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Social, economic and cultural factors that influence access and utilization of sexual and reproductive health services under decentralization In Kampala, Uganda

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ABSTRACT

This research evaluated the social, economic and cultural factors that influence access and utilization of sexual and reproductive health services under decentralization in Kampala, Uganda. It examined social, economic and cultural factors that limit access and utilization of 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 indicated that decision making in households especially on where and when to go for maternal health care, household's decision, and control over physical and financial resources are mostly undertaken by males *(husbands).* Women's level of decision making is minimal due to gender and cultural norms and practices that prohibit them to do so. This combined with the beliefs that led to delays in seeking for SRH can lead to complications and even death either the baby or mother. Basing on the findings, the following are recommended; There is need to address the existing gender and social cultural factors that limit women's liberation, through empowering women economically, income generating projects to enable them have resources to seek care, health education, community sensitization, and teaching of mothers on the importance of SRH more so antenatal care visits.
Keywords: Social, economic, cultural factors, sexual and reproductive health services

INTRODUCTION

World over, access to and utilization of reproductive health services, is viewed as a basic need, a human right and phenomenal for country's growth, thus it is recognized in a number of international, regional and national policy documents in various countries including Uganda. For instance, Article 25(2) of Universal Declaration on Human Rights (UDHR) of 1948, Articles 12 of International Covenant on Economic and Social and Cultural Rights (ICESCR) of 1966 guarantee the fundamental human rights to physical, social, and psychological health including sexual and reproductive health and rights to those in need. Furthermore, Articles 10 and 12 of Convention on Elimination of all Forms of Discrimination Against Women (CEDAW) of 1979 which in particular advocates for elimination of all forms of discrimination into access to specific educational information that can help to ensure the health and well-being of families including information and advice on SRH services like family planning. It also guarantees women and girls the right to access the same range, quality and

standard of free or affordable health care and programs as provided to other persons, including those in the area of sexual and reproductive health and population-based public health programs. Furthermore, Article 33 of the 1995 Constitution of the Republic of Uganda emphasizes that health of women including SRH is a fundamental right that every woman and girl has a right to it without discrimination. All the above policy documents serve as guidelines for states parties to provide for substantive health care to all and on impartial basis to everyone in need. Uganda as a country has gone ahead and domesticated some of the provisions from international police documents into national laws and policies that aim at protecting health including SRH of women and girls in the country. This is because health care and more so SRH shapes the society and plays a key role in society's advancement and its wellbeing [1]. Hence, its importance in any society cannot be overlooked.

The need to improve the sexual and reproductive health (SRH) and rights of women and girls is increasingly acknowledged. Unfortunately, women in low- and middle-income settings, including countries like Uganda, face several barriers (including structural, financial, physical, social, cultural and attitudinal) to accessing and utilizing SRH services and care. Researches have consistently shown that sexual and reproductive health utilization especially in developing countries more so in Africa are prone to gender, economic and socio-cultural factors [2]. For instance, male-domination, low status of women, poverty, cultural beliefs and practices and high fertility combined affect women and girls SRH access and utilization outcomes in most societies in the continent, particularly in Sub-Saharan Africa. It should also be noted that, although, with very few exceptions, African societies are patriarchal in nature where norms, values and expectation are defined and sustained by men in all spheres of life. Maternal issues for instance in Africa are prone to crises for several reasons. Women are subjected to repeat childbearing at short intervals for instance to satisfy their husbands' quest for large family size. The situation is exacerbated by cultural beliefs and practices and poor medical delivery system that hinder access and use of hospital facilities during emergencies. In some communities, women's socio-economic status is significantly low to enable them contribute meaningfully to family discourse. Consequently, men take sole decision that affect members of their families. The implication of such attitude, in a male dominated society is that activities that influence SRH more so maternal health outcomes are taken for granted, ultimately resulting in maternal health complications among many women [3]. [4] as cited in [5] observed that the use and non-use of health services are determined by one's socio-cultural environment, which, in most cases, is shaped by its patriarchal structure. This position was collaborated by [3] where they noted that many culture bonds syndromes are effectively managed through an informed knowledge of their cultural contexts and the background of patients. Some socio-cultural factors, which not only prevent women from getting out of their homes to access and utilize SRH facilities, even in emergencies, but also prohibit them from making decisions on a number of children they desire to have [6].

Gender Relations

Gender relations refers to social and economic relationships which exist in any family, community, workplace or society between males and females [7]. Traditionally, many societies were socialized to accept that men are more powerful than women, and therefore women were always taught how to be "feminine'' while men were taught to be "masculine''. Biblically, the man is the head of the households and oversees it and therefore, many societies acknowledged men to respect this religious dimension for their position, roles and responsibilities as husbands. Up to now, in many developing countries especially in Africa, with Uganda inclusive, men still exercise great influence over women on almost all aspects of their life including family decision making and control over resources leading to incapacitating women even taking their own health decision. Most societies until now still considers female's duties as housewives who belong to the kitchen and who should not have much say in decision making both at home, workplace or in the community [8].

Control over financial and physical resources

Studies conducted by [9] among others have revealed that generally women have limited access to control over financial and physical resources. In most cases women are attributed to low status in society as compared to their male counterparts who have high opportunities for training and employment. [10], associated it with the fact that men are highly involved at various levels of planning, decision making and management. However, [11] maintained that women's limited control over resources is a king of marginalization internalized in the cultural ideology which gives men an effective control over resources and reproductive relations. This influence still exists in many parts in Uganda whereby SRH especially maternal health access by women are still greatly influenced by gender relations. For instance, decisions on when and where to access maternal health services by mothers are not made by themselves [12].

Decision making

[13], identified decision making as one of the major gender asymmetry of SRH and maternal deprivation to health. They insisted that, in many spheres of life, women as compared to their male counterparts have far less access to health care, education and paid labour. This is because their powers to decide are limited by cultural ideology which makes women believe that they are inferior and cannot be equal to men. [14], in his study that aimed at empowering women in Uganda, found out that discrimination against women starts at birth and continues until she breathes her last breathe, simply because of her low status. It was also revealed that when a mother fell sick, the husbands and other family members would get some medicine for her without her decision on which kind of medication to use. This shows that women have little say in or influencing decisions and treatment. Hence, these factors limit access to and utilization of SRH.

Aim of the Study

To determine social, economic and cultural factors that influence access and utilization of sexual and reproductive health services under decentralization by women in Kampala district.

Research Question

What social, economic and cultural factors that influence access and utilization of sexual and reproductive health services among women 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 [15]. 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 [15]. 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 [16] 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 [17]. 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 further investigation.

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 using questionnaires.

Sample Size

[18] 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 [19]. Therefore out of this number, 11.4% error margin was considered to select a sample size of 61 respondents. This was arrived at using [20] 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 [21] 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 [22], 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 [22], 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 following formula.

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

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 [23].

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 [24], 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 [23].

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 2: 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 [25]. 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 [26], 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.

Social, economic and cultural factors associated with access and utilization of SRH

One of the best way of analyzing social, economic and cultural factors that limit women from accessing and utilizing SRH services among women, was to first examine how gender relations particularly decision making, division of labour and

control of resources in households influences women's health particularly SRH outcomes. This is because the concept of gender revolves around culturally constructed roles rather than biological. These may differ from one society to another. By asserting these roles, one is able to know who does what, where and when and who is closely responsible for what. According to this study, this was a critical concept that could influence SRH outcomes among women not only in Kyanja but across Uganda and beyond.

Division of labour and its impact on women's health

During in-depth interviews, focus group discussion and on questionnaires, various reactions were raised about the daily activities undertaken by both female compared to their husbands in most of the households in Kyanja parish, something that leaves then with almost no time to concentrate on their SRH. The results confirmed that women in Kyanja parish have tight daily schedules characterized by heavy work load and little time allocation to switch from between activities in their schedules. This not only gave the idea of how activities are shared out by gender but also showed tasks which took up most of women's time and energy. This was important in classification and analysis of data in relation to how these activities affect access to and utilization of SRH services by women. A summary of gender workload is presented in table below using a standard normal day activities drawn from questionnaires.

Table 3: Daily activity profiles by women

Time	*Activities done by women* (n=48)	%
5:30am	Already woken up	89.6
6:00am	Prepare breakfast for children and husband	70.8
6:30am	Escorting children to school	56.3
7:00am	Digging, going to work/shop, Washing clothes, cleaning the house	66.7
11.00am	Doing housework like fetching water, cleaning utensils	60.4
12.00pm	Preparing lunch	43.8
1.00pm	Eating lunch	47.9
2.00pm	Cleaning utensils	37.5
3.00pm	Fetching firewood, charcoal and water	54.2
4.00pm	Going to the market for vegetable, cleaning the compound, etc.	64.6
5:00pm	Picking children from school	45.8
6.00pm	prepare evening tea	16.7
6.30pm	Bathing children	77.1
7.30pm	prepare supper	85.4
9.00pm	Eating supper and clean utensils	12.5
10:00pm	Preparing children to sleep	81.3
10:30pm	Cleaning utensils	14.6
11:00pm	Sleeping	75.0

The results in table above indicate that women have a very fixed work load to perform on a normal day either at the same time or at different times. For instance, the study found out that majority of women wake up as earlier as 5am. Whereby, 43 (89.6%) of women mentioned that they normally wake before 5:30 am to start doing their daily work especially preparing kids for school, breakfast among others and about 75% of these women sleeps from 11pm. It was also noted that whereas domestic chores such as cooking, cleaning and washing clothes took muck of women's time, many women stated that their husbands work schedules tend to be relaxed throughout the day. These findings are therefore an indication of a typical African scenario, whereby in many areas, women remain unliberated from patriarchy. They wake up before the sun rise to perform some

hard work on agricultural holdings, fetch water sometimes from distant sources and hardly get time for resting. In African, and especially the rural woman as compared to her husband is never free because of obligations designed for her. This means that she is peculiarly vulnerable to super exploitation and unable to fully meet her SRH needs such as maternal health needs when she needs them. Furthermore, during focus group discussion sessions, similar responses were mentioned. For instance, one respondent stated that;

> *"Men in this community leave all their work for the women for example my friend's husband wakes up and goes to town and comes back without any money to help the family hence the woman has to do the house work at home and even go out to look for money to pay school fees for her five children. If this woman is pregnant or if she get any other SRH problem she does not go for antenatal checks on a regular basis as required because of busy schedule in household chores"* ***Nanteza, in a*** **focus group discussion,**

Another female respondent who was a key informant also had this to say;

> *"Women have a lot of work to perform for the family to survive, many women wake up early in the morning and start sweeping the compound, then prepare breakfast for the family, go to the market to do business so as to earn a living, other woman who are lucky work with their husbands and when they are pregnant they are given leave to stay at home until they give birth ,however even when they are home they have to do some light house work and even engage in making crafts like baskets, mats table mats and other which can be sold to earn some money. Therefore, because of these factors, women often end up getting less time for medical check as a result of their work and gender roles in the family"*

It is found out that men hardly lend a hand to their spouses in doing household work unless there is a special need to do so. For instance, a 34 year old man who was a key informant during interview raised the following point concerning gender and cultural norms pertaining gender roles in households in general;

> *"From experience as a man I know that men only get involved in domestic work and child care in times of crisis, for instance when she is seriously sick and when there is nobody at all to help"*

In-depth interview with a male key informant at Kyanja Central zone Decision making and control over resources in households and its influence on women's health

The respondents were asked to reveal who in the family decides on major aspects which included; health for instance where and when to go for health checkups, decisions on education, and others. The findings are illustrated in the proceedingtable

Table 4: Decision making and control over resources in households

	How often have you been experiencing limitations in accessing and utilizing SRH services in the last 12 months?			
Who makes decisions and control over resources associated with the following; health, education, income	Very often		Not often	
	n=35	%	n=13	%
Woman (self)	6	17.1	2	15.4
Man (husband)	29	82.9	11	84.6

Source: Field work data, 2020

The results from the table revealed that more than 80% of women whose decisions making and control over resources in their respective households about health, education, income as well as visits were made by men, reported to have been experiencing limitations in access to and utilization of SRH in the last 12 months. While only 11 women whose decisions making and control over resources were controlled by men did not often experience hardships. This is an evident that women's rights including maternal health care are compromised on. However, despite 17.1% of women having reported that they had power of making their own decision, also had been experiencing some form of hardships in accessing and utilizing SRH services. This could be because of other factors such as busy schedules, distance among other factors that could have been hindering them from seeking for such services. When a 42 year old key informant was asked to comment on effects of decision making and control over resources in households over SRH outcome among women, this is what he had to say;

"Women do not make decisions on their own, if they want to go for any treatment apart from giving birth, it is the man to decide for them. The man is the one to tell the woman which hospital to go to depending on the money in his pockets."

Key informant 2020

In a focus group discussion, one of the women stated that;

"I'm a Muslim woman and our husband does not allow us to control resources both financial and assets, so we all work for him and he decides on where we should go for antenatal care, delivery or any other treatment when one of us is sick. Sometimes when he does not have money, we deliver from a traditional birth attendant (TBA)"

***Focus Group Discussion*, Walufumbe Zone A.**

The above finding indicate that, men's high rate of participation in decision making and control of resources within the households generally continue to limit women from access to and effective utilization of SRH services most especially when women are pregnant. Due to inferior gender roles played by women and limited decision making as well as control over resources among women in most of the households, especially as a result of cultural norms have negatively affected on their health status. Most women have been denied the rights especially to have the number of children they opt for, rights to seek health in desired places and in most cases they been forced to believed that some conditions which arise most especially during pregnancy period for instance are cultural and can be treated with cultural practices like drinking or bathing with herbs, thus many women have died due to this assumption in the community. One of the key informants supported this assumption when he stated that;

"Fertility rates in Uganda are very high at 6.7 and women are giving birth in poor health conditions, consequently this has been attributed to the cultural and gender practices amongst the communities in Uganda. Most pregnant mothers sometimes they tend to run to elderly woman to get herbal medicine for drinking and bathing in the hope of treating and protecting the fetus from bad luck. Others would want to go the hospital for checkup and treatment but they cannot make a decision on the facilities to use for their condition. They come to the hospital in a very poor condition and are usually brought in by their husbands. We find that most people both men and women think that some SRH problems such as minor infections can be treated with herbs, thus many women have had difficult in accessing and utilizing effective SRH services due to this assumption in the community".

Gynecologist, Kungu, 2020

Apart from busy schedules, decision making and control over resources that limit women from accessing and utilizing SRH services, the researcher further sought to find out whether the distance between households' homes and health facilities affected women's access to and utilizing SRH. The findings were as illustrated in table below;

Table 5: Distance of health from respondents homes

How far is the nearest health center located from your home?	Frequency	Percent
Less than 1 Km	3	6.3
1-3 Km	11	22.9
More than 3 km	34	70.8
Total	48	100.0

Source: Field work data, 2020

The results indicated that most of the health facilities that offer SRH services are located in more than 3 km away from their homes as indicated by 70.8% of respondents respectively. Only 6.3% of respondents stated that the health facilities were located in less than one kilometer.

In a FGD, various reactions were given on the issue of the distance. For instance, one of the respondents stated that;

> *I have three children, but during the period of 6 years that I delivered them, I could only visit the hospital for antenatal twice before giving birth. This was because of long distance from this place to mulago which is the nearest public hospital yet I had busy schedules in operating my business as I was also the bread winner in my household. Also despite the fact that most of SRH services are given almost free of charge at mulago, the number of women seeking for such services is often very high in that you can spend the whole day there, something that scares most women from going there. Otherwise every woman would want to go to the hospital every time they have any SRH problem.* ***Eva, in an FGD, Kyanja Central Zone***

Discussion of the findings

Social, economic and cultural factors that limit access to and utilization of SRH among women

The concept of gender revolves around culturally constructed roles such as who does what, where and when and who is closely responsible for that [6]. Studies such as [27]; [9] have indicated that gender and social cultural factors still are an obstacle developing better mechanisms on how women and girls can freely be able to access and utilize SRH without intimidation in Uganda. In relation to this study, for instance, it was found out that gender and cultural norms have a negative effect on women's health rights. Most women especially those ones suffering from various SRH complications at times fail to make their own decision for instance on when and where they can be able to access maternal health care from. The findings indicated that more than 80% of decision making in most of the households in Kyanja especially about health, control over resources, education, and income among others are made by men and only a limited number of decisions are undertaken by women. This is an evident that women's rights including SRH has been compromised on. While carrying out a study on socio-cultural factors affecting pregnancy outcomes among the Ogu speaking people of Badagry area of Lagos state, Nigeria, [7], found out that, In spite of modernization, the culture of the people in different communities in Africa still play dominant role in reproductive behavior. This is even worse especially when a woman is suffering from SRH complication or any other disease that requires immediate attention. Men's high rate of participation in decision making within the households generally continue to limit women from effective utilization

of shaping their SRH services most especially when they are pregnant and in cases when they are suffering from any SRH related disease [28]. Regarding gender roles by sex, the study found out that, the effect of gender and cultural norms in Uganda are also manifested in the daily activities undertaken by both female and males in the district. For example, most women have a lot of work to perform for the family to survive, they wake up early in the morning and starts doing domestics chores such as sweeping, cooking for the family, digging and sometimes going to the market to do some petty business so as to earn a living unlike men whose daily schedules are always relaxed. These roles according to Okong, (2014), makes women more peculiarly vulnerable to super exploitation and unable to fully meet their SRH needs especially when they are pregnant.

CONCLUSION

The study findings reveal women's access to and utilization of sexual and reproductive health services in Kyanja is highly influenced by gender roles within households which in most cases leaves women with limited or no free time to visit health centers for SRH care. This is because the concept of gender revolves around culturally constructed roles such as who does what, where and when and who is closely responsible for what. Furthermore, economic and cultural norms and practices, for instance, a limited number of women and girls that participated in the current study were working. Most of them were housewives while some were engaged in informal businesses which have little income that cannot be enough to fund medical care. Limited number of women also had the powers in decision making in the households, own and control over resources like land, finances and houses.

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