SOCIO-ECONOMIC AND DEMOGRAPHIC FACTORS ASSOCIATED WITH ENHANCING REPRODUCTIVE HEALTH OF WOMEN IN BUNYAFA SUB-COUNTY, SIRONKO DISTRICT

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S22/MUC/BSW/048

A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF BACHELOR OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF UGANDA CHRISTIAN UNIVERSITY

July, 2024

UGANDA CHRISTIAN UNIVERSITY
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DECLARATION

I **NAMUHENGE MORREN** declare that this research report has been written out of my own efforts. It has never been submitted to any institution of higher learning for any award.

Signature:……………………………………. Date:…………………………

NAMUHENGE MORREN

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APPROVAL

This is to certify that this research report has been completed under my supervision on behalf of Uganda Christian University Mbale College and is ready for submission.

SIGN……………………………………………..DATE………………………………………

MR BYARUHANGA CHRIS

RESEARCH SUPERVISOR

DEDICATION

I dedicate this work to my family for their kind financial and moral support to my Education. I pray that the almighty God Bless you all.

ACKNOWLEDGEMENT

My great gratitude goes to God the Almighty who has enabled me to successfully complete this wonderful exercise. I take this honor to convey special thanks to Uganda Christian University fraternity for their academic support and for this note, I greatly thank my research supervisor, Mr. Byaruhanga Chris for his technical guidance rendered to me during proposal development and dissertation amidst his tight schedules. I pray he may live to witness more great years on earth.

I also appreciate my family and relatives, not forgetting classmates whose emotional and physical support was significant for my completion of my research and general academic studies. God bless you all.

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LIST OF ACRONYMS

AWLU	Association of Women Lawyers in Uganda
ACD	Action for development
AGOA	African Growth and Opportunities Act of the USA
AUMWD	Association of Uganda Medical Women Doctors
CDM	Clean Development Mechanisms.
CDRN	Community development network
CDWCG	Community Development Workers Conditional Grant.
CEDOVIP	Center for domestic violence prevention
COPE	Complementary Opportunities for Primary Education
CSO	Civil Society Organization.
DANIDA	Danish International Development Agency.
DFID	Department for International Development
DRIS	District Resource Information System
DWNRO	Disabled women's network and resource organization
EMOC	Emergency Material and Obstetric Care
ENR	Environment and Natural Resources
ERRP	Emergency Relief and Rehabilitation
ERT	Energy for Rural Transformation
HMIS	Health Management Information System
NGO	Non-Governmental Organization
PDM	Parish Development Model

ABSTRACT

Background: Many women do not have access to reproductive health leading to high morbidity and high child mortality.

Objective: This aimed at assessing social, economic and demographic factors associated with enhancing reproductive health of women in Bunyafa sub county of Sironko district.

Method: The study used cross-sectional study with the help of both qualitative and quantitative approaches. Data was collected from 80 respondents in Buyafa Sub-county using a semi structured questionnaire and interview guide. Purposive sampling technique was used to select research participants. Quantitative data was analysed using descriptive statistics and content analysis for qualitative data.

Results: The findings of the research study show that limited decision making (39%0 hinder access to reproductive health services by women alongside gender roles (29%). In addition, socio-demographic factors of age (36%) and place of residence (rural or urban) (45%) determines access to reproductive health of women. Further, socio-economic factors such as such as income levels (42%), peer influence (53%) and levels of women's education have been cited as central determinants of access ton reproductive health of women,

Conclusion: Young women without decision making power and residing in rural areas with low income and low educational levels have been found to have less or no access to reproductive health.

Recommendations: The Ministry of Health (MoH) together with Gender, Labour and Social Development counterpart should strengthen enforcement of policies regarding universal access to reproductive health by women, curtail social exclusion and improve availability, accessibility and utilization of reproductive health by women. Also, the government should reduce taxation on entrepreneurial businesses so as to boost economic household income through Business Incubation, skilling and Parish Development Model (PDM) for the empowerment of marginalized and economically unsound persons including women groups

Key Terms: *Cultural determinants, individual economic wellbeing, Health Education.*

CHAPTER ONE

BACKGROUND

1.0 Introduction

This chapter highlights information of the background to the study, problem of the statement, objectives of the study, scope of the study, significance of the study, limitations and delimitations to the research study.

1.1 Background to the Study

Reproductive health has faced a lot of challenges globally with millions of women failing to access RH services. RH refers to the physical state of the reproductive system and functions, as well as the mental and social adaptations in the reproductive process. At the 4th International Conference on Population and Development in Cairo, WHO proposed the global goal of "reproductive health for all by 2015", and the conference brought RH to the forefront of world attention. In 2020, the Outline for the Development of Chinese Women (2020–2021) mentioned "improving women's reproductive health and ensuring women's access to reproductive health technology services" as a goal of national and social development

The Reproductive health is the core science of human life and is critical to the healthy and sustainable development of human society and since 1980, China has been implementing a one child policy in ensuring good RH among mothers of the reproductive age and this has helped in socio-economic development of the country (Wombeogo, 2021). Despite their extreme importance, there has not been sufficient funding to increase access to sexual and reproductive health (SRH) services for most people across the globe. This is even more pronounced in lower- and middle-income countries where funding for sexual and reproductive health and rights (SRHR) is largely donor driven

Normally, women are excluded and limited to participate in decision making, economic programs such as NAADS and livelihoods diversification both in their households and their communities. These lead to women being unable to diversify their livelihoods. Moreover, lack of

access to financial services coupled with gender suppressive tendencies as a result of tradition could lead to low enhancing reproductive health and social rights of women (Wombeogo, 2021).

Despite of economic empowerment of women programs, the majority of women are still struggling with poverty which has indirectly affected their RH. They hardly access family planning, contraceptives, ANC and post natal care leading to constant infant and maternal morbidity and death which calls for a combined effort to address

In Africa, RH is still a challenge especially in developing countries like Uganda, Mali and Gambia. For example in Nigeria, women still use herbs to treat infections, otters visits TBA which puts them at high risks of maternal deaths and other challenges. Women and men in sub-Saharan Africa, along with those in south Asia, are among the poorest in the world, both in real incomes and in access to social services. The World Bank report (2021) indicate that about 45% of the approximately 590 million households in sub-Saharan Africa which have low incomes.

Klasen and Lamanna (2020) have previously scrutinized the connection between gender issues and economic growth from a macroeconomic perspective, especially through cross-country regression analyses. Dollar and Gatti (2019), Klasen (2022) all look at the ways in which gender gaps in participation in livelihood, resources management and decision making in many Asian countries. Although details vary, they have typically found a negative correlation. A micro approach, on the other hand, can lay out a comprehensive context for understanding how gender inequality is linked to the growth of household income and levels of poverty and inequality. The decomposition methodology developed by Bourguignon et al. (2021) for these micro simulations has previously been used for the analysis of wage differentials, including the gender wage gap. In this case, counterfactual household income distributions are compared to the original to estimate the impact of each simulation.

A probity equation estimated that income for urban households in Côte d'Ivoire in 2017 indicated that education helped reduce the likelihood of being poor. For the rural folks, the results showed that with the lower stock of human capital, any additional year of education for women of a rural household had a poverty reducing effect that was more than twice as high as in the urban household. Another important factor found to influence the poverty level in urban areas was the

location effect, which makes it much more likely that otherwise similarly endowed households would be poorer in other towns relative to the capital city, Abidjan. It was also found that income diversification in rural areas did not play a significant role in bringing about enhanced enhancing reproductive health and social rights of women (Grootaert, 2019).

Uganda is one of the poorest countries in the world, with a per capita income of Ush91,144 in 2020. The trends in aggregate per capita growth rates indicate not only that Ugandan household have low incomes but are also increasingly vulnerable and deprived. Average per capita income levels conceal the extent and depth of poverty since Uganda suffers from a skewed distribution of income (Nuwagaba, 2018). Results from the household budget survey of 2023 confirm the wide spread of expenditure patterns and marked differences in expenditure levels between and within rural and urban areas in Uganda (Connick, 2020). The average urban household spent 2.5 times as much as the average rural household as a result of gender empowerment, with a large proportion of the rural households clustered in the lowest expenditure groups. Over 90% of all rural households spent Ush10, 000 or less in a month in 2021, compared with less than 60% of urban households.˙ As time eroded the study of gender differences has become the overweening passion of development partners, of course, have been thoroughly indoctrinated with the idea that their first responsibility is to be aware of and sensitive to such differences in their development interventions.

In Bunyafa sub county of Sironko district, more than four in 10 births (43%) are unplanned (UDHS, 2011). The proportion of births that are unplanned is higher among rural, poor and less educated women than among their urban, wealthier and better educated counterparts (Rubinah, 2013). Uganda government has made impressive strides in increasing access to sexual and reproductive health services for youths over the past 20 years, but access to RH by women in Buyafa Sub County is still very low. et al., 2018). In 2017 the sub county revised its original commitment of 2012 to reduce the unmet need among adolescents from 30.4% in 2016 to 25% in 2021(Family Planning, 2020). Despite the commitments and interventions by the government in Buyafa Sub County, the sub county's total fertility, maternal mortality, and teenage pregnancy rates remain among the highest in the country (Namasivayam, 2019). This has prompted the

researcher to carry out this study by assessing socio-economic and socio-demographic factors associated with access to RH by women in Bunyafa Sub County of Mbale district.

1.2 Problem Statement

The RH of women in Buyafa Sub-County is poor. For example the study by Okilinge et al., (2022) found that there are high rates of infant and maternal deaths due to a low uptake of family planning services among women of reproductive age (18-45 years). In 2022, the MoH found that only 12% of pregnant mothers visited ANC Clinic. This has subsequently led to high fertility rates and increased population growth in the face of economic instability facing Uganda and if not addressed, teenage pregnancies and STIs coupled with population growth are like to undermine the country's efforts of socio-economic development and attainment of vision 2040.

The total fertility rate in Bunyafa Sub County is estimated at 6.2 leading to 7,297 pregnancies and 7,727 expected births per year (Mbale District Local Government, 2022). Bunyafa Sub County has an estimated contraceptive prevalence rate of 8%, uptake rate of 16% and an unmet need for family planning at 21.9% (UDHS & ICF, 2022). Despite various efforts by Ministry of Health and other implementing partners in the bid to ensure that contraceptives are available to women in Bunyafa sub county like provision of better health facilities, empowerment of VHTs, effective communication through the TVs and radio stations, counseling services and free family planning service provision, most women still don't make use of the contraceptives. Furthermore, there is limited published information about socio-economic and socio-demographic factors associated with enhancing reproductive health Bunyafa Sub-County, Sironko district. It is therefore against this background that this study aims to assess the socio-economic and socio-demographic factors associated with enhancing reproductive health Bunyafa Sub-County, Sironko district.

1.3 Objectives of the Research Study

1.3.1 General Objective

The major objective of this research study was to assess socio-economic and socio-demographic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district.

1.3.2 Specific Objectives

I. To determine the Reproductive Health status of women in Bunyafa Sub-County, Sironko district.

II. To examine socio-demographic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district

III. To establish socio-economic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district

1.4 Research Questions

I. What is the reproductive health status of in Bunyafa Sub-County, Sironko district?

II. What are the socio-economic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district?

III. What are the demographic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district?

1.5 Scope of the Study

1.5.1 Content Scope

The research study was about socio-economic and demographic factors associated with enhancing reproductive health Bunyafa Sub-County, Sironko district. It specifically looked at gender empowerments associated with enhancing reproductive health and socio-economic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district. It also looked at socio-demographic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district

1.5.1 Time Scope

The study was carried out in a period of three months i.e. from Jan to April, 2024. This period has been chosen because its when the researcher will be able to collect adequate and reliable data for the research study.

1.5.2 Geographical scope

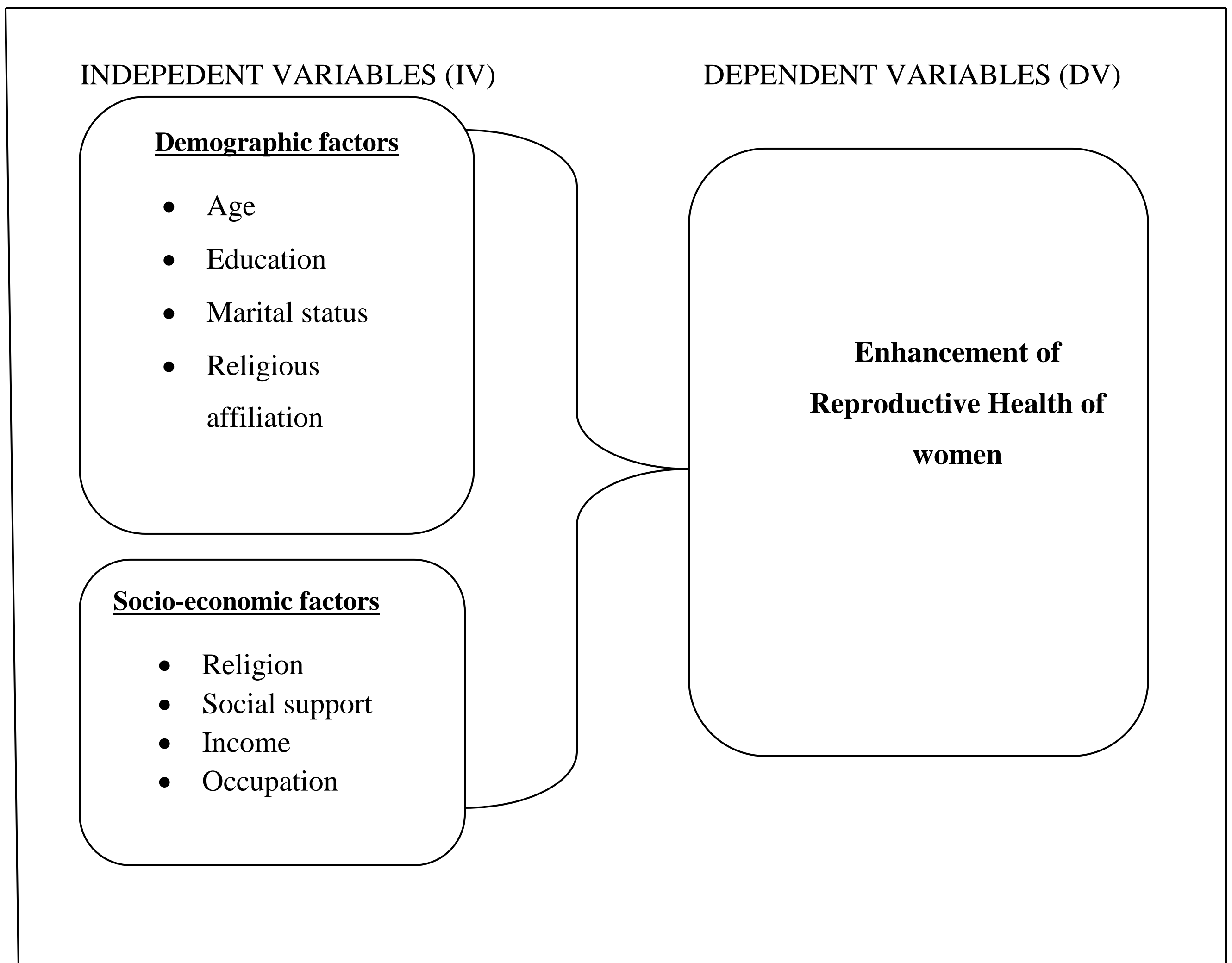
This research study took place in Bunyafa Sub-County, Sironko district. This sub-county is bordered by Buteza on the North, Buwasa sub-county on the west, Busedani on its East and Buyobo sub-county on its southern hemispheres.

1.5 Significance of the Study

The study when completed may have the following benefits:

The study results may be used by the government and development partners in designing policies and measures of intervention that can lead to increase in enhancing reproductive health and social rights of women. The study results may be used as a point of reference to future researchers. Also the study results may add to the existing body of literature on the socio-economic and demographic factors associated with enhancing RH. It may create awareness and capacity of men and women to formulate projects that have direct bearing on their lives.

1.7 Conceptual framework



Source: Researcher's Model; 2024

Figure 1. 1 Conceptual framework *developed from literature of Okiria and Okiidi (2019)*

From the above conceptual illustration, it is noted that equal participation in livelihoods, resource management and equal participation indecision making constitutes independent variables and if supported, they lead to increased improved investment, increase in assets, improved saving as dependent variables. However, community sensitization, provision of micro credits and capacity building are put in place for their effective use, enhancing reproductive health and social rights of women may be enhanced.

1.10 Key operational terms of terms

Reproductive health:

Reproductive health refers to the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive systems and how it functions and processes (MoH, 2021).

Reproductive health:

These are modern services needed by women for safe motherhood including child delivery and post-natal care services (MoH, 2021).

Socio-economic factors:

This refers to the socio-economic status and sociological combined total measure of a person's work experience and of an individuals or family access to economic resources and social positions in relation to others like, Income Education, employment status (Mwiti et al., 2020)

Socio-demographic factors:

This refers to the different index variables which are formed on the basis of socio demographic characteristics. They include, age, sex, education, migration, background and ethnicity, religious affiliation, marital status, household and unemployment (Mwiti et al., 2020).

Enhancement: A change, or a process of change, that improves something or increases its value (Ojangole et al., 2017)

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter highlights information about the review of the literature related to the area of study. The review has been conducted according to the objectives of the research study.

2.1 Reproductive health enhancement of women

Several studies have reported that reproductive health enhancement has found a lot of challenges in developing countries like Uganda. A study done in Ethiopia by Abdulia and Rees et al. (2020) showed that reproductive health status of women and factors such as poverty, low education and poor attitudes from government health facilities and related factors are attributed to this problem.

Enhancement of reproductive health was also reviewed by WHO (2020) where it was found that reproductive health services developed specifically for women are essentially limited to reproductive needs, especially childbearing. Services addressing other women's health problems have been underdeveloped, and are non-existent or inaccessible within public health care. Thus, girl-children, elderly women, the disabled, the unemployed and others with special needs have had limited access to reproductive health. Even Mwit et al., (2021) study showed that women from rural areas throughout the region have particularly limited access to reproductive health. services. Many rural areas suffer severe shortages of health personnel, medical equipment and other supplies. Women often must travel long distances to health centers.

The inadequacy of health services to meet women's reproductive needs in Kenya can be observed best with respect to reproductive health (Furgson et al., 2019). Family planning counseling and services usually do not constitute an integral part of reproductive health services. Women in most countries have easier access to free abortion services (with the exception of Poland where abortion is illegal) while contraceptives, when they are available at all, are usually not reimbursed

Several studies for example Karamouzian et al., (2016) and WHO (2020) found increased incidence of reproductive health problems like unwanted pregnancy, abortion, stillbirth,

morbidity, and mortality in women with high risk sexual behavior (like sex workers) and their children, indicating inadequate reproductive health services and lack of knowledge in these women

2.2 Demographic factors associated with reproductive health of women

Age

The age plays an important role in the process of deciding when women will start and finish the process of giving birth and how long to wait after the birth of the next child. As well as the use of family planning. In a recent study by Sserwanja in 2021, the use of family planning was found to be highest among women aged between 20 – 39 years compared to those below 20 years and above 39 years (Sserwanja, 2021). Rice and Leyland in their study in 1996 reputed that 49% of the women that were using contraceptives were aged 20- 29 years, 41% were aged between 30 - 39 years, while no woman aged 50 years and above was found to be using any form of family planning services.(Rice & Leyland, 2020). Many other studies also show that younger age especially age group (15-24) years was more likely to be associated with use of modern contraceptive.

Examining the relationship of age with access to maternal health care services and information, Okutu (2019) argued that younger (aged less than 20years) and middle aged mothers (aged 20-34years) are more likely to seek pregnancy-related care services from skilled attendants compared to mothers aged 34 and above years in Uganda. Another study by Abajobir_and Seme (2014) on reproductive health knowledge and services utilization among rural adolescents in East Gojjam revealed that age was associated with reproductive health services utilization and knowledge of reproductive health. This is supported by a study conducted in Nigeria by Nwosu, et al. (2018) which found that health seeking behaviour increases with age and decreases at older ages, thus, establishing that age has a relationship with health information seeking behaviour. In the contrary, Reynolds, Wong and Tucker (2019) cited by Kalule-Sabiti, Amoateng and Ngake (2014) found no significant differences between young and old mothers with regard to seeking antenatal and delivery health care services in Uganda

Marital status

Marital status refers to whether one is married or single (de Vargas Nunes Coll et al., 2019). Oyedokun et al. (2017) in his study revealed that family planning varies across marital status with married women using the services most compared to single women due to high incidences of sexual activities compared to single women. Thus contraceptives was aimed at helping to space children and prevent unwanted pregnancy among the married women (Oyedokun ,et al., 2017). With respect to marital status, there is a strong belief that married women in unions are more likely to access maternal health care services and information during their first trimester compared to those who are not.

The positive influence of marital status on the likelihood of using family planning services could be attributed to the fact that couples might decide to postpone raising children by resorting to use of family planning services. A study by Otim in 2020 reputed that the value of the marginal effect simply means that a married woman is 2 percent more likely to use family planning services than a single woman (Otim, 2020). Another study in rural Lagos, Southwest of Nigeria by Afo;ani et al. showed that there was a discrepancy in contraceptive use among married and single women in May of 2015 as the overall utilization of contraceptive use was 51.9% with nonuse of contraceptives among married women being 43% and 67% among singles(Afolabi et al., 2015)

Parity

A study by Oyedokun et al. in 2017 reputed that sex combinations of surviving children and women's education were the most important significant determinants of family planning use and method choice (Oyedokun ,et al., 2017). Mahidu et al. in 2020 stated that the positive influence of the number of living children on the likelihood of using family planning services could be attributed to the woman's desire for children having been satisfied (Mahidu et al., 2017). Feldman et al. in his 2009 study found that out of the women that were using family planning services, 36 percent had 4 – 6 children, followed by those with between 1-3 living children at 30 percent. On the other hand, 17 percent of those respondents using family planning services had between 7 – 9 living 15 children, while 15 percent had no living child. Women in Zimbabwe who had several children wanted to avoid further pregnancies (Feldman et al., 2019). This

reveals that the higher the number of living children, the more the desire to use family planning services.

Place of residence

Many studies support that social factor such as place of residence, affect the contraceptive utilization patterns. A study by Otim in 2020 showed that urban women were found more likely to use contraceptives compared to rural women. These differences were attributed to better availability of social services such as education, access to health services, information and family planning services, majority of the respondents (82.3%) resided in rural areas while only 17.7% resided in urban areas. A statistically significant relationship was found between place of residence and FP uptake. FP uptake was higher among respondents in urban areas (78.6%) relative to those in rural areas (54.7%) (Otim, 2020). Rural/urban residence Studies have shown that rural-urban differences in contraceptive adaptation are the highest in Sub Saharan Africa. In some areas the rate is more than twice as high as among urban than among rural (25). This difference can be attributed to more exposure of urban women to information leading to access to health facilities in terms of good infrastructure and availability of FP services.

One study in Ghana showed that distance to health facilities also influences the use of modern contraceptives where women living more than 2km away from the nearest health centre that provides modern contraceptives were less likely to use contraceptives. In developing countries rural women have difficulties of accessing health facilities compared to women in urban areas due to long distance between the nearest health facility and home.

2.3 Socio-economic factors associated with reproductive health of women

Religion

Srikanthan & Reid, 2018 reputed that religiosity affiliations have been found to have no significant role to contraceptive use and choice, education among the youth had an association consistently (Srikanthan & Reid, 2018). In his study, basing on religious background of the woman, out of the 51 percent that were using contraceptives, 52 percent were Protestants, 35 percent Muslims while only 13 percent were Catholics. This is an indication that use of

contraceptives vary across religion with Catholics using the least. The probability of a woman using family planning services if she was a Catholic was 28 percent lower compared to others with different religious background such as Protestant and Muslims. This is because catholic faith discourages its faithful from using contraceptives as birth control measures. This finding clearly indicates a significance difference in the use of family planning services between Catholics and other religions. Neeti et al, 2017 explored the perceptions and attitudes of Muslim women towards FP and currently available contraceptives and facilitating factors and barriers that determine adoption of contraception especially terminal methods.

Partner's consent in making a final decision

The most important determinant of the likelihood of the respondents in slums using family planning services was partners' approval, 56 percent of the women sought approval before using contraceptives, while 23 percent did not bother (Raiford et al., 2018). The remaining 21 percent of the respondents were however uncertain an indication that they were either not having a regular sexual partner whom they could seek approval from, or that they were not sexually active. The high percentage of those who sought approval from a partner clearly indicates the importance of a partner's consent in making a final decision on use of family planning services. Another study by Wolff et al. in 2000 reputed that the wife and husband's approval of FP use positively influenced the adoption of all methods. Partner opposition was found to cause a statistically significant increase in unmet need accounting for as much as 20 percent of unmet need reported by women (Wolff et al., 2020).

Peer influence

There are individual factors that determine a person's use of services such as FP is mediated by the characteristics of the community in which the individual lives. It is important to look beyond individual factors when examining FP use or non-use (Stephenson & Tsui, 2019). Disapproval by friends, neighbors and relatives, stories from social networks proved to be more salient than medical opinions in shaping safety and perceptions. Women with strong social networks such as friends are likely to use short term methods.

Income

A study in Kenya by Sharma et al. in 2020 showed that out of the total number of women using contraceptives, 31 percent had an average monthly income of Ksh 20,000 and above while 28 percent had an average monthly income of between Ksh.15, 000 to 20,000. On the other hand, 7 percent of users had an average monthly income of less than 5,000. Those with no income were, however, the least users of family planning services. The results thus reveal that in the absence of an income source, usage of family planning would decline. The lower the economic status of the households, the higher the non-users.

Education

Education is a strong determinant of modern contraceptive utilization and exposes women to reproductive health information and empowers them to make appropriate decisions. A study in Uganda by Assiimwe et al. in 2004 showed that increase in education levels were significantly associated with high contraceptive use. Contraceptive nonuse among less schooling women can be associated to lack of knowledge, fatalism, and lack of contraceptive access. However no study in Uganda can justify the differences in effect of women's educational level on contraceptive nonuse across all regions(Otim, 2020). In another study by Sultan Ayaz and Sengul Yaman in 2019, It was found that women who had a primary school graduate or higher education, had 1–3 pregnancies and did not want more children in the future got higher scores on the family planning attitude scale(Sultan Ayaz and Şengül, 2019). As the level of education increases, the number of children required decreases. The reason for this can be explained by the opportunity to learn about family planning and to raise awareness about the issue.

Mswia, et.al. (2018) conducted a study to examine the progress made towards the Safe Motherhood Initiative goals in three areas of the United Republic of Tanzania. The result shows that higher educational status at the community level relates strongly to lower maternal mortality. It specifically found that an additional year of education for household heads at the community level, was associated with a 62% lower maternal death rate. It is assumed that the additional education achieved enabled them to gain additional health knowledge through enhanced access to and utilization of health information. This is buttressed by Idowu, Osinaike and Ajayi (2022)

who asserts that the influence of education on maternal health care and information access could be derived from the various dimensions of the educational experience such as the impartation of literacy skills, which enables people to process a wide range of information and stimulate cognitive development. Graczyk (2018) acknowledged that lack or inadequate education can affect health when it limits young women's knowledge about nutrition and births

2.4 Gaps in literature

Several studies have been carried out in the area of maternal health. While majority of them have concentrated on the medical factors that affect maternal health, few others have focused on the socio-demographic factors related to maternal health care use (Falkingham, 2022; Ogujuyigbe and Liasu, 2021 and Zuzulya, 2021). No attention has been paid to relationship between prevalence and socio-demographic variables with access and utilization of maternal health information in achieving reduction of maternal mortality and morbidity. This study therefore is concentrated on filling this gap in literature.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methodology that was used in the study and some of the areas that will be covered include: research design, area and population of the study, sample size, sample selection technique, sources of data, data collection instruments, data quality control and data analysis

3.2 Research Design

The research study used cross-sectional design using both qualitative and quantitative research approaches to analyze the effect of gender empowerment on house hold incomes. This design will help the researcher to generate more sufficient data and relevant information that support the variables and objectives of the research study

3.3. Study Population

The study targeted pregnant and non-pregnant mothers in reproductive age (15-49) and midwives in ANC clinics.

3.4 Sample size

The total population (N) is 220 people and therefore the sample population shall be 140 persons using Krejcie and Morgan (1973) methods of determining sample size from the population.

Table 3.1 Summary of the Sample Size and Sampling Technique

Category	Target population	Sample size	Sampling techniques
Pregnant mothers	100	40	Simple random sampling
Non pregnant mothers	100	24	Simple random sampling
Midwives	20	16	Purposive sampling
Total	**220**	**140**	

Source: Sample size according to Coach run formula

3.5 Sampling Techniques

The researcher used the following sampling techniques:

3.5.1 Purposive Random Sampling

Purposive sampling technique was used because some individuals in the population have special knowledge that makes them become “privileged” to participate for the purpose of the study. According to Kothari (2020) purposive sampling is a type of sampling where the researcher purposively chooses persons who, in his judgment about some appropriate characteristic required of the sample members are thought to be relevant to the research topic and are easily available. A purposive, or judgmental, sample was used because respondents in parent category were selected randomly based on the knowledge they have regarding the purpose of the study.

3.6 Research Instruments

The researcher used both questionnaires and interview guide.

3.6.1 Questionnaire

The researcher used self-administered questionnaire as research tool to collect data from the parents’ category. The questionnaire had three sections: Section A included the respondents’ demographic information, Section B, C and D focused on the general and closed ended statements. The researcher got a list of community members selected through stratified random sampling to which the questionnaires were administered to pregnant and non pregnant mothers of the sampled population and district staffs were purposively selected for to provide information

According to Fisher (2004), a questionnaire is used because it is easy to administer, not so expensive, and help to collect unbiased data. The nature of the questions were in form of structured and close ended questions where by a 5 Likert scale of measurement was on close ended questions based on a scale of strongly agree (5), agree (4), unsure (3), disagree (2), strongly disagree (1).A questionnaire was used because it allowed respondents to provide fist hand information which is free of bias and it is also easy to use

3.6.2 Key informant interviews

This is a qualitative in-depth interview with people who know what is going on in the community (Saunders, et al, 2017). The researcher interviewed mid wives, non pregnant mothers and midwives. The purpose of key informant interviews is to collect information from a wide range of people including professionals and residents who have firsthand knowledge about the community.

3.7 Data quality control tools

3.7.1 Validity and reliability

The validity and reliability of research instruments was arrived at by carrying out a pretest method and in SPPS at 95% confident level.

3.8 Data Processing and Analysis

3.8.1 Bivariate analysis

This is a form of quantitative analysis involving two variables for the purpose of determining empirical relationship between them and it is helping in testing simple hypothesis of association.

3.9 Ethical Considerations

The researcher used every opportunity available to protect respondents from harm. Respondents will be assured of confidentiality through explaining to them the purpose of this research study respondent's identity was held anonymous. Participations in the research study was based on the principle of voluntary and informed consent where respondent after getting information about the research study chosen either to participate or not.

CHAPTER FOUR

ANALYSIS OF STUDY FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents on data analysis and interpretation based on the study objectives identified earlier. It begins with the analysis of the demographic data as seen below;

4.2 Background characteristics of the respondents

The first part of this chapter is a presentation and analysis of preliminary data obtained from the study. It includes the background information of the respondents and the variables involved are age (in years), gender of respondents, educational level and marital status**.** Data obtained has been presented in tables below.

Table 4.2 contains the age distribution of respondents who participated in the study. The purpose was to find out the average age of respondents in the study area. Table 2 show that the majority 54% of the study respondents were between 40 to 49 years of age. The findings of the study imply that since majority of the respondents were 40 years above, this mean that they were mature enough and information acquired from them was reliable. Old age has been viewed by several studies as important in determining responses on factors that determine individual economic well-being.

Table 4.1: Frequency and percentage distribution of respondents' background information

Variables	Category	Frequency	Percent (%)
Age	21- 29	60	42
	30-39	43	31
	40-49	38	27
Marital Status	Single	30	21
	Married	77	55
	Widow	10	8
	Separated	23	16
Education level	Primary	40	29
	Secondary	68	49
	Post-Secondary	32	22
Sex	Male	82	58
	Female	58	42

Source: *Primary Data 2024*

The respondents were asked to indicate their sex by ticking the appropriate column they belonged. The purpose was to find out the number of males and females who actually participated in the study.

The study findings revealed that out of the 140 respondents who participated in the study, majority 58% were males. The finding means that there are more male than females who participated in the study, studies have revealed that males and females have different attitudes and views towards individual economic well-being and since females are home makers, they tend to remain at home and this explains their low level of access to reproductive health (Singer, 2020).

Findings in table 4.1 above show that the majority (55%) of respondents were married. Marital status has implications on access to reproductive health by women single mother mothers find it difficult in making productive decision.

Further, according to the findings of the study in table 4.1 shows that majority of the respondents have attained some level of education whose opinions and views regarding access to reproductive health can be trusted. This is in line with Umar (2021) who argued that it is important in social investigation research to involve people that have attained an acceptable level of literacy and numeracy in order to be in position to understand and interpret content in the questionnaire and give valid responses.

4.2 Reproductive Health enhancement of women

The findings from the present study assessed Reproductive Health enhancement in form of a linkert scale (SD=Strongly Disagree, D=disagree, NS- Not Sure, A=Agree and SA= Strongly Agree)

Table 4.2: Showing Reproductive Health enhancement of women

Question statements	SD	D	NS	A	SA
Poor attitudes by women towards health facilities has limited access to RH services	9%	7%	19%	39%	24%
Poverty limited access to RH services	5%	16%	24%	49%	9%
Low education levels of women limited access to RH services	4%	11%	11%	56%	18%
Unavailability of RH services limited access to RH services by women	5%	10%	15%	66%	4%

Source: Primary data, 2024

The study investigated whether limited decision making by women hinder access to reproductive health. According to the findings in the table 4.2 above, 49% of the respondents agreed that limited decision making by women hinder access to reproductive health. The above results therefore mean that limited decision making by women hinder access to reproductive health.

Even during interviews, one of the respondents reported that, *"……….women's lack of decision making power directly constrains them from making accessing reproductive health services"*.

Study findings in the table 4.2 above show that 29% of the respondents agreed that women's gender roles do not favor access to reproductive health. This finding implies that women's gender roles do not favour access to reproductive health and this was supported by qualitative data collected from interviews was it was revealed that women's gender roles do not favour access to reproductive health "*………….our gender roles which includes digging, collecting firewood, fetching water and cooking do not allow us time to go and look for reproductive health services*", Lydia reported.

The study findings also revealed the majority (56%) of respondents strongly agreed that gender stereotypes prohibits women from accessing reproductive health. This is because gender stereotypes leads to exclusion and social stigma against women and this makes them fail to access reproductive health. This finding was backed up by data collected during interviews where participants also mentioned that gender stereotypes prohibits women from accessing reproductive health. *"Gender stereotypes against women are common here making it harder for women to access reproductive health…………..."*Sandra reported.

Study findings in table 4.2 also revealed that gender discrimination hinder access to reproductive health by women as 66% of respondents agreed with the statement. This is because gender discrimination does not allow universal access and ultimately prevents its victims from accessing reproductive health. Even qualitative data collected from respondents from interviews reveals that gender discrimination hinder access to reproductive health by women. "…………*gender discrimination greatly hinder access to reproductive health by women"* said Florence.

4.3 Demographic factors associated with enhancing reproductive health of women

The findings from the present study assessed demographic factors associated with enhancing reproductive health of women in form of a linkert scale (SD=Strongly Disagree, D=disagree, NS- Not Sure, A=Agree and SA= Strongly Agree)

Table 4.3: Showing demographic factors associated with enhancing reproductive health of women

Question statements	SD	D	N	A	SA
Age determines access to reproductive health where young women of lower ages do not access reproductive health	12%	15%	23%	36%	14%
Marital status where single mothers have limited access to reproductive health	14%	14%	20%	28%	24%
Place of residence where women in rural areas of residence have limited access to reproductive health	12%	15%	18%	31%	24%
Some religious beliefs do not reproductive health	0%	10%	36%	45%	9%

Source: Primary data, 2024

The study investigated whether age determines access to reproductive health where young women of lower ages do not access reproductive health and study findings in table 4.3 above revealed that the majority (36%) of the respondents agreed to the statement that age determines access to reproductive health where young women of lower ages do not access reproductive health. This finding therefore implies that age determines access to reproductive health where young women of lower ages do not access reproductive health and data collected from interviews show that age determines access to reproductive health where young women of lower ages do not access reproductive health where one of respondents reported:

"…………..young women of lower ages do not access reproductive health".

The researcher further investigated whether marital status where single mothers have limited access to reproductive health revealed that the majority (28%) of respondents agreed that to the statement that marital status where single mothers have limited access to reproductive health. This finding is in line with the qualitative data collected from respondents during interviews where Juliet reported that:

"………..single mothers have limited access to reproductive health because they lack someone close to consult".

This findings thus implies that marital status where single mothers have limited access to reproductive health

Further, the study also investigated whether place of residence determines access where women in rural areas of residence have limited access to reproductive health. The majority of (31%) respondent strongly agreed with the statement noting that the place of residence determines access where women in rural areas of residence have limited access to reproductive health. Even respondents during interviews mentioned that place of residence determines access where women in rural areas of residence have limited access to reproductive health where Nandutu (Midwife) said that:

"…………… women in rural areas of residence have limited access to reproductive health services".

This finding therefore implies that place of residence determines access where women in rural areas of residence have limited access to reproductive health

The present findings also revealed that the majority (45%) of the respondents agreed that some religious beliefs do not reproductive health. Even qualitative data collected from interviews show that some religious beliefs do not reproductive health where Paul, a respondent explained that

"……………..my religion does not allow women to use reproductive health services apart from natural remedies only".

This therefore implies that some religious beliefs do not reproductive health.

4.4 Socio-economic factors associated with enhancing reproductive health of women

The findings from the present study assessed socio-economic factors associated with enhancing reproductive health of women in form of a likert scale (SD=Strongly Disagree, D=disagree, NS-Not Sure, A=Agree and SA= Strongly Agree)

Table 1.4: Socio-economic factors associated with enhancing reproductive health of women

Question statements	**SD**	**D**	**N**	**A**	**SA**
Income where poor women with low income level do not access reproductive health	12%	14%	20%	42%	22%
Peer influence determine accessibility to reproductive health	12%	13%	22%	35%	18%
Level of education of women determine accessibility reproductive health	12%	13%	14%	45%	16%
Income where poor women with low income level do not access reproductive health	13%	14%	22%	35%	16%

Source: *Primary data, 2024*

The study investigate whether income where poor women with low income level do not access reproductive health. Results in table 4 above show that about 42% of the respondents agreed with the statement that poor women with low income level do not access reproductive health. This was backed by qualitative data where most of respondents stated that poor women with low income level do not access reproductive health *".....poor women in my area find it hard accessing reproductive health"* Mudenya, a pregnant mother reported. This therefore implies that poor women with low income level do not access reproductive health

Based on the current study, it was revealed in the table 4.4 above that peer influence determines accessibility to reproductive health as majority of respondents (35%) agreed to the statement. Similar findings were obtained from face to face interviews where it was found that peer influence determines accessibility to reproductive health.

*"……..peer influence determines accessibility to reproductive health by women….."*Muhammed said. This finding therefore implies that peer influence determines accessibility to reproductive health.

Additionally, study findings show that level of education of women determine accessibility reproductive health where the majority (45%) of respondents agreed with the statement that noting that level of education of women determine accessibility reproductive health. This finding was also reported in qualitative data obtained from interviews where Namusabi said that: "……………. *level of education of women determine accessibility reproductive health as women without any education do not have information about various reproductive health services available"*

From the findings in table 4.4, the majority 35% of the respondents agreed that income where poor women with low income level do not access reproductive health. Even qualitative data from interviews show that "……………… income where poor women with low income level do not access reproductive health*",* reported by a respondent.

4.6 Discussion of the findings

Enhancement of RH services of women

Poor attitudes by women towards health facilities have limited access to RH services and this was supported by 39% of the respondents who participated in this study. Even the findings of Abdulai and Crole Rees, (2021) found that poor attitudes by women towards health facilities have limited access to RH services.

Study findings also show that poverty limited access to RH services by women where 29% of the respondents agreed. This finding is also supported by the findings of the research study by Adetunji and Adepoju (2019) where it was reported that poverty limited access to RH services.

Barrett and Reardon (2020) found that low education levels of women limited access to RH services and this supports the finding of this study where 40%) of respondents strongly agreed that low education levels of women limited access to RH services.

During the study, it was revealed that unavailability of RH services limited access to RH services by women as 46% of respondents agreed with the statement. Even Berkvens' (2019) finding show that unavailability of RH services limited access to RH services by women.

Demographic factors associated with enhancing reproductive health of women

Researchers such as Campbell, Kozanayi, and Luckert (2022) found that age determines access to reproductive health where young women of lower ages do not access reproductive health and similar findings was also discovered by this study where majority respondents (36%) respondents agreed to the statement that age determines access to reproductive health where young women of lower ages do not access reproductive health.

Marital status where single mothers have limited access to reproductive health and this was revealed in the findings of Chambers and Conway (2018). The findings of this study is also in line with the findings of Chambers and Conway (2018) where it was found that marital status where single mothers have limited access to reproductive health with the majority (28%) of respondents supported the statement.

The study findings of Argawal (2019) argued that place of residence determines access where women in rural areas of residence have limited access to reproductive health and this singing supports the findings of this study where it was discovered that place of residence determines access where women in rural areas of residence have limited access to reproductive health with majority of (31%) respondents strongly agreed with the statement.

According to Chambers (2017), some religious beliefs do not reproductive health. This supports the finding of the present study where it was noted that present by 45% of the respondents that some religious beliefs do not reproductive health. Even qualitative data collected from interviews show that some religious beliefs do not reproductive health.

Socio-economic factors associated with enhancing reproductive health of women

The study found that poor women with low income level do not access reproductive health with 43% (majority) supporting the statement. This is in line with the study results of the research study carried out by Bryceson (2022) where it also discovered that poor women with low income level do not access reproductive health.

Abdulai and Crole Rees (2021) found that peer influence determines accessibility to reproductive health and similar finding was obtained by this study where it was found that by the majority of respondents (42.5%) that peer influence determines accessibility to reproductive health.

According to Cleaver (2019), level of education of women determines accessibility reproductive health and this finding is in line with results of this study where it was revealed by majority (45%) of respondents both in quantitative and qualitative data that level of education of women determines accessibility reproductive health.

Study findings show that income where poor women with low income level do not access reproductive health. This is in line with the findings of Department for International Development (DFID), (2019) where it was found that income where poor women with low income level do not access reproductive health.

CHAPTER FIVE

SUMMARY CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusion, and recommendations about the study. It also presents at areas for further research.

5.2 Summary

The findings of the research study show that poverty (39%) hinder access to reproductive health services by women alongside low education levels (29%). In addition, socio-demographic factors of age (36%) and place of residence (rural or urban) (45%) determines access to reproductive health of women. Further, socio-economic factors such as such as income levels (42%), peer influence (53%) and levels of women's education have been cited as central determinants of access ton reproductive health of women,

5.3 Conclusion

In conclusion, poverty, poor attitudes towards health facilities and residing in rural areas with low income and low educational levels have been found to have less or no access to reproductive health.

5.4 Recommendations

The Ministry of Health (MoH) together with Gender, Labour and Social Development counterpart should strengthen enforcement of policies regarding universal access to reproductive health by women, curtail social exclusion and improve availability, accessibility and utilization of reproductive health by women.

Also, the government should reduce taxation on entrepreneurial businesses so as to boost economic household income through Business Incubation, skilling and Parish Development Model (PDM) for the empowerment of marginalized and economically unsound persons including women groups.

5.5 Areas for further study

Socio-economic exclusion and empowerment of women in

REFERENCE

Abdulai, A. and Crole Rees, A. (2021).Determinants of income diversification amongst rural households in Southern Mali.*Journal of Food Policy*. 26:437-452.

Adar, G. (1996). *Women in the Changing Kibbutz.* Haifa: Institute for Research on the Kibbutz.

Adetunji M.O. and Adepoju A. (2019).Household resource management by rural women in Ibarapa East Local Government Area of Oyo State.*Journal of AppliedSciences Research*. 5(6):636-644.

Akram-Lodhi, A.H. (2017). The unitary model of the peasant households.*Journal of Economic Issues.*2(1):27-42.

Argawal, B. (2019). The gender and environmental debate: Lessons from India. *Journalof Feminist Studies.*18(1):119-158.

Barrett, C. B., Reardon, T., and Webb, P. (2021). Nonfarm income diversification and household livelihood strategies in rural Africa: Concepts, dynamics and policy implications. *Journal of Food Policy.* 26(4):315–331.

Barrett, C. B. and Reardon, T. (2020). *Asset, Activity and Income Diversification AmongAfrican Agriculturalists, Some Practical Issues*. Project report to the USAIDBASIS CRSP, March 2020.

Berkhout, F., Leach, M., and Scoones, I. (2023). *Negotiating Environmental Change: New Perspectives from Social Science.*UK: Edward Elgar Publishing.

Berkvens, C.B. (2019). Immerized growth in liberalized agriculture.*Journal of WorldDevelopment.*26(5):745-753.

Briones, A. (2022). *Organic Agriculture and Rural Poverty Alleviation:Potential and Best practices in Asia.* Bangkok, Thailand: United Nations

Economic and Social Commission for Asia

Bryant, L. and Pini, B. (2019). Gender, class and rurality: Australian case studies.

*Journal of Rural Studies.*25(1):48-57.

deBruaw, A. and Rozelle, S. (2022). *Household Investment through Migration in RuralChina.Working Paper*. University of California: Department of Agricultural and

Bryceson, D. (2022). The scramble in Africa: Reorienting rural livelihoods. *Journal ofWorld Development.*30(5):725–739.

Carr, E.R., (2015). Development and the household: Missing the point? *Journal ofGeojournal.*62(1):71-83.

Carr, E.R., (2018). Men’s crops and women’s crops: The importance of gender to the understanding of agricultural and development outcomes in Ghana’s Central Region. *Journal of World Development.* 36 (5):900–915.

Campbell, S., Kozanayi, W., and Luckert, M. (2022).*Household Livelihoods in Semi-*

Arid Regions: Options and Constarints. GFOR.

Countryside Agency (2023).*The Role of Women in the Rural Economy: An ImportantRural Resource.* Wetherby: Countryside Agency.

Chambers, R. and Conway, G. (2018). *Sustainable Rural Livelihood: Practical ConceptsFor the 21st Century.* UK: Institute for Development Studies.

Chambers, R. (2017). *Whose reality Counts? Putting the First Last. Intermediate.*

London:Technology Publications.

Chant, S. (1994). Women, work, and household survival strategies in Mexico 1982-1992:

Past trends, current tendencies and future research. *Journal of LatinAmerican Studies*. 13(2):203-223.

Cleaver, F. (2019). Choice, complexity and change: Gendered livelihoods and management of water. *Journal of Agriculture and Human Values.* 15(4):293-299.

Deere, C.D., Duran, R.L., Mardon, M., and Masterson, T. (2004).*Female Land Rightsand Rural Enhancing reproductive health and social rights of women in Brazil, Paraguay and Peru.Working Paper, 2004-08*. Amherst: University of Massachusetts.

Department For International Development (DFID), (2019) *Sustainable livelihoodguidancesheets.* http://www.livelihoods.org/info/info_guidanceSheets.html05July 2018.

APPENDICES

APPENDIX I: CONSENT LETTER

I am **NAMUHENGE MORREN** a student of Uganda Christian University, currently undertaking research on a topic "Effects of gender empowerment on enhancing reproductive health and social rights of women ." You are privileged to participate in this research and your selection has been based on random sampling. Please feel free as you respond because the information you give will only be used for academics purposes, treated confidential and will be held anonymous before publication.

Thank you

SECTION A: REPONDENT'S BIO - DATA

INSTRUCTIONS

Please fill in the blank spaces or tick in the boxes provided where necessary.

1. Name: (optional)

   ……………………………………………………………………………………………….

2. Age: 15 – 30 ☐ 31 – 45 ☐ 46 – 60 ☐ 60 + ☐
3. Sex: Male ☐ Female ☐
4. Marital status: Single ☐ Married ☐ Divorced ☐ Separated Widowed ☐ ☐
5. Location:

   Cell ……………..………… Parish ………..……….. Sub – county ………………………….

6. Levels of education:

   None ☐ Primary ☐ Secondary ☐ Tertiary and above ☐

   Other (please specify)

   …………………………………………………………………………………………………

   …………………………………………………………………………………………………

7. Religion: Protestant ☐ Catholics ☐ Muslims ☐ Born again ☐

   Others (please specify)…………………………………………………………………

SECTION B: QUESTIONNAIRE FOR PREGNANT AND NON-PREGNANT MOTHERS

SA	A	NS	D	SD
Strongly agree	agree	Not Sure	Disagree	Strongly disagree

Reproductive health enhancement for women						
1.	Poor attitudes by women towards health facilities has limited access to RH services	1	2	3	4	5
2.	Poverty limited access to RH services	1	2	3	4	5
3.	Low education levels of women limited access to RH services	1	2	3	4	5
4.	Unavailability of RH services limited access to RH services by women	1	2	3	4	5
Demographic factors associated with enhancing reproductive health of women						
8.	Age determines access to reproductive health where young women of lower ages do not access reproductive health	1	2	3	4	5
10.	Marital status where single mothers have limited access to reproductive health	1	2	3	4	5
11.	Place of residence where women in rural areas of residence have limited access to reproductive health	1	2	3	4	5
12.	Some religious beliefs do not reproductive health	1	2	3	4	5
Socio-economic factors associated with enhancing reproductive health of women						
15.	Income where poor women with low income level do not access reproductive health	1	2	3	4	5

16.	Peer influence determine accessibility to reproductive health	1	2	3	4	5
18.	Level of education of women determine accessibility reproductive health	1	2	3	4	5
19.	Income where poor women with low income level do not access reproductive health	1	2	3	4	5

Thank you

INTERVIEW GUIDE FOR MID WIVES

1. What is your occupation?
2. What challenges do women face in accessing reproductive health?
3. How has reproductive health of women been enhanced in Bunyafa Sub-County, Sironko district?
4. What are the socio-economic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district?
5. What are the socio-demographic factors associated with enhancing reproductive health of women in Bunyafa Sub-County, Sironko district?

APPENDICE 11

Work plan schedule

Duration / Activity	J	F	M	A	M	J	J	A	S	O	N	D
Developing Questionnaires				■								
Data collection					■	■						
Data processing and analysis							■					
Writing Draft and Final Report								■				
Submission of Report									■			

APPENDICE 11I

BUDGETARY ESTIMATES

S/No	ITEM (S)	Quantity (qty)	Unit cost (Ugshs)	Total Coast (Ugshs)
01	Printing/ photo copying papers	1 ream	20,000	20,000
02	Ruled papers	1 ream	16,000	16,000
03	Flash disk	1 (2GB)	40,000	40,000
04	Pens, pencil and note book	Assorted	10,000	10,000
05	Photocopying expenses	45 PAGES	@100	4500
06	Word typesetting expenses	45 PAGES	@1000	45,000
07	Spiral binding expenses	3 BOOKS	@5000	15,000
08	Airtime		10,000	10,000
09	Transport expenses		50,000	50,000
10	Contingency		50,000	50,.000
11	**TOTAL**			**400,000**

UGANDA CHRISTIAN UNIVERSITY
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Office of the Academic Registrar

To THE SENIOR
ASSISTANT SECRETARY BUNYAFA S/C

SENIOR ASSISTANT SECRETARY
28 FEB 2024
BUNYAFA SUB-COUNTY

Received on 28/2/2024 & allowed to carry out her research. WEZIBA GERSHOM

Dear Sir/Madam,

Re: Academic Research

Christian greetings!

We are honored to introduce to you Mr. Mrs./Miss NAMUKHENGE MORREN

Of Registration Number; S22/MUC/BSW/048 pursuing a Masters' Degree/Postgraduate Diploma / Bachelor's Degree BSWASA

He/ she is required to carry out an academic research on the topic
SOCIO-ECONOMIC AND DEMOGRAPHIC FACTORS
ASSOCIATED WITH ENHANCING REPRODUCTIVE HEALTH OF WOMEN IN BUNYAFA S/C

and thereafter produce a well bound hard cover research report (**MAROON**) in color for undergraduate and three (**BLACK**) copies for Postgraduate students as a University requirement for the award of a degree/diploma in the academic discipline that he / she is pursuing.

We shall be grateful for the help you may offer to him or her accordingly.

Thank you.

Yours faithfully,

UGANDA CHRISTIAN UNIVERSITY
22 FEB 2024
ACADEMIC REGISTRAR
MBALE UNIVERSITY COLLEGE

Mr. Akampurira Timothy

Academic Registrar