholars were reviewed to supplement primary sources.

Data Management and analysis

Qualitative data from interviews were immediately organized in line with the study objectives on what we would have discussed during the meetings to limit errors or misinterpretations. In case there is any recorded data, transcriptions were undertaken to transform the collected information into a well-organized interpretations. Data from open-ended questions were captured into Microsoft spread sheet, whereby they were categorized and coded to check for errors and inconsistence. These data were later exported into Statistical Package for Social Sciences (SPSS), where they were stored before analysis. A copy of data was stored on a backup device like a flash disk or an external hard drive for emergency cases if any. Simple descriptive tabulations of the coded data was carried out, where frequency, percentages and means were generated. Further cross tabulations were performed to establish the relationship between demographic information and various challenges associated with access to and utilization of SRH services. This data were presented in form of frequency distribution tables for the cases of quantitative data while qualitative data were presented thematically.

Ethical Considerations

Ethical consideration in this study were of great concern and therefore specific ways were articulated during the research processes to ensure integrity, ethics and quality of research. For instance;-

- Approval to conduct the research was obtained from the University before proceeding to the field. The researcher also informed local leaders in the area of study about the intention of the study. At this level a permission was also obtained from them in form of written consent before conducting the study in the area. On the other hand, before the participation of different participants, a verbal consent was obtained from each participant.
- Research subjects were respected and informed fully about the purpose, methods and intended possible use of the research findings.
- The confidentiality of information unveiled by research subjects and the anonymity of respondents were also be respected.
- The participation of study subjects in this study was done on a voluntary basis and free from any coercion and harm.

Limitations of the Study

Basing on the sensitivity of this study, much more time was required to finish up data collected as many respondents were not comfortable in disclosing their personal sexual health information despite the challenges experienced. However, a thorough explanation on intended use of the findings was done hence the anonymity of each set of data collected and treated with utmost confidentiality.

RESULTS AND DISCUSSION OF FINDINGS

Socio-demographic characteristics of respondents

These include respondent's age, sex, religion educational level, marital status, of the respondents.

Table 1: Socio-demographic characteristics of respondents

Characteristics	How often have you been experiencing limitations in accessing and utilizing SRH services in the last 12 months?					
	Very often		Not very often		Total	
	n=35	%	n=13	%	N=48	%
Age						
20- 24 years	7	20	0	0.0	7	14.6
25-29 years	7	20	3	23.1	10	20.8
30-34 years	8	22.9	4	30.8	12	25.0
35-39 years	10	28.6	5	38.5	15	31.2
40-44 years	2	5.7	0	0.0	2	4.2
45-49 years	1	2.9	1	7.7	2	4.2
Education attainment						
Never attended school	2	5.7	1	7.7	3	6.2
Primary school	16	45.7	2	15.4	18	37.5
Secondary schools	17	48.6	8	61.5	25	52.1
Post-secondary	0	0.0	2	15.4	2	4.2
Marital status						
Married/ Cohabiting	24	68.6	7	53.8	31	64.6
Single	11	31.4	6	46.2	17	35.4
Separated/divorced	0	0.0	0	0.0	0	0.0
Occupation						
House wife	20	57.1	4	30.8	24	50.0
Farming	12	34.3	5	38.5	17	35.4
Business (informal sector)	3	8.3	2	15.4	5	10.4
Civil servant	0	0.0	2	15.4	2	4.2
Total	**35**	**100**	**13**	**100**	**48**	**100**

Source: Field work data, 2020

Distribution of the respondents by age

The section presents the findings on age of the respondents who participated in the study. The distribution of the population by age is one of the most

important characteristics in understanding their views about particular problems [28]. Age indicates the level of maturity of individuals. Therefore, age was so important to examine the responses. The results on age of the respondents from the participants who took part in the study as illustrated in table 4.1 shows that age group of participates was more dominated by those within the age group 35 and 39 years and the lower number was among those respondents who were aged between 40-49 years. Furthermore, about 28.6% of those in age group 35-39 years reported to have often experienced limitations in their quest to seeking SRH services while none of the responded to have experienced limitations among those aged 40-44 years. According to [29], age contributes to the formation of psychological development in maturity and adulthood development for self-management. Therefore it can be concluded that since most of the respondents were above 20 years, then the respondents were mature enough and able to self-manage answering questions without due influence from other persons.

Distribution of the respondents by education background

Education is one of the most important characteristics that might affect the person's attitudes and the way of looking and understanding any particular social phenomena. In a way, an individual responds, is likely to be determined by his or her educational status and therefore it becomes essential to know the educational background of the respondents. The results suggest that a higher percentage (45.7%) of respondents who had at least attained primary education reported to have often experienced limitations in seeking for SRH while none of those with post-secondary education reported any limitations. The implications of such distribution can be concluded that education plays an important role in preventing the occurrence of patriarchy that limit women's decision making concerning their health needs.

Distribution of the respondents by marital status

Marriage is one of the most important social institutions. The perceptions and attitudes of a person can also differ by the marital status of the persons because the marriage might make the persons little more responsible and mature in understanding and giving the responses to the questions asked. The details of the marital status of the respondents from the respondents indicate that 68.6% of respondents who were married reported to be experiencing limitations in seeking for SRH as compared to 31.6% who were single.

Distribution of the respondents by the occupation

The findings on occupation status revealed that higher number (57.1%) of women were housewives often experienced limitations compared to only 8.3% of those that were self-employed, most of whom were in informal businesses. Among respondents who were in civil service, none of them reported to have ever often experienced challenges in seeking for SRH services. This could be an indication that self-reliance in terms of income creates freedom in seeking for health among women.

Knowledge and awareness of women on sexual and reproductive health services

The study explored respondent's level of knowledge and awareness of women on sexual and reproductive health services.

Knowledge on SRH

This section presents the findings of the level of knowledge and awareness about SRH. The table below shows how the respondents defined and understood sexual and reproductive health services.

Table 2: Knowledge on SRH

Respondents knowledge about SRH services	How often have you been experiencing limitations in accessing and utilizing SRH services in the last 12 months?			
	Very often		Not very often	
	n=35	%	n=13	%
These are general services that enhance women and men's reproductive health	9	25.7	1	7.7
SRH services are services that helps families in making decisions i.e. on having a manageable number of children for instance family planning	7	20.0	1	7.7
SRH services helps to protect women from getting any problem including getting diseases during pregnancy	5	14.3	4	30.8
SRH services refers to teachings about marriage and family formations i.e. how women and men should behave towards each other	5	14.3	5	38.5
SRH services involves information about modern family planning methods	1	2.9	0	0.0
SRH refers to empowerment of women and men on how to make decisions about their sexual lives	3	8.6	2	15.4
SRH involves services that can help men and women to know about their health status ranging from STDs to general health	3	8.6	0	0.0
Others (i.e. counselling and guidance)	2	5.7	0	0.0
Total				

Source: Field work data (2020)

The results of the study revealed that about 25.7% of respondents that had been experiencing limitation in accessing SRH and 7.7% of those that had not been experiencing limitations believed that SRH services were general services that enhance women and men's reproductive health. While 20% and 7.7% of respondents who had been experiencing limitation and those that did not believed that SRH services are services that helps families in making decisions i.e. on having a manageable number of children for instance family planning. Others stated that SRH services involve services helps to protect women from getting any problem including getting diseases during pregnancy, teachings about marriage and family formations i.e. how women and men should behave towards each other as well as empowerment programmes for women and men on how to make decisions about their sexual lives. Focus group discussions also revealed similarities in definitions and understanding of SRH as illustrated in the above table. For instance a 24 years old respondent stated,

> *"I think SRH services are services that are offered to pregnant women from the time of conceiving up to the time of giving birth. In other words these; could include; antenatal and post natal care but this can also include advice to unmarried women and girls on how to keep safe as females"* ***Rebecca, in an FGD, Katumba Zone***

Another respondents stated that;

SRH services are general guidance on safe motherhood. Personally, I engaged in early sexual activities when I was in primary school, by then I did not know the calculation of mistral cycle. A onetime incident resulted to have unwanted pregnancy at a very young age. After that incident, each and every person including midwife where I used to go for checkups, blamed me for conceiving my first born at the age of 15 without knowing that I was not aware of SRH but if I was taught about such services early, I think I would be a professor at this time. But it was maybe Gods plan that my education ends in primary school after pregnancy" ***Akello, in an FGD, Kondogoro Zone A***

Among the key informants, the level of knowledge and awareness about SRH was well understood since most of the key informants were medical specialists. For instance, one of the gynecologist stated that, *"SRH is a general reproductive health that is administered to both men and women from the onset of puberty"*.

Community perception on SRH services

The findings indicated that despite high level of knowledge about SRH among women and girls in the area of study, some few community members especially men had their own perception when a person was seen seeking for any information about SRH services. For instance, in the questionnaires, respondents were also asked to give their views on how community members perceive reacts towards someone who intends or goes to seek for SRH services, and the table below illustrates some of the responses.

Table 3: Community perception on SRH services

	How often have you been experiencing limitations in accessing and utilizing SRH services in the last 12 months?			
What are often the perception of people in your community when they see you seeking for SRH services like family planning, information on contraceptives like condoms, HIV testing etc.?	Very often		Not often	
	n=35	%	n=13	%
Many people especially men believe that it is immoral to get associated with seeking for SRH services like family planning	18	51.4	6	46.2
They become supportive	8	22.9	5	38.5
They say that it is a normal for women to seek for SRH services such as antenatal	1	2.9	1	7.7
They just ignore	7	20.0	1	7.7
Others	1	2.9	0	0.0

Source: Field work data, 2020

As illustrated in the table above, about 51.4% of respondents who stated that they have been experiencing hardships in accessing and utilizing SRH in the last 12 months, confirmed that many people especially men believe that it is immoral to get associated with seeking for SRH services like family planning. However, there are some who are often supportive to those that seen seeking for SRH services and others often tend to ignore if such a thing happens. Based on the above responses, it is evident that women who are in need of SRH services are likely to get little support from community members especially men of which the findings quoted them as being less supportive to SRH.

DISCUSSION OF THE FINDINGS

Knowledge and level of awareness about SRH

Using focus group discussions, in-depth interviews and questionnaires, investigations were undertaken on the level of knowledge and awareness as well as local perception about SRH and its influence on general reproductive health outcome among women in Kyanja parish. The findings indicated that, a big number of respondents knew what SRH services were all about especially. However, the level of understanding about it varied according to respondents' gender. For instance, the results indicated that, SRH involved general health services that enhance women and men's reproductive health where examples given included; maternal health care, guidance and counselling, family planning and decisions making on having a manageable number of children among others. However, seeking for SRH was also perceived differently among the community members in the area of study. For instance, some men believed that however seeks for SRH such as information on contraceptives, then it implied that such a person was considered as being immoral, something that sometimes makes women and girls to shun in seeking for such services. According to the study by [30], which was carried out on the risk factors for severe SRH complications like pre-eclampsia and eclampsia in Mulago Hospital, found out that, the level of understanding about the causes of severe pre-eclampsia among some respondents in Kampala included, the belief that pre-eclampsia is a culturally inherited disease which is associated with the family history among the women's family, therefore whenever a woman would get it, they would accuse her based on her family background without helping her to seek for SRH guidance. Hence the above findings gives a similar picture on why many women in Kyanja are sometimes faced with challenges in accessing and utilizing SRH due to fear of being mistaken.

CONCLUSION AND RECOMMENDATIONS

Knowledge and level of awareness about SRH services among women and girls

The findings indicated that there was high levels of understanding about SRH and related services and they influence health among women and girls in Kyanja central. However, seeking for SRH services and information like family planning, information of contraceptives such as condoms, pills among others are locally perceived by majority of residents as sources of immorality among those in need of them. Despite vast knowledge among women and girls who participated in the study, many of them also believed that SRH services offered by trained medical health workers are the same as those services offered by traditional herbalists and counsellors commonly known as (Ssengas and Kojjas). These herbalists sometimes do mislead women and girls by recommending use of unapproved medicines and information that in most cases lead to various sexual and reproductive complications or death especially during pregnancy. Furthermore, sometimes these herbalists engage in illegal activities such as abortion which are against the law.

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