SOCIAL IMPACTS OF REPRODUCTIVE HEALTH SERVICES ON GENDER IN MULAGO HOSPITAL OF KAMPALA DISTRICT UGANDA

BY

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A DISSERTATION SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR'S DEGREE IN SOCIAL WORK AND SOCIAL ADMNISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

SEPTEMBER, 2016

DECLARATION

I Akamberaho Angella declare that to the best of my knowledge, the work presented here is original and has never been presented to any institution of learning for any academic award.

Signature..... Date.....29/09/2016.....

APPROVAL

This is to acknowledge that this research dissertation has been under my supervision as a University Supervisor and is now ready for submission.

Signature.....Date.....29th/09/2016.....

Mrs. Nakalema Faith

DEDICATION

I wish to dedicate this research to the almighty god who protected me during my three years course.

In as special way I wish to dedicate this research to my parents Mr. Karekoona Fred, mum Mrs. Arinaitwe Eunice for the endless support, love and care since my childhood thank you so so much, it is an endless appreciation but God should keep you alive.

To all my dear friends Nampwera Noume, Ndagire Sarah and Kigula Martin who gave me good advices and support and every one who has been their, for me ever since I started campus.

Lastly to my supervisor Mrs. Nakalema Faith who always supported me in compiling work inside this research. Thank you very much.

ACKNOWLEGDEMENT

I would like to extend my sincere gratitude to the lecturers at Kampala International University who imparted skills, knowledge and abilities which I found very relevant during the course at large.

I recognize the favor of all friends which gave me strong courage in finishing my three years course.

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ABSTRACT

The purpose of this study was to establish the social impacts of reproductive health services on gender in Mulago hospital, Uganda. The study was guided by three research objectives specifically to assess reproductive health services provided at Mulago hospital, to investigate knowledge and altitudes of local people towards reproductive health services in Mulago hospital and to examine the effects of gender relations on reproductive health service usage in Mulago hospital. The study involved secondary sources of data where the research related her study to different author's work and authentication and afterwards she made conclusions. The study used a descriptive research design to get an estimation of the respondents' views in regard to the objectives of the study. The target population was health practitioners and patients. The study therefore used a sample of 60 respondents from a target population of 193 through use of Morgan and Krejcie's table of sample size estimation. It employed a random sampling and purposive to avoid bias in data presentation. This study also used both primary and secondary sources which all involved data from the field and literature already written by other authors. Due to limited time the researcher only used questionnaires. After data collection, it was ethically analyzed by use of frequency tables and percentages. The findings revealed that male participated more in the study with a percentage of 53.3% and 46.7% for female respectively, respondents aged 31-40 years participated more than other age groups with a percentage of 50%, most of the respondents were degree holders with a 61.7% response yet a high percentage of them were single with 55.0% response in comparison to other status and most of them had worked with Mulago hospital for more than 5 years making 36.7%. The study findings depicted that most reproductive health services provided at Mulago hospital have been effective and sustaining. Objective two analyzed that amongst the effects of gender relations on reproductive health services are that it leads to health sector reform and improvement to quality. The study concluded that Mulago hospital has tried to sensitize the public on usage of the services though others still respect tribal differences and traditional beliefs meaning that Mulago has tried to create awareness.

LIST OF ACRONYMS

AIDS.....Acquired Immune Deficiency Syndrome

CBDs.....Community-Based Services

EAC.....East African Community

FWCW.....Fourth World Conference on Women

HIV.....Human Immunodeficiency Virus

ICPD.....International Conference on Population and Development

MDGs.....Millennium Development Goals

MoH.....Ministry of Health

PHN.....Population, Health and Nutrition

RHS.....Reproductive Health Services

RHU.....Reproductive Health Uganda

STDs.....Sexually Transmitted Diseases

STIs.....Sexually Transmitted Infections

UNICEF.....United Nations Children's Education Fund

USAID.....United States Aid

WHO.....World Health Organization's

CHAPTER ONE

INTRODUCTION

1.0 Introduction

In this chapter the researcher described the background to the study, problem statement, objectives of the study, research questions, scope of the study and the significance of the study. Within the framework of the World Health Organization's (WHO) definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, reproductive health or sexual health/hygiene, addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth could provide couples with the best chance of having a healthy infant (WHO, 2010).

1.1 Background to the study

In Africa, promoting reproductive health is a priority issue in countries like South Africa for example many reproductive health services are poorly developed and inaccessible to those most in need. This is reflected by high rates of other largely preventable conditions such as STDs, teenage pregnancy, cervical cancer, unsafe abortion and ill-health related to pregnancy and child birth. There are also many who do not have easy access to family planning services and hence do not have the ability to choose when to have children. In addition, some worrying statistics in this age of globalization showing the growing prevalence of HIV emphasises the importance of promoting good reproductive health. Despite all these observations, we still do not have accurate and reliable figures on the extent of these problems, (Jenkins, 2016).

Despite this overall progress, evidence suggests that the East African Community (EAC) region is still grappling with major gaps in access and quality in reproductive health services. Even though contraceptive knowledge is nearly universal in the region and contraceptive prevalence has increased in the past two decades, the unmet need for contraception remains high in all the countries. Whereas proven strategies to reduce unplanned pregnancy such as increasing access to and correct use of effective contraception and contraceptive counselling exist, on average, only 46% of all sexually active women who would want to use contraceptives in East Africa in 2012 could access them, (Caster line, 2012).

Reproductive Health Uganda (RHU) was established in 1957. It now provides services in 29 of the country's districts through 768 service points that is 17 static clinics, 74 mobile facilities, 35 associated clinics and a network of hundreds of community-based distributors/community-based services (CBDs). RHU's comprehensive range of services includes family planning, the prevention and treatment of HIV and AIDS, the diagnosis of sexually transmitted infections and post-abortion care. The number of currently married women using contraceptives increased from 19% in 2000-01 to 30% in 2011. The increase is especially pronounced in the use of modern methods, increasing from 8% to 26% during the same period. The use of traditional methods has remained constant at 7% to 4% over the last decade, (Goldstein, 2009).

One of the targets of the Ministry of Health in the Health Sector Strategic and Investment Plan is an increase in the contraceptive prevalence rate from 24% in 2006 to 35% in 2015. The results in the 2011 UDHS show that the government is on track to achieve this indicator (MoH, 2010). The most popular method of family planning is the injectable, because women can easily access it without the consent of their spouses and only have to be reinjected every 6 months. In many health centres drugs and other supplies are not consistent and this leads to inconsistency in utilization of services. Gender and use of reproductive health services in Mulago hospital are greatly interlinked because gender relations continue to have a big impact on the reproductive health systems in Uganda.

Social relations of human reproduction and production among Ugandans give advantage to men in re-enforcing their control over women. Land ownership is in the hands of men, inheritance is patrilineal and a woman has access in her marital home but not her native home; These processes

in the household and the wider community are likely to influence the coping and survival strategies in general and reproductive health in particular. Such processes within the socio-cultural, socio-economic and geo-political institutions include social and gender relations, gender-based violence, livelihoods including land and food security and reproductive health programs (United Nations, 2012).

1.2 Statement of the problem

Women other than men in developing countries and economically disadvantaged women in the cities of some industrial nations suffer the highest rates of complications from pregnancy, sexually transmitted diseases and reproductive cancers. Lack of access to comprehensive reproductive care is the main reason that so many women suffer and die. Most illnesses and deaths from reproductive causes could be prevented or treated with strategies and technologies well within reach of even the poorest countries. Men also suffer from reproductive health problems, most notably from STIs but the number and scope of risks is far greater for women for a number of reasons. Married women's use of modern contraceptives has increased significantly in recent years, nearly doubling (from 14% to 26%) between 2000 and 2011.However, modern contraceptive use remains too low to address the high rate of unintended pregnancy. Male partners also may influence whether a woman will practice contraception. One qualitative study found that some Ugandan men believed that contraceptives can cause health problems, such as infertility and cancer, while others felt that contraceptive use might cause women to have extramarital affairs (Uganda Bureau of Statistics, 2012).

Trying to meet both women's and men's practical needs for health care and their strategic needs (whatever women need to overcome subordination related to safeguarding their reproductive health and rights in a particular social context) are part of taking a gender perspective in reproductive health programs. Hence there is need to eliminate barriers to family planning services so as to reduce unmet need for contraception. The government should ensure that free or affordable public-sector contraceptive services reach all women, especially those who are poor, are young or live in rural areas. Programs should offer comprehensive family planning services that is, provide counseling, information and a wide range of contraceptive methods to enable women to choose the method the best meets their needs, to use methods effectively and to switch

methods when desired. Policies and programs should prioritize youth-friendly services that offer confidential reproductive health counseling and information as well as provision of family planning methods. It was against this background that the study intends to find out several untold dimensions in gender relations and reproductive health issues, (Simmons, 2014).

1.3 Purpose of the study

To examine the impact of Reproductive health services on gender in Mulago hospital of Kampala district

1.4 Objectives of the study

i) To assess reproductive health services provided at Mulago hospital.

ii) To investigate the knowledge and attitudes of local people towards reproductive health services in Mulago hospital.

iii) To examine the effects of gender relations on reproductive health service usage in Mulago hospital.

1.5 Research questions

The study sought to answer the following questions

i) What are the reproductive health services provided at Mulago hospital?

ii) What are the knowledge and attitudes of local people towards reproductive health services in Mulago hospital?

iii) What are the effects of gender relations on reproductive health service usage in Mulago hospital?

1.6 Null hypothesis

There was no significant relationship between the use of reproductive health services and gender.

1.7 Scope of the study

1.7.1 Geographical

The study was carried out from Mulago hospital found in Kampala district. Mulago National Referral Hospital, commonly known as Mulago Hospital, is a hospital in Uganda (Google, 2015). In Mulago, the national referral hospital, conditions are said to be very unhygienic especially in the labour ward, Waiting time is too long in many units with no privacy especially at Mulago where many students converge.

1.7.2 Content scope

The study focused on finding out the nature of in termers of effects of gender relations on the usage of reproductive health services, knowledge and attitudes of people on reproductive health, factors affecting the provision and usage of reproductive health services in Mulago hospital.

1.7.3 Time scope

The study was run for a period of five months starting from April-September which enabled the researcher to get enough time to collect data and analyze critically to produce a comprehensive report.

1.7.4 Theoretical scope

The study was based on rights-based approach to access which represents a shift from policy-making based on population level rationales such as population growth, economic and environmental factors, to recognition of the needs and rights of individuals. This came about largely as a result of the women's rights movement, culminating in the Beijing conference and consolidated by the work of other RSH-related pressure groups such as LGBT (lesbian, gay, bisexual and transgender) and treatment access groups. A rights-based approach means as well as providing to SRH services & information, paying attention to sexuality & sexual rights of different groups. A rights-based approach also implies responsibilities that is to say there is a requirement for the individual to behave responsibly but this assumes they have the relevant knowledge, skills and resources to do so which depends on responsibilities of others like

researchers, health professionals, religious leaders, national governments, donor governments (Shaw, 2011).

1.8 Significance of the study

Health workers

The findings of this study will be of great importance to health and social workers in knowing where there are gaps in the provision of reproductive health services.

Academicians

The study will be helpful to other scholars, academicians, researchers and development practitioners and will partially fill the existing gap in knowledge about gender relations and reproductive health.

Local people

The findings will increase the share in value since there will be an improvement in the provision of quality reproductive health care.

Government

The study will be significant to the government in that it will provide solution to problems of gender relations and reproduction health through the implementation of new policies to deal with the problems that will be identified by the stakeholders.

Researchers

The study will be significant to the researcher in fulfilling one of the requirements for the award of degree in social work and social administration.

1.9 Operational definition of key terms

Social impacts

The effect of an activity on the social issues of the community and well-being of the individuals and families.

Gender

This refers to the socially constructed characteristics of women and men such as norms, roles and relationships of and between groups of women and men.

Reproduction

Reproduction is defined as the creation of a copy of something, a copy of something, or the act of sexual intercourse to create an offspring.

Health

In the Constitution of the World Health Organization, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Reproductive health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes.

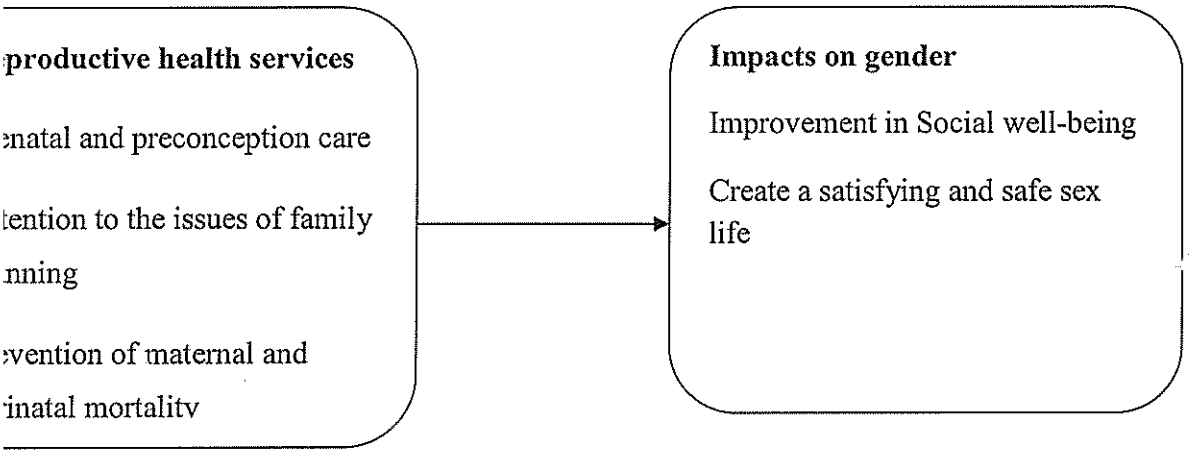
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter explained what other researchers have in relation to social impacts of reproductive health services on gender. Information gathered here was mainly from textbooks, journals, magazines, newspapers plus the internet.

2.1 Conceptual framework



Source; UN Population Fund (UNFPA), 2014

From the above conceptual framework, Prenatal and preconception care, attention to the issues of family planning, prevention of maternal and perinatal mortality are some of the reproductive health services provided by medical personnel. These cause impacts like improvement in social well-being and create a satisfying and safe sex like good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

2.2 Impact of Reproductive health services on gender

Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services for safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health is life-long, beginning even before women and men attain sexual maturity and continuing beyond a woman's child-bearing years, (Tavrow, 2015).

Reproductive health is crucial part of general health and central feature of human development to every community, becoming a universal concern, of great importance. It is a reflection of health during childhood and crucial during adolescence and adulthood and sets the stage for health beyond the reproductive years for both men and women and affects the health of the next generation. Access to and delivery of reproductive health services in Uganda is open to all categories of people and free in public hospitals; however, there is limited utilization of the reproductive health services due to gender related issues which results into reproductive health problems of sexually transmitted diseases, maternal and child health, family planning, unwanted or unsafe pregnancy, abuse, exploitation and death, (Shelton, 2012).

Gender relations largely affect women and young children. Men too have reproductive health concerns and needs though to a lesser extent than is the case of women. The focus is put on women's reproductive health, more often ignoring the concerns and needs of young children, adolescents and males. Gender norms in many societies lead the rural families, uneducated to miss out on the information and accessing reproductive health services. In general, emphasis is exclusively put on women taking little account of the gender relations of the social, cultural and intimate realities of men's reproductive lives and decision making powers. Ignoring the problems of men, non-child bearing women, the adolescence and more importantly; the determinants of reproductive ill health that lie in poverty, gender and other forms of inequity, social injustice marginalization and development failures has resulted reproductive health problems high infant and maternal deaths, early pregnancies, sexually transmitted diseases (STDs), unsafe abortions, limited use of family planning methods; leading to increased reproductive health problems on the already existing, (World Health Organization, 2011).

The complex concept of gender and gender mainstreaming is not yet well understood by planners, implementers and providers of health and other services and is sometimes rejected as feminist stridency. Much of the fear and defensiveness about incorporating gender perspectives into all development activities will weaken with increased understanding of the true concept of gender in reproductive health i.e. to empower women and strengthen the family bond. A deeper understanding of how the empowerment of women is a fundamental pre-requisite of their own health and the well-being of their family will evolve over time with increased awareness and public education about the gender issues, (Becker, 2010).

For many years, reproductive health programs simply did not address men, in part because women's centrality to reproduction was taken for granted (an assumption that itself reflects social norms) and in part because so little was known about men. Recent years have provided much useful information about men. A 1999 review by the Panos Institute provided extensive evidence on the special role that men were playing in spreading HIV and linked men's behaviors to underlying gender norms. A comprehensive analysis of men's reproductive health needs worldwide by the Alan Guttmacher Institute provides much-needed information about men, though it does not strongly address the ways in which gender norms constrain reproductive health for both men and women, (Bertrand, 2015).

Over the past decade, numerous programs involving men have been developed and documented. These programs involve men in safer motherhood, offer diagnosis and treatment of sexually transmitted infections, develop men's parenting skills, encourage men's support of women when they seek services, and provide basic information and counseling, among the range of their offerings. The wide universe of programs can be glimpsed in the pages of several important reviews. For example, a United Nations Population Fund review effectively divides male involvement efforts into those that promote family planning, serve men's needs or attempt to address gender inequity, but does not dwell on evaluation efforts. A UNICEF review similarly includes a wide variety of programs, some of which attempt to change social norms. But whether these programs have been evaluated is not discussed for the most par, (Bruce, 2010).

Inspirational, life-changing, informative; these words can describe nearly the entire myriad of programs designed to change gender norms. Unfortunately, "evaluated" and "demonstrably

effective" are not on that list of descriptors. Several promising programs that are widely recognized as being innovative and influential in their work to change perceptions of gender roles have not been evaluated in ways that would make their replication possible. For example, Fathers Inc., in Jamaica, is a training and support program that teaches and encourages men to nurture their roles as fathers and to assume the position of a gender-equitable role model for their children and communities. PAPAI works with adolescent fathers in Brazil, stimulating public discussion on the importance of young men's participation in sexuality, reproduction and parenthood. The organization creates a space for young fathers, who are an invisible and undervalued group, where they are appreciated and challenged to assume greater responsibility by developing their parenting skills and expanding their concepts of gender, rights, and citizenship. In Mexico, the Male Collective for Equitable Relationships supports creative, emotional, and respectful constructions of masculinity through programs focused on nurturing men as fathers and preventing gender-based violence. It also galvanizes community support to address these issues politically. Saludy Género, based in Mexico, sensitizes men to the detriments of socialized masculinity, especially violence and how they affect both men and women. The organization emphasizes working with men facing social and economic issues in all-male or mixed-gender groups, (Cotton, 2012).

The Society for Integrated Development of Himalayas focuses instead on achieving social justice through educational programs with youth and network-building between commensurately empowered men and women. In the Dominican Republic, the Catholic Institute for International Relations has conducted gender workshops to explore and address the social and cultural processes that enable gender-based violence. The institute has also been involved in similar efforts in Haiti, facilitating discussions analyzing cultural impediments and enablers that affect the power balance between men and women that in turn influence issues of gender and development. The Botswana National Youth Council works with youth broadly by addressing their needs and anxieties about male sexuality, including intimate partner relations, through a program focused on preventing HIV infection. Thandizani, a Zambian nongovernmental organization, engages communities in meaningful dialogue on the interconnectedness of gender, sexuality, and vulnerability to HIV in order to stimulate change in community norms. The University of Edinburgh has worked with the Meru ethnic group in Kenya, providing education

on gender issues to men undergoing the initiation rite of circumcision. These are just a few of the worthwhile programs affecting the lives of men of all ages in different contexts. Unfortunately, it cannot be stated definitively whether the above-mentioned programs have been effective enough to be expanded or replicated in other settings, (Cohen, 2010).

Influencing deeply entrenched social norms such as those addressing gender, is not easy, but clearly, it has already been done. One-hundred years ago, women in the United States could not vote, and very few went to college or worked outside the home. Women's emancipation, like all great social changes, was in part due to organized efforts and in part due to economic and other forces. Given the worrying state of reproductive health throughout the world, including HIV/AIDS, we do not have 100 years to wait. Good programs given sufficient reach can accelerate the pace of progress. The programs described here meet the criteria of successfully challenging gender norms as well as improving reproductive health behaviors as outlined in the Framework for Men in Reproductive Health programs. Adoption of the highest criterion that which changes socially defined male-female roles for the better will avoid problems of some male involvement programs that have unintentionally reduced women's autonomy or increased violence in their efforts to recruit men to use family planning, (Dempsey-Chlam, 2013).

2.3 Types of Reproductive health services

The subcommittee on research and indicators of the USAID Population, Health and Nutrition (PHN) Interagency Gender Working Group has outlined what constitutes gender-sensitive research for reproductive health and has compiled a list of research gaps related to the reproductive health and rights aspects of the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW). This report lists the gaps in research in the areas of biomedical, policy/programmatic, social science research and in the research process and then presents a short bibliography of research studies on the topic that best exemplify a gender perspective, (DiMatteo, 2014).

The UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural context of their lives but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold

uncompromising attitudes toward adolescent sexual behavior. Moreover, current adolescent programs often do not include all segments of the youth population. Two categories in particular are often excluded those who are out-of-school or most at risk such as street children and teenage sex workers and married adolescents. Even though adolescent childbearing outside marriage is increasing, the majority of births to adolescents are still to married adolescents, (Easterlin, 2015).

Unfortunately, it is often assumed that once an adolescent is married, the usual vulnerabilities do not apply. Yet, these young women share age and parity risk factors and many of the social risk factors including being vulnerable to sexual violence and unaware of good health-seeking behavior. In many parts of the world, the sexual behavior of adolescents is rapidly changing, promoted by relaxation of traditional norms governing premarital sexual behavior, migration (particularly rural to urban, but also intraregional and transnational migration) and exposure to mass media.

In those countries where the age of sexual initiation is decreasing and less rigid attitudes toward and sanctions against premarital sexual relationships are emerging, early sexual experience now places adolescents at high risk for unintended pregnancy and sexually transmitted infections, including HIV/AIDS. In parts of the world that have remained more isolated, young people, many of whom are married, also face significant health risks stemming from poor knowledge of reproductive health issues and low status as females. Because of age, immature physiology and gender, young women both married and unmarried are particularly vulnerable to exploitation that in turn leads to significant reproductive health problems, (Greene, 2010).

2.4 Knowledge and attitudes of local people towards reproductive health services

Circumstances that make menopause a different experience in the developing world, such as under-nutrition, repeated episodes of infectious disease and a lifetime of exposure to agricultural pesticides or indoor air pollution, have not been explored. In developing countries, nutritional deficiency of the general population is even more pronounced in aging women; years of child bearing and sacrificing her own nutrition for that of her family often lead to chronic anemia and because of postmenopausal women's reduced importance in some cultures, improving a household's access to food does not guarantee that older women in the family will receive sufficient food or nutrition, (Greenhalgh, 2010).

Postmenopausal women remain sexually active, although in some cultures it is a taboo subject, particularly for widows. The women in this group are still at risk of (and are) contracting STIs or HIV/AIDs, due in part to a lack of programs targeting reproductive health messages to them. The extension of basic literacy programs to aging women so they may reap the same reproductive health benefits as younger women would help in this regard. Often there is reluctance by families to provide resources necessary for medical needs and there are few reproductive health programs and few trained medical personnel addressing the needs of this cohort. While the World Health Organization and the Pan American Health Organization have done literature reviews of the research pertaining to "Women of the Third Age," gender aspects of post menopause research questions are a relatively new and uncharted challenge, (McNicoll, 2012).

As previously mentioned, the international policy context is clear on issues of reproductive health programme of action (less so on sexual health). However, there is a general lack of national & international political will to act to implement international policy, especially on sensitive issues such as abortion, and services for marginalized groups and adolescents (Langer, 2006). The local legal framework is also important repressive laws can prevent people's access to services, but others can enable access when enforced (Cook 2006). In many countries systems are not in place for the population to demand accountability of the government to provide quality services, and there are limited opportunities for civil society groups to participate in policy debates. However, there are examples of where social mobilisation has been successful in pushing issues onto the political agenda and helped to achieve increased access to services, for example on issues such as HIV/AIDS and sexuality (gay rights movement), (Sherman, 2011).

2.5 Effects of gender relations on reproductive health service usage

Ugandans have free access to mass media, including the press, radio and television broadcast. Information, education and communication programs have been found to influence behavior. There are a number of programs targeting the young people that are aired on radio and television related to adolescent sexual and reproductive health. Adolescents who have been exposed to such messages are reported to be more knowledgeable and more likely to have changed their behavior than those who were not exposed, (Obeng-Quaidoo, 2010).

Health sector reform; Neoliberal policies such as the structural readjustment policies promoted by the IMF and World Bank have led to increasing privatisation of services in some countries, and promotion of user fees as a strategy for sustainable financing of health services. These approaches have been seen to increase access to services in some countries but have been demonstrated to increase inequity between the wealthier and poorer segments of the population, as the poorest are denied access to services (Raberg 2002). It has also raised issues of service quality, as the private sector has been in some places allowed to explode with relatively little regulation (Ravindram, 2005).

Gender norms in most societies tend to make men macho, women passive and transgender people marginalized making all of them vulnerable in different ways to SRH problems and inhibiting access to services. For example, men may take risks in their sexual relations that expose them to HIV and STIs and may be reluctant to seek services which are often focused on women. Women are often economically dependent on men and have limited power to claim their SRH rights, for example through condom use or determining resource use for accessing services. It is also often culturally unacceptable for women to express sexuality which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV as well as indirect such as fear of accessing services, requesting use of condoms (Amnesty International, 2005).

In maternal health, there has been a focus on maternal mortality for example MDGs, neglecting maternal morbidity, which contributes hugely to women's ill health world wide. The focus on

maternal mortality has also been prioritized over perinatal mortality, which is only recently coming to the forefront as a key public health issue (Martines, 2005), for example with the recently created Partnership for Maternal, Newborn and Child Health. This recent recognition raises challenges for service provision, since maternal health interventions are largely curative, while community-based prevention interventions can be effective in improving perinatal health. An example of this is training traditional birth attendants, which is generally agreed to be ineffective in reducing maternal mortality but could be effective in reducing neonatal mortality, as well as improving maternal health and increasing communities' confidence in health services (International AIDS Vaccine Initiative, 2009).

In many societies, sexual knowledge is taboo for women before the initiation of sexual intercourse. Most of the world's health services have yet to effectively incorporate information on STIs and HIV/AIDS prevention, intervention, management, diagnosis, testing and counseling into programs that reach out to women who may be at risk yet are not considered high risk. Commercial sex workers have traditionally been seen as vectors of transmission rather than deserving of health services, yet few health programs address the needs of commercial sex workers or offer them training to pursue other means of economic survival (Kilmarx, 1998).

Studies have shown that HIV risk reduction efforts with outreach to women separately prior to interaction with men can be effective, either in community-wide efforts or as part of small group interventions (Gupta and Weiss, 1998). The challenge is to provide these interventions on a large enough scale to prevent the currently 12.1 million women infected with HIV from continuing to grow in numbers and to provide humane and effective care for those who are already infected, (Sherman J. 2011).

Of the data reviewed, several studies discussed that whilst young people were educated with regards to sexual and reproductive health matters, one of the barriers cited were poor relationships with those that provided the services. The recently published South African study Farzana et al, (2013) which focused on the topic of interpersonal relationships with youth and

their workers stated poor relationships served as a deterrent and adequate training was needed to overcome communication problems between workers and their clients, (Lockwood, 2005).

A recently published Australian study by Ambresin et al (2013) in The Journal for Adolescent Health compiled a literature review on youth perspectives on health care and also noted the staff attitudes as important across all aspects of care but physical environment not so important. This study provided a framework that can be used when assessing a service as being 'youth friendly' but it was not specific to sexual and reproductive health.

A content analysis published in the European Journal of Contraception (2013), reviewed service access barriers as perceived by young people and emphasized the importance of recognizing the personal nature of the process of attending a sexual and reproductive health service when you are young. Braeken's et al (2012) recently published study in The International Journal of Gynaecology and Obstetrics also drew attention to the need to gather data on the perceptions of young people to inform policy development and design services that are youth friendly and easily accessible, (Murphy, 2012).

The discussion also highlighted the appealing aspects for young people when accessing services those being; physical space, cost, staff and health promotion. It was also noted that it is not necessary for separate facilities but that the existing, local health services should be better organised to accommodate young people and their unique needs. The effectiveness of youth centres in increasing the use of sexual and reproductive health services was studied by Zuurmond, (2012), where considerable consistency across the studies that were systematically reviewed was noted. It found that the uptake of services was generally low despite widespread emphasis on youth centres as a strategy for encouraging young people to attend. The analysis of the cost effectiveness of the service was not undertaken but was likely to also be low, (Robinson, 2011).

Conclusion

The literature concludes that gender disparities between girls and boys and how this affects their differential health profiles both during childhood and later in the life cycle have yet to be fully explored. Both the health and the quality of life of girls are lower than that of boys in many developing countries. The benefits of programs that specifically address gender disparities and provide girls with opportunities for education, sexuality education and improved health and nutrition need to be documented as girls grow older and enter adulthood. In addition, many undocumented childhood health hazards affect both boys and girls such as pesticide exposure. Pesticide exposure may potentially have negative reproductive health consequences when the child reaches puberty and later in the life cycle (UNICEF, 1991).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In critically examining the gender relations and reproductive health, the researcher employed several methods of data collection. This chapter presented the overall methodology used in process of carrying out the research. It included the procedures that were followed and the methods that were used in research design, data collection methods, presentations and analysis.

3.1 Research Design

The study adopted a descriptive research design in examining the impact of reproductive health services on gender in Mulago hospital. The study also adopted both qualitative and quantitative approaches of data collection and analysis with quantitative approaches.

The researcher aimed at examining and describing the association and relationship between the variables that is gender and reproductive health services. This was because several researches (Bryman, 1995) suggest that a combination of qualitative and quantitative research methods; contextualizes the analysis by providing richer details and initiates new line of thinking through attentions and surprises, turning ideas around and providing fresh insights.

3.2 Research Population

The target population of this study was 255 respondents from Mulago hospital in categories of health practitioners and patients in the hospital, distributed as 10 specialists, 40 medical officers, 180 patients and 25 nurses & midwives as presented in the table;

Table 1: Category of respondents

Category of respondents	Target population	Sample size
Specialist	10	10
Medical officers	40	36
Patients	180	123
Nurses & midwives	25	24
Total	**255**	**193**

Source: Source: Krejcie & Morgan (1970:608)

3.3 Sample Size and its determination

The sample size was determined using Krejcie, R.V. & Morgan's formula (1970) and emphasis was put on the Table for determining sample size for finite population. Hence in accordance to Morgan and Krejcie's table for sample size determination; the sample size was 193.

3.4 Sampling Procedure

The study employed random sampling and purposive sampling techniques. The major purpose of the purposive was to ensure that precise information was got from the respondents who were not easy to allocate yet crucial for the study. Furthermore, the purposive sampling was important because informants were selected and a great deal of knowledge about the subject under the study.

3.5 Research Instruments

These were tools or devices which assisted the researcher to collect the necessary data. Questionnaire and structured interview guides were the main instruments used in this study.

Questionnaire

A questionnaire was directly administered to the respondent at the various levels of the population samples so as to get relevant data required in the study. Questionnaire involved open-ended and they were translated to other local languages used by the people. These instruments were developed and adapted to the various selected respondents.

Interviews

Interviews were administered to different groups of people in Kampala and local authorities from the district. Structured interviews were designed in such a way that more specific and truthful answers related to the usage of reproductive health services were got. Interviews were preferred because according to Gupta (2003), they give an opportunity to probe and obtain detailed information on the issue.

3.6. Validity and reliability of instruments

Validity

The research instrument was validated in terms of content and face validity. The content related technique measured the degree to which the questions items reflected the specific areas covered.

Reliability

The researcher will measure the reliability of the questionnaire to determine its consistency in testing what they were intended to measure. The test re-test technique was used to estimate the reliability of the instruments. This involved administering the same test twice to the same group of respondents who had been identified for this purpose.

3.7 Data Gathering Procedures

Questionnaires were tilled on the spot then after the researcher collected the questionnaire and response data was put together from all respondents of different areas and transformed to statistical data.

3.8 Data analysis

Both quantitative and qualitative approaches were used for data analysis. Quantitative data from the questionnaire was coded and entered into the computer for computation of descriptive statistics. The Statistical Package for Social Sciences (SPSS version 11.5) was used to run descriptive statistics such as frequency and percentages so as to present the quantitative data in form of frequency tables based on the major research questions. The qualitative data generated from open ended questions were categorized in themes in accordance with research objectives and reported in narrative form along with quantitative presentation. The qualitative data was used to reinforce the quantitative data.

3.9 Ethical Considerations

The researcher explained to the respondents about the research and that the study was for academic purposes only. It was made clear that the participation is voluntary and that the respondents were free to decline or withdraw any time during the research period. Respondents were not coerced into participating in the study. The participants had an informed consent to make the choice to participate or not. They were guaranteed that their privacy was protected by strict standard of anonymity.

3.10 Limitations of the Study

Failure to respond to certain questions and providing of false information was a challenge due to the fear by some respondents that the researcher would expose some of their reproductive health issues to the public as they were too confidential and personal. However, the researcher used logical questions such that the respondents would be able to release such information needed by the researcher.

Failure of respondents to understand the language used to draft questionnaires. This was likely to hinder the smooth process of data collection; however, the researcher interpreted the English language and translated technical questions into the local languages (Luganda and Runyankore) which most of the respondents understood. This was achieved through pre-testing the tools of data collection to ensure that they were reliable in terms of language used and quality of data collected.

CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF FINDINGS

4.0 Introduction

This chapter presented and discussed the finding of the study that included a sample of 70 respondents. The study was aimed at looking at the impact of Reproductive health services on gender in Mulago hospital of Kampala district. However, due to working in sifts problem in Mulago hospital, the researcher tried to collect only 60 questionnaires as presented below;

4.1 Bio Data of respondents

In this section the background characteristics of respondents such as gender, age, level of education marital status and period of employment at Mulago hospital were presented. Below were the tables showing the analysis of the finding from the field;

Table 1: Gender of the respondents

Response	Frequency	Percentages
Male	32	53.3
Female	28	46.7
Total	**60**	**100**

Source; Primary Data, 2016

From Table 1, the staff of Mulago hospital is made up of more male (53.3%) than females (4.6.7%)

Table 2: Distribution of the respondents by age

Response	Frequency	Percentages
Below 20	8	13.3
20-30	12	20.0
31-40	30	50.0
41 years and above	10	16.7
Total	**60**	**100**

Source; Primary Data, 2016

From Table 2, the finding revealed that the majority of respondent were between 31-40years with a percentage of 50%, 12 out of 60 respondents representing 20% were between 20-30years, 16.7% were aged 41years and above, yet 13.3% were aged below 20years.

Table 3: Level of education of the respondents

Response	Frequency	Percentages
Masters	8	13.3
Degree	37	61.7
Diploma	9	15.0
Certificate	6	10.0
Total	**60**	**100**

Source; Primary Data, 2016

From Table 3, finding revealed that 61.7% were degree holders 15.0% had diploma 13.30 hold masters degree while 10.0% hold certificate. This implies that Quality employees qualified people hence it is full of experts and people ready to innovate.

Table 4: Marital status of the respondents

Response	Frequency	Percentages
Married	23	38.3
Single	33	55.0
Separated	1	1.7
Widow	3	5.0
Total	**60**	**100**

Source; Primary Data, 2016

From Table 4, 55.0% were single, 38.3% were married, 5% were widowed while 1.7% had separated. This implies that most of Mulago hospital's employees are single and can get time to work full time (day and night and in shifts).

Table 5: Length of employment at Mulago hospital

Response	Frequency	Percentages
Less that 1 year	17	28.3
1-4 years	15	25.0
5-9 years	22	36.7
10 years and above	6	10.0
Total	**60**	**100**

Source; Primary Data, 2016

Results from Table 5 reveal that 28.3% had worked for less than 1 year, 25.0% had worked for 1-4 year, and 36.7% had worked for 5-9 years while 10% had worked for 10years and above. This implies that most of the respondents had worked for more than 1 year and therefore were

more knowledgeable about the dynamic of operation of e-procurement and impact on organizational operational efficiency.

4.2 Most effective reproductive health services provided at Mulago Hospital

Table 6: Reproductive health services provided at Mulago Hospital

Reproductive health services on gender	**Mean**	**Std. Deviation**
Access to effective reproductive health measures	4.00	1.06
Effective reproductive health services	3.58	1.08
Access to delivery services	3.07	1.30
Access of safe preventative measures	4.18	1.00
Availability of reproductive services **for both gender**	3.28	.92

Source; Primary Data, 2016

From Table 6, the respondents strongly agreed that patients at Mulago hospital get access to effective reproductive health measures because they were leaving a health life (mean = 4.00) and they as well get access to effective reproductive health services (mean= 3.58). The respondents further agreed that Mulago hospital patients get access to effective reproductive health services (Mean=3.58). Mulago hospital patients also get availability of reproductive services for both gender (Mean=3.28) and others get access to delivery services (Mean=3.07).

Knowledge and altitudes of local people towards Reproductive Health Services

Table 7: Awareness of the effects of RHS

Awareness of the effects of RHS	Mean	Std. Deviation
Know issues related to family planning from health centers	3.60	1.03
Get training from health personnel	3.02	1.19
Get training from neighbors on usage	3.00	1.16
Awareness from traditional herbalists	3.03	1.26
Awareness from Mulago hospital	2.92	1.50

Source; Primary Data, 2016

From table 7, the respondents strongly agreed that they mostly get awareness from health centers but not Mulago hospitals and this was got due to the fact that most of them come from distant areas (mean=3.60), get training from health personnel to avoid the likely impacts of reproductive health services (Mean=3.03) and pro· ides information access to geographically dispersed patients leading to fair usage of the services (Mean=3.02). This implies that Mulago hospital has tried to sensitive people on proper usage of reproductive health services and most of them are aware. Still awareness is at times created by neighbors who go on spreading rumors on the best reproductive health service (Mean=3.00). The respondents were also accessing information about usage from Mulago hospital especially when they go for antenatal services they get time and ask questions from service providers in the hospital(mean =2.92).

Table 8: Awareness of the available RHS

Awareness of the available RHS	Mean	Std. Deviation
Low	3.88	.94
High	3.97	.80

Not sure	4.02	.77
Wish to ask health professionals	4.23	1.37

Source; Primary Data, 2016

From table 8, the respondents strongly agreed that they have never taken time to find out details on reproductive health services due to the fact that they have never heard of it hence when asked they said that wish to ask health professionals to know details (mean = 4.23) and others were not sure of either asking or practicing because for them they use herbs (Mean=4.02). The respondents agreed that awareness is too high due to the fact that they have ever heard of it (Mean=3.97), as compared to those who said that it is low because they have never heard of anyone talking about reproductive health services due to remoteness and distance from health centers (Mean=3.88). This implied that Mulago hospital has tried to create awareness of reproductive health.

Table 9: Awareness of the cost of RHS

Awareness of the cost of RHS	**Mean**	**Std. Deviation**
Low	3.15	.99
High	3.20	.94
Not sure	2.92	1.50

Source; Primary Data, 2016

From table 9, the respondents strongly agreed that the costs of reproductive health services is low because they use government hospitals like Mulago and Kampala Capital City Authority hospitals though they complained that services are slow (mean=3.15). Some of the respondents further argued that it is high due to the fact that at times they fear going to government hospitals due to the poor service delivery and harassment from medical personnel decide to use regional referrals which are at times expensive (Mean=3.20). This implied that at times patients who visit Mulago hospital use outside clinics due to delays in services of the biggest hospital. However,

some respondents were not sure of the high and low cost because they had never used RHS (Mean=2.92).

4.3 Descriptive statistical tables showing the effects of gender relations on reproductive health service usage

Table 10: Improvement of safe access of RHS

Improvement of safe access of RHS	Mean	Std. Deviation
Through exposure to RHS messages	4.02	.77
Health sector reform	4.23	1.37
Extension of reproductive health services	3.57	.74

Source; Primary Data, 2016

From table 10, the respondents strongly agreed that improvement of safe access of RHS has been achieved through exposure messages by Mulago hospital in regard to usage of RHS for instance the recently on going advert which advises adults to use condoms and their proper usage (mean=4.02). The respondents also agreed that safe access to reproduction has been achieved through health sector reforms as it is on going in Mulago where the hospital is under maintenance and patients were asked to go to neighboring hospitals like Kiruddu(Mean=4.22) , others also supported the view that there has been extension of reproductive health services to respondents of Kampala like respondents in Makindye instead of going to Mulago go to Namuwongo KCCA hospital which services relate to Mulago(Mean=3.15).

Table 11: Improvement to quality of RHS

Response	Mean	Std. Deviation
Improvement of knowledge concerning RHS	2.92	1.50
Improvement to quality of RHS	3.88	.94
Increased access to receive safe places to RHS	3.97	.80

Source; Primary Data, 2016

From table 11, the respondents strongly agreed that improvement to quality has been achieved through improvement of knowledge concerning RHS (mean=2.92). The respondents also strongly agreed that improvement of quality of RHS by Mulago hospital has been achieved through improvement to quality of RHS (Mean=3.88). It was also revealed that improvement of quality has been achieved through increased access to safe places of RHS (Mean=3.97). This therefore indicated that most respondents appreciated the quality of service delivery in Mulago hospital.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 introduction

This chapter provided the summary of the finding presented in the preceding chapter, discussion, conclusions and recommendations. Suggestion for areas that should be researched on was also indicated.

5.2 Summary of the finding

5.2.1 Reproductive health services provided at Mulago hospital

From the findings, there was a positive perception of the respondents regarding the usage of reproductive health services. These services include family planning services which have strongly reduced on the high birthrate as supported by Shelton, (2012), who argued that the usage of Reproductive health services is a reflection of health during childhood and crucial during adolescence and adulthood and sets the stage for health beyond the reproductive years for both men and women and affects the health of the next generation. Access to and delivery of reproductive health services in Uganda is open to all categories of people and free in public hospitals; however, there is limited utilization of the reproductive health services due to gender related issues which results into reproductive health problems of sexually transmitted diseases, maternal and child health, family planning, unwanted or unsafe pregnancy, abuse, exploitation and death

5.2.2 Knowledge and attitudes of local people towards reproductive health services in Mulago hospital

From the findings, access to effective reproductive health measures, effective reproductive health services, access to delivery services, Access of safe preventative measures and Availability of reproductive services for both gender. The respondents agreed on the most variables under the study that they live a happy life due to the fact that they get free medical services, get free education on proper usage of RHS. However, some of these services are not imparted effectively due to the fact that youth still make mistakes like unsafe abortion. This view is supported by

authors like Easterlin, (2015) who argued that the UN resolutions underline the fact that adolescent sexual and reproductive health care needs are not being adequately met. This is in part because their needs are not clearly understood within the social and cultural context of their lives but also because researchers, service providers, and policy makers often avoid the sensitive issue of adolescent sexuality or hold uncompromising attitudes toward adolescent sexual behavior. Moreover, current adolescent programs often do not include all segments of the youth population. Two categories in particular are often excluded those who are out-of-school or most at risk such as street children and teenage sex workers and married adolescents.

5.2.3 Effects of gender relations on reproductive health service usage in Mulago hospital

From the findings respondents indicated that just like other health services, reproductive health has also been effective in such a way that Health sector reform, HIV risk reduction efforts, improvement to quality of RHS and improvement of knowledge concerning RHS. This view was supported by Amnesty International, (2005) that gender norms in most societies tend to make men macho, women passive and transgender people marginalized making all of them vulnerable in different ways to SRH problems and inhibiting access to services. For example, men may take risks in their sexual relations that expose them to HIV and STIs and may be reluctant to seek services which are often focused on women. Women are often economically dependent on men and have limited power to claim their SRH rights, for example through condom use or determining resource use for accessing services. It is also often culturally unacceptable for women to express sexuality which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV as well as indirect such as fear of accessing services, requesting use of condoms

5.3 Discussion of the findings

5.3.1 Impact of Reproductive health services on gender

Respondents argued that reproductive health services have posed many impacts like information sharing at the grassroots which has enabled many people to know and analyze the best health service suitable for application as stipulated by World Health Organization, (2011) that gender norms in many societies lead the rural families, uneducated to miss out on the information and accessing reproductive health services. In general, emphasis is exclusively put on women taking little account of the gender relations of the social, cultural and intimate realities of men's reproductive lives and decision making powers. Ignoring the problems of men, non-child bearing women, the adolescence and more importantly; the determinants of reproductive ill health that lie in poverty, gender and other forms of inequity, social injustice marginalization and development failures has resulted reproductive health problems high infant and maternal deaths, early pregnancies, sexually transmitted diseases (STDs), unsafe abortions, limited use of family planning methods; leading to increased reproductive health problems on the already existing.

Further Tavrow, (2015) observed that men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services for safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health is life-long, beginning even before women and men attain sexual maturity and continuing beyond a woman's child-bearing years

The findings also revealed that there has been a greater improvement of safe access of RHS which according to Shelton, (2012), has been open to all categories of people and free in public hospitals; however, there is limited utilization of the reproductive health services due to gender related issues which results into reproductive health problems of sexually transmitted diseases, maternal and child health, family planning, unwanted or unsafe pregnancy, abuse, exploitation and death.

The findings also revealed that there has been health sector reforms like opening up more referral hospitals for instance in Namuwongo which according to Cotton, (2012) Inspirational, life-

changing, informative; these words can describe nearly the entire myriad of programs designed to change gender norms. Unfortunately, "evaluated" and "demonstrably effective" are not on that list of descriptors. Several promising programs that are widely recognized as being innovative and influential in their work to change perceptions of gender roles have not been evaluated in ways that would make their replication possible. For example, Fathers Inc., in Jamaica, is a training and support program that teaches and encourages men to nurture their roles as fathers and to assume the position of a gender-equitable role model for their children and communities.

5.3.2 Knowledge and attitudes of local people towards reproductive health services

From the findings, it was revealed that respondents knew issues related to family planning from health centers and this was due to the good gender balance of considering both women and men in issues related to reproductive health and as well aging women as supported by authors like McNicoll, (2012) who argued that Postmenopausal women remain sexually active, although in some cultures it is a taboo subject, particularly for widows. The women in this group are still at risk of (and are) contracting STIs or HIV/AIDs, due in part to a lack of programs targeting reproductive health messages to them. The extension of basic literacy programs to aging women so they may reap the same reproductive health benefits as younger women would help in this regard. Often there is reluctance by families to provide resources necessary for medical needs and there are few reproductive health programs and few trained medical personnel addressing the needs of this cohort. While the World Health Organization and the Pan American Health Organization have done literature reviews of the research pertaining to "Women of the Third Age.

The findings also revealed that they get training from health personnel to help them choose the most effective health service as proclaimed by Sherman, (2011) who argued that the local legal framework is also important repressive laws can prevent people's access to services, but others can enable access when enforced. Hence he argued that in many countries systems are not in place for the population to demand accountability of the government to provide quality services, and there are limited opportunities for civil society groups to participate in policy debates. However, there are examples of where social mobilisation has been successful in pushing issues

onto the political agenda and helped to achieve increased access to services, for example on issues such as HIV/AIDS and sexuality (gay rights movement),

According to McNicoll, (2012), Postmenopausal women remain sexually active, although in some cultures it is a taboo subject, particularly for widows. The women in this group are still at risk of (and are) contracting STIs or HIV/AIDs, due in part to a lack of programs targeting reproductive health messages to them. The extension of basic literacy programs to aging women so they may reap the same reproductive health benefits as younger women would help in this regard. Often there is reluctance by families to provide resources necessary for medical needs and there are few reproductive health programs and few trained medical personnel addressing the needs of this cohort. While the World Health Organization and the Pan American Health Organization have done literature reviews of the research pertaining to "Women of the Third Age," gender aspects of post menopause research questions are a relatively new and uncharted challenge.

5.3.3 Effects of gender relations on reproductive health service usage

From the findings, it was reveled that RHS have helped to create surveillance through condom use or determining resource use for accessing services. It is also often culturally unacceptable for women to express sexuality which for example could make them unwilling to seek condoms. Violence against women has direct effects such as increased risk of STIs/HIV as well as indirect such as fear of accessing services, requesting use of condoms which view was supported by Amnesty International, (2005), which said that gender norms in most societies tend to make men macho, women passive and transgender people marginalized making all of them vulnerable in different ways to SRH problems and inhibiting access to services.

The findings also revealed that there has been an achievement in creating awareness of the costs of the services and how people benefit from such services as findings by earlier studies like Obeng-Quaidoo, (2010) expressed that Ugandans have free access to mass media, including the press, radio and television broadcast. Information, education and communication programs have been found to influence behavior. There are a number of programs targeting the young people that are aired on radio and television related to adolescent sexual and reproductive health.

Adolescents who have been exposed to such messages are reported to be more knowledgeable and more likely to have changed their behavior than those who were not exposed.

From the findings, it was also observed that there has been improvement to quality of RHS through knowledge, quality and easy access to RHS to all people who go to Mulago hospital as shown by Ravindram, (2005), Health sector reform; Neoliberal policies such as the structural readjustment policies promoted by the IMF and World Bank have led to increasing privatisation of services in some countries, and promotion of user fees as a strategy for sustainable financing of health services. These approaches have been seen to increase access to services in some countries but have been demonstrated to increase inequity between the wealthier and poorer segments of the population, as the poorest are denied access to services (Raberg 2002). It has also raised issues of service quality, as the private sector has been in some places allowed to explode with relatively little regulation.

5.4 Conclusions

From the findings of this study, major conclusions can be drawn in line with the problem statement and more specifically on the basis of the objectives of the study. On the types of reproductive health services used in Uganda, the findings revealed that patients at Mulago hospital get access to effective reproductive health measures because they were leaving a health life and Mulago hospital patients get access to effective reproductive health services. The study concluded that Mulago hospital has tried to sensitive people on proper usage of reproductive health services and most of them are aware. This implied that Mulago hospital has tried to create awareness of reproductive health.

5.5 Recommendations

The researcher made the following recommendations;

I would recommend that management of Mulago hospital to organize a free sensitization basis to overcome challenges from lack of awareness by local people in regard to reproductive health services.

I would recommend that focus be put on Quality invests in Research and Development such that more understanding is created about the usage of Reproductive health services especially to people in rural areas who argued that they at times find it hard to get education and sensitization on reproductive health.

I would recommend the need for integrating health services delivery in both rural and urban areas for example much focus needs to be put on strengthening relationship between health service delivery in rural and urban areas that is to say health services should be balanced and equal.

5.6 Areas for further research

The researcher recommends further research into the following areas;

(i) Factors affecting patients decision on usage of reproductive health services
(ii) Causes of poor usage of reproductive health services
(iii)Solutions to the challenges faced in implementation of reproductive health services

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APPENDIX A

QUESTIONNAIRE

SOCIAL IMPACTS OF REPRODUCTIVE HEALTH SERVICES ON GENDER IN MULAGO HOSPITAL OF KAMPALA DISTRICT UGANDA

Dear Sir/ Madam,

I am carrying out a research on "Social **Impacts of Reproductive Health Services on Gender in Mulago Hospital of Kampala District Uganda** "You are expected to know areas that you think need improvement so as to provide you with best reproductive health services. It is against this background that you have been selected to participate in the research by completing the Questionnaire. It would thus be very helpful if you assist by answering the questionnaire as per the instructions at the beginning of sections. You should provide the most appropriate answer in your opinion. Your responses will be kept confidential, after the questionnaire is anonymous.

Thank you.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. **Gender**

   Male ☐ Female ☐

2. **Age**

   15-19 ☐ 20-24 ☐ 29-34 ☐ 35-39 ☐

   40-44 ☐ 45-49 ☐

3. **Educational level**

   Non-formal ☐ Primary education ☐

   Secondary education ☐ Diploma tertiary education ☐

SECTION B: Please react to the following opinions using a scale where

1=Strongly disagree, 2=Disagree, 3=Agree, 4=Strongly Agree

REPRODUCTIVE HEALTH SERVICES PROVIDED AT MULAGO HOSPITAL

Most effective reproductive health services provided at Mulago Hospital

Most effective reproductive health service	**Strongly disagree(4)**	**Disagree(3)**	**Agree(2)**	**Strongly Agree(1)**
Access to safe reproductive health measures				
Access to effective reproductive health measures				
Effective reproductive health services				
Access to delivery services				
Access of safe preventative measures				

Availability of reproductive services for both gender				

Knowledge and Attitudes of Local People towards Reproductive Health Services in Mulago Hospital

. Knowledge and attitudes of local eople towards reproductive health ervices in Mulago hospital	**Str ngly disagree(4)**	**Disagree(3)**	**Agree(2)**	**Strongly Agree(1)**
wareness othe effects of RHS				
wareness of the available RHS				
wareness of the cost of reproductive ervices				
wareness of the risk and potential of HS				

Effects of gender relations on reproductive health service usage in Mulago hospital

). Effects of gender relations on eproductive health service usage in Mulago hospital	**Strongly disagree(4)**	**Disagree(3)**	**Agree(2)**	**Strongly Agree(1)**
mprovement of safe access of RHS o both men and women				
mprovement quality of RHS				

Improvement of knowledge concerning RHS				
Increased access of safe places to receive RHS				

Give recommendations for improvement of reproductive health in Mulago hospital?

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-END-