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A situational analysis of Access to and utilization of sexual and reproductive health services under decentralization in Kampala, Uganda

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ABSTRACT

This is an assessment of access to and utilization of sexual and reproductive health (SRH) services in Kampala district. It examined knowledge and perceptions about SRH, social, economic and cultural factors that limit access and utilization of SRH, and the strategies for addressing the challenges faced. 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. The study also 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: Access, utilization, sexual and reproductive health services.

INTRODUCTION

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 [1]. According to [2], 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. 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 [3]. Hence, its importance in any society cannot be overlooked.

Despite the above policies, there is still an increasing worldwide concern about the health and development problems of women related particularly to reproductive health care access and utilization of related services, something that continues to endanger the lives of many women and girls. This is because failure to have access to quality SRH make women particularly vulnerable to unplanned pregnancies and the associated consequences like maternal mortality as well as being at risk of infections such as HIV/AIDs. According to World Health Organization's 2020 statistics, approximately 12 million girls aged 15–19 years and at least 777,000 girls under 15 years as well as about 23 percent of married women gets pregnant each year in developing regions [4]. Among these pregnancies, at least 10 million of them are unintended due to lack of proper SRH services where estimated 5.6 million are aborted with about 3.9 million using unsafe means while the remaining in most cases results into complications during pregnancy and childbirth [5]. Out of with 90% of unplanned pregnancies that takes place in developing countries, highest risks are in Africa and in other developing countries in Asia for instance in Afghanistan, Bangladesh, Guatemala, Haiti, Nepal, Nicaragua and Yemen [6].

Studies that have been undertaken on SRH show that despite it being a global issue, countries in sub Saharan- Africa are mostly affected dues to social and cultural factors. For instance, according to [7], many communities in Uganda including those in Kampala district are highly patriarchal. Meaning that in these communities, gender determines access to SRH care including the number of children a woman is supposed to have, benefits in households, division of labor, power and control over financial and physical resource allocations. Gender biases continue to exist and persist mainly because customary beliefs, laws and practices that consider women to be minors or subordinate [8]. Perhaps, these affect women to a great extent than men in obtaining dependable credit essential for accessing quality medical care including SRH care. These cultural myths have had adverse effects on women's health and the lives of their children. For instance, when women are poorly educated, they tend to have little knowledge about their health, nutrition requirement, hygiene and their legal rights. This does not only affect the

women but also the entire family due to the roles played by women [9]. However, despite all efforts made by the World Health Organization (WHO) and its partners in Africa and Ministry of health Uganda, in trying to improve and strengthen women's health, access to and utilization of sexual and reproductive health care still remains a constant challenge. The number of women attending clinics and hospitals seeking for SRH care services like; family planning, antenatal among others is still very low partially due to various barriers. Among these could include; economic factors, social cultural factors among others. This has continuously contributed to unplanned pregnancies which in the long run comes with various effects. This could be one of the reasons why maternal mortality rate (MMR) in Uganda has remained high at 343 per 100,000 live births [10]. For instance, according to [11], it is estimated that approximately, 16 women die every day in Uganda as a result of pregnancy related complications. However, while previous studies have explored the factors affecting access to and utilization of health services by women in general, in most cases studies focuses on adolescent girls below 24 years and very few studies have explored the challenges faced by all women in child bearing age in accessing SRH services and more so in suburbs like Kyanja parish. This presents a missed opportunity for understanding the challenges that these people go through in accessing SRH services, and impedes the government's ability to assist them to enjoy the same health services that girls enjoy. The current study therefore seeks to bridge this gap by exploring the challenges faced by female in child bearing age in accessing and utilizing SRH services in Kyanja parish with a focus of economic, social and cultural factors.

Aim of the Study

To examine the challenges associated with access to and utilization of sexual and reproductive health services under decentralization by women in Kampala district

Specific Objectives

(i) To assess the level of knowledge and awareness of women on sexual and reproductive health services under decentralization.
(ii) To determine social, economic and cultural factors that influence access and utilization of sexual and reproductive health services under decentralization.
(iii) To establish strategies for addressing barriers that are associated with access to and utilization of sexual and reproductive health services by women under decentralization.

Research Questions

(i) What is the level of knowledge and awareness of women on sexual and reproductive health services under decentralization?
(ii) What social, economic and cultural factors that influence access and utilization of sexual and reproductive health services among women under decentralization?
(iii) What are strategies that can be employed to address barriers that are associated with access to and utilization of sexual and reproductive health services by 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 [12]. 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 [12]. 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 [13] 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 (KCCA), 2017). 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 usingquestionnaires.

Sample Size

[14], 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 [15]. 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 [16] 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 [17], 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 [17] 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.

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

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 [18].

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 [19], 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 [18].

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: 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

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.

Table 4: Places where women and girls seek for SRH and why they go there

	Places where women seek for SRH											
	Private clinics		Government Hospitals		Use of herbal medicines		TBA's		Others		Total	
Reasons why women choose to go for diagnosis in such places?	N	%	n	%	N	%	n	%	N	%	n	%
Due to lack of any say in decision making	10	37.0	2	7.4	4	14.8	4	14.8	7	25.9	27	100
It was my choice since SRH services are crucial issues to women & can only be diagnosed in such place	5	29.4	6	35.3	3	17.6	1	5.9	2	11.8	17	100
Other reasons	2	50.0	1	25.0	0	0.0	1	25.0	0	0.0	4	1001
Total	17	35.4	9	18.8	7	14.6	6	12.5	8	18.8	48	100

Source: Field work data, 2020

The results indicate that 35.4% and 18.8% of respondents confirmed that most women go for medical checkups in clinics and Government hospitals respectively. While 14.6% use herbal medicine and 12.5% use Traditional birth attendants (TBA). Reasons for going in such places however, varied. For instance majority of women who seek medical attentions for example in herbal medicines (14.8%) stated that they use them because they are often not the ones who make decisions. while 29.4% of those that use clinics and 35.3% of those that use government hospitals know that SRH services are crucial to women and if there is any problem, it is better to be diagnosed in hospitals. While conducting an FGD with women who had ever experienced challenges in accessing and utilizing SRH, one of them gave the following response after being asked about the practices associated with health seeking behaviors in her community;

> *"I am a Moslem woman and I am in a polygamous union where our husband married three of us. He loves us equally, however, however when one of us get any sickness including SRH problem, he first calls the sheikh to pray for you because most diseases can be associated with witchcraft. But if the condition deteriorates then he can decide in which hospital they can take you".* ***Amina, in an FGD, Kyanja Central Zone***

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.

Table 5: 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.

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 proceeding table

Table 6: 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 8: 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*** **Strategies for addressing the effects that are associated with access to and utilization of SRH among women**

Sexual and Reproductive Health (SRH) services especially maternal health services like antenatal care, STI's diagnosing and treatment among others are very vital for women and girls. This is because, these services can be helpful in early detection and reduction of any reproductive health risks that may occur as a result of various complications that are associated with reproduction among women. The SRH services presents opportunities to reach women with a number of interventions that may be vital to their health and wellbeing of the infants. It is also used to inform women about the risks of labor and delivery and providing the route for ensuring that pregnant women deliver with assistance of skilled health care providers [20]. The current study therefore examined better policy option that can be employed by the government together with health care

providers to enhance the level access to and utilization of SRH services among women and girls not only in the area of study but across the country. During focus group discussions, in-depth interviews a as well as on questions, a number of policy options were raised by respondents on how access to and utilizations of SRH can be improved. For instance, one of the women during an FGD session stated that;

> *"Myself I used to go for antennal in one of the clinics which is located not far from this area, this facility was near my home and managed my condition very well, I would go there in the morning and come back home by lunch time to prepare meals for my children from school. The medical bill was also friendly but unfortunately when the owners of that clinic shifted from this place, we are suffering a lot because other clinics charge a lot of money yet most us we don't have money. There are some SRH issues that sometimes women fear even to tell their husbands but if they have money they can go to the clinic but if better clinics are far, it can bring misunderstanding between a man and his wife in the households. So I would suggest for more hospitals to be built in this area by the government together with its partners to allow women access all the services they need"* **Immy in a focus group discussion, Kyanja Central zone**

The study also found out that, though there were some health facilities found to be available in kyanja, some women stated that they do not sometimes utilize them for various reasons. For instance, a 31 year old woman in a FGD reported that

> *"One day I experienced abdominal pain when I woke up in the morning. I was twenty-one weeks pregnant and my whole body was very weak, paralyzed and vomiting my husband asked me to go to the hospital. I went to one of the government operated health centre but only got pain killers; otherwise there was nothing big that is why other women shun the services. Also the fact that the mid wives are not always available really discourages us to go for antenatal services. Many women here have resorted to calling traditional birth attendants (TBA) to come and check on the progress of the pregnancy from home rather than wasting time to go to the hospital and you end up getting nothing in return. So I would advise that all the government health facilities be equipped with all medical equipments and medicines"* **Babirye, in an FGD, Kyanja Central zone,**

Another respondent stated that;

> *The government of Uganda in partnership with NGOs, CBOs and local leadership should sensitize men to respect women and girls' rights by bestowing them with chance to make their own decisions on where and when to go for medication*

However apart from blaming the government for its inefficiency in providing for health care services, one of the key informant stated that sometimes women are also to be blamed for their poor health seeking behaviors, she said that;

> *"Women needs to improve their health seeking behaviors. However, we are also working with our partners to extend to them primary health care accompanied with literacy programmes where Women and girls can be encouraged to seek for SRH regularly and should not wait until they become sick or upon seeing any symptom as well as going to right place for instance hospitals and not believing in myths. The Government is also working towards extending cost friendly health services to all services to all communities for easy access by all groups of women. This is being done through building more hospitals nearby to avoid excuses of long distances among the victims".* ***Local Leader in a KII interview, Kyanja central zone***

Another key informant suggested that;

> *"We as an NGO, we are encouraging for the formation of women organizations at village level to address women's health needs. If such initiatives are put in place can improve SRH such as family planning, diagnosis as well as safe delivery. On this we are working with the government and other non-governmental organizations to design and implement appropriate micro-finance support interventions targeting women at the household level to enable them improve their income generating projects. However, before that, we encourage that seeking for SRH services should be taken as a normal medical care that every woman and girl should seek for in their reproductive age. SRH services like Family planning in particular should be emphasized to reduce an intended pregnancy frequencies",* ***one of the representative from an NGO in a KII, Kyanja Central, 2020****".*

Another 27 year old respondent in a FGD, stated that patriarchy has been a key contributor in limiting women from accessing and utilizing SRH. There she said that;

> *Women and girls should be given chance to make their own decisions on where and when to go for medication*

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 [21], 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.

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 [22]. Studies such as [23]; [24] 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, [25], 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 [26] 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 [27], makes women more peculiarly vulnerable to super exploitation and unable to fully meet their SRH needs especially when they are pregnant.

Strategies for addressing the effects associated with access and utilization of SRH

Sexual and reproductive health care such as antenatal care and general checkup of mothers during pregnancy are very vital for any mother in reducing the risks of complications, since this is a period that presents a one chance to reach mothers with a number of interventions that may be vital to their health and wellbeing of the infants [28]. It is also used to inform women about the risks of labor, delivery and providing the means for ensuring that pregnant women deliver with assistance of skilled health care providers [29]. Though the results from the current study indicated that majority of the respondents have access to government hospitals and private clinics, which are also friendly in terms of medical bills and better treatment, many women still shun a way from utilizing them and instead prefer to use other alternatives such as traditional healers because of factors such as; long distance for instance most government hospitals are located in more than 3 km away, unfriendly behaviors among the service providers among other factors. However, traditional healers and TBAs are preferred due to being near to their home, listening and they are cheaper than some the hospitals. According to Uganda demographic health survey 2011, the results indicated peoples' health seeking behaviors is dependent upon the enabling factors such as accessibility and affordability, predisposing factors like age, parity and perception factors. [7] found out that women will always go for health checkups if and only when the services are affordable and accessible. Therefore, if more hospitals which are affordable are constructed in near places, more women can be encouraged to seek for and utilize SRH services.

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.

Social, economic and cultural factors that influence access to and utilizing of SRH among women and girls.

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.

Strategies for addressing barrier associated with access and utilization of SRH among women and girls

According to the findings, though some of the respondents were aware of the strategies to address barriers associated with access and utilization of SRH among women and girls, their access and utilization of SRH was limited. This was attributed to reasons like long distances, attitude and perceptions of health care givers towards them as well as high cost of accessing SRH. So they recommended for construction government hospitals that offer free or affordable SRH services.

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