AVAILABILITY AND ACCESSIBILITY OF SEXUAL REPRODUCTIVE HEALTH SERVICES FOR WOMEN REFUGEES: A CASE OF KYANGWALI REFUGEE SETTLEMENT, MARATATU D ZONE

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RS19M13/113

A DISSERTATION SUBMITTED TO THE SCHOOL OF SOCIAL SCIENCES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A DEGREE OF MASTER OF DEVELOPMENT STUDIES OF UGANDA CHRISTIAN UNIVERSITY

July, 2026

UGANDA CHRISTIAN UNIVERSITY
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DECLARATION

I, INNO DAPHINE, hereby declare that to the best of my knowledge, the dissertation presented is in its original state and has never been presented for any academic award in any institution of higher learning.

Signature:

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Date: **16th July 2026**

APPROVAL

I certify that I have read and hereby approve the submission of corrected dissertation entitled "**Availability and Accessibility of Sexual and Reproductive Health Services for Women Refugees: A Case of Kyangwali Refugee Settlement, Maratatu D Zone" as** per the recommendations of the examiners in partial fulfilment of the requirements for the award of the **Master of Development Studies** degree.

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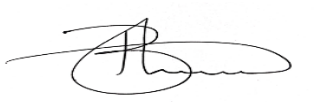

LIINO BUKENYA Date: **17th July 2026**

SUPERVISOR

DEDICATION

I dedicate this dissertation to my parents, Mr. Ichuma Mathew and Mrs. Amusugut Topister, for their steadfast support towards my academic journey.

ACKNOWLEDGEMENT

I express gratitude to the Almighty God for granting me the opportunity to complete this dissertation.

Special thanks to my parents for their constant provision and encouragement, shaping me into a responsible woman; may God bless them. I extend my appreciation to my University Supervisor, Mr. Lino Bukenya, for his continuous and invaluable guidance in my research, along with my lecturer, Mr. Mwije Solomon, for his insightful advice.

I am grateful to the Office of the Prime Minister under the department of refugees for granting me permission to conduct my study among women refugees in Kyangwali refugee settlement. In a special way, I extend my sincere gratitude to all the respondents at Maratatu D zone, Kyangwali refugee settlement, especially the women refugees (15-49) and key informants, for their instrumental participation in this study by sharing the essential information I required. I would also like to express my appreciation to my translator Ochola David, for skilfully translating the questions to respondents, particularly those who had limited proficiency in English.

Lastly, heartfelt thanks to my friends, Nasolo Jacob, Babu Teddie, Muyanja Ronald Kwagala, Babyesiza Geoffrey and my siblings, Kizza Byron, Asere Constance Ichuma, Imoni Joseph Ichuma, and Nyakoojo Marcus Ichuma, for their constant encouragement throughout my research journey.

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LIST OF ABBREVIATIONS

AAH-U	Action Africa Help-Uganda
ANC	Antenatal Care
ART	Antiretroviral Therapy
CERF	Central Emergency Response Fund
GBV	Gender-Based Violence
GIS	Geographical Information Systems
GOU	Government of Uganda
HIV/AIDs	Human immunodeficiency virus/acquired immunodeficiency syndrome
HPV	Human Papillomavirus
HSIRRP	Health Sector Integrated Refugee Response Plan
IGAD	Intergovernmental Authority on Development
IRC	International Rescue Committee
LWF	Lutheran World Federation
MTI	Medical Team International
NGOs	Non-government Organizations
OPM	Office of the Prime Minister
REHOPE	Refugee and Host Population Empowerment
SGBV	Sexual Gender-Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Right

SRHS	Sexual Reproductive Health Services
STIs/STDs	Sexually Transmitted Infections/Sexually Transmitted Diseases
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations Commissioner for Refugees
VHTs	Village Health Teams
WHO	World Health Organization

ABSTRACT

This study evaluated the SRH Services Availability and Accessibility of women refugees in Kyangwali refugee settlement, Maratatu D Zone. The research design adopted was mixed-methods research which incorporated questionnaires, interviews, observation and a review of the secondary documents. Participants were selected using simple random and purposive sampling techniques and the data analyzed to identify the types of services available, level of access to services and barriers to service utilization.

The results revealed that there was availability of maternal health support and HIV testing services, which were generally acceptable to respondents. But there were still some services that were not available, such as psychological counselling, female condoms and contraceptive options. Long distance to health centres, transportation difficulties and language barriers were found to be significant barriers to access to sexual and reproductive health services.

The study findings indicate that SRH services are available in Kyangwali Refugee Settlement, but there are gaps in ensuring equitable access to SRH services for refugee women. It suggests increasing outreach of contraceptive services, enhancing the availability of reproductive health commodities, increasing psychosocial support, and creating safe facilities, and tackling transport and economic challenges to increase access to quality sexual and reproductive health services.

CHAPTER ONE

INTRODUCTION

1.0 GENERAL INTRODUCTION

Chapter one of this study presents the general introduction which consists of the following: introduction, background to the study, statement of the problem, the purpose of the study, research objectives, research questions or hypotheses, scope of the study, Justification of the study, the significance of the study, and the conceptual framework.

1.1 Introduction

One of the greatest humanitarian and health challenges in the world today is forced displacement. Today millions of people are still displaced, seeking refuge and protection as a result of armed conflict, political instability, persecution, human rights violations, natural disasters, climate change and economic crises. The forced displacement of people has grown substantially in the last ten years, as a result of long and protracted conflicts in a number of countries, including Syria, South Sudan, the Democratic Republic of Congo (DRC), Afghanistan, Myanmar and most recently Ukraine (UNHCR, 2022b). Women and children are the primary victims of displacement and are often vulnerable during displacement, particularly in terms of their health, social and economic status. Sexual and reproductive health (SRH) services are vital to the humanitarian response because refugee women face multiple risks to their reproductive health due to disrupted health systems and separation from family members, poverty, insecurity, and limited access to essential services.

Sexual and reproductive health includes a wide variety of preventive, promotive, curative and rehabilitative health services designed to help people enjoy a complete state of physical, mental and social well-being in every aspect of sexual and reproductive health. Sexual and reproductive health is a fundamental human right that ensures women and girls have the autonomy to make decisions about their reproductive

lives, lowers the risk of preventable maternal deaths, unintended pregnancies and unsafe abortions, and decreases the occurrence of gender-based violence and sexually transmitted infections (STIs) (WHO, 2022; UNFPA, 2019). Services needed for SRH include family planning, antenatal services, skilled birth attendance, emergency obstetric services, postnatal services, HIV and other STI prevention and treatment, cervical cancer screening, sexual and gender-based violence prevention and treatment, infertility services, and comprehensive sexuality education (UNFPA, 2019). These services are especially critical in humanitarian contexts where women are at higher risk of sexual violence, poor maternal health care and restricted access to essential reproductive health services and interventions that could save their life.

Numerous studies have shown the impact of good access to SRH services on health outcomes for women of reproductive age. Access to family planning means allowing women to have birth at the appropriate time and space and avoid unwanted pregnancies, which helps to lower maternal and neonatal mortality rates. Likewise, attendance at ante- and post-natal services enables detection and management of pregnancy-related complications at an early stage and skilled birth attendants helps prevent the death of mothers and infants. Prevention and treatment of sexually transmitted infections, including HIV, also help to promote reproductive health and well-being. As a result, low access to SRH services has been linked to higher rates of maternal morbidity and mortality, unsafe abortions, incomplete medical attention for RLTIs, suboptimal neonatal outcomes, and reduced QOL of IDPs (WHO, 2022; UNFPA, 2019).

Access to sexual and reproductive health is thus an integral part of international humanitarian action. International organizations like the United Nations High Commissioner for Refugees (UNHCR), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), and humanitarian partners have created policy frameworks and operational guidelines, which focus on ensuring equitable access to SRH services for refugee populations. These frameworks highlight that refugee people should be provided with health services similar to those available to their host populations, and without discrimination. However, although policy commitments have

been made, access to quality SRH services is still inequitable in many countries hosting refugees, due to resource limitations, poor health infrastructure, lack of skilled personnel, socio-cultural barriers, language barriers, insecurity, and growing refugee populations straining the capacity of existing health systems.

One of the greatest humanitarian and health challenges in the world today is forced displacement. Millions of people continue to be displaced today and take refuge and protection due to armed conflict, political instability, persecution, human rights violations, natural disasters, climate change and economic crises. Over the past decade there has been a significant rise in forced displacement, due to the protracted and prolonged nature of conflict in several countries, such as Syria, South Sudan, the Democratic Republic of Congo (DRC), Afghanistan, Myanmar and most recently Ukraine (UNHCR, 2022b). Women and children are the primary victims of displacement and are often vulnerable during displacement, particularly in terms of their health, social and economic status. Multiple risks to refugee women's reproductive health linked to disrupted health systems and separated family members, poverty, insecurity, and lack of access to essential services are all linked to sexual and reproductive health (SRH) services being critical to the humanitarian response.

Sexual and reproductive health includes a wide variety of preventive, promotive, curative and rehabilitative health services designed to help people enjoy a complete state of physical, mental and social well-being in every aspect of sexual and reproductive health. Sexual and reproductive health is a fundamental human right that ensures women and girls have the autonomy to make decisions about their reproductive lives, lowers the risk of preventable maternal deaths, unintended pregnancies and unsafe abortions, and decreases the occurrence of gender-based violence and sexually transmitted infections (STIs) (WHO, 2022; UNFPA, 2019). Services required for SRH comprise family planning, antenatal care, skilled birth attendance, emergency obstetric care, post-natal care, HIV and other STI prevention and treatment, cervical cancer screening, sexual and gender-based violence prevention and treatment, infertility care and comprehensive sexuality education (UNFPA, 2019). These services are particularly important when a woman is living in a humanitarian situation and she

is more likely to be at risk of sexual violence, having limited access to maternal health care and/or necessary reproductive health interventions or services that could save her life.

The importance of good access to SRH services on health outcomes for women of reproductive age has been demonstrated in many studies. When women are able to plan their births, they are able to give birth at the right place and at the right time, and avoid unwanted pregnancies, thus reducing maternal and neonatal mortality. Likewise, attendance at ante- and post-natal services enables detection and management of pregnancy-related complications at an early stage and skilled birth attendants helps prevent the death of mothers and infants. Prevention and treatment of sexually transmitted infections, including HIV, also help to promote reproductive health and well-being. This has been associated with increased maternal morbidity and mortality, unsafe abortions, inadequate post-partum health care, poor neonatal health care, poor quality of life of IDPs, and inadequate management of RLTIs (WHO, 2022; UNFPA, 2019).

The right to sexual and reproductive health, therefore, is part and parcel of international humanitarian efforts. International organizations like the United Nations High Commissioner for Refugees (UNHCR), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), and humanitarian partners have created policy frameworks and operational guidelines, which focus on ensuring equitable access to SRH services for refugee populations. These frameworks highlight that refugee people should be provided with health services similar to those available to their host populations, and without discrimination. Yet despite the policy commitments, access to quality SRH services continues to be inequitable in many countries hosting refugees, constrained by limited access to resources, substandard health infrastructure, insufficient health workers, social and cultural barriers, language differences, insecurity, and the increasing refugee population pushing existing health systems to their breaking point.

1.2 Background to the Study

Forced displacement in the world today has never been more extensive because of armed conflicts, political instability, persecution, climate change disasters, and the widespread violation of human rights. By mid-2022, over 103 million people were forcibly displaced globally, including over 32 million refugees under international protection (UNHCR, 2022b). Recent estimates around the world suggest that numbers of displaced persons have persistently risen, driven by continuing conflicts in Ukraine, Sudan, the Democratic Republic of the Congo, Myanmar and the Middle East. Women and children make up the bulk of the displaced and are especially vulnerable due to lack of access to and disrupted health care systems, poverty, insecurity, gender-based violence and other vulnerabilities. These are all factors that greatly contribute to the need for comprehensive sexual and reproductive health services during humanitarian crises.

Sexual and reproductive health is seen as part of universal health coverage and humanitarian action by the international humanitarian community. Goal 3 of the Sustainable Development Goals is about ensuring healthy lives and promoting well-being for all through sexual and reproductive health education, including by providing universal access to sexual and reproductive health services. Likewise, the Programme of Action of the International Conference on Population and Development and the Guttmacher–Lancet Commission call for comprehensive SRH services, which include family planning, maternal health services, prevention and treatment of STIs, prevention of cervical cancer, safe abortion (if legal), prevention of GBViP, management of GBViP, infertility care, and reproductive health education (UNFPA, 2019). Such interventions help to lower maternal mortality, increase the chances of newborn survival, foster reproductive rights and overall betterment of women's lives.

Sexual and reproductive health is broadly defined as a human capital investment from a development perspective, and is viewed as such rather than just a health intervention. The Human Development Approach, developed by the Nobel Laureate Amartya Sen and later championed by the United Nations Development Programme (UNDP), focuses on the ability and freedom of individuals to live healthy, productive

and dignified lives. The quality of sexual and reproductive health services improves the capability of women by mitigating avoidable illness and maternal death, empowering women to be more involved in education, livelihoods and community development. Improving SRH services also helps to build the resilience of refugees, to ensure their social inclusion, and to minimize their reliance on humanitarian assistance, which are key goals of sustainable development and refugee response policies.

The current development discourse also underscores the Humanitarian–Development – Peace Nexus, encouraging the shift from humanitarian operations to operations that contribute to resilient health systems and contribute to development outcomes. Equitable access to SRH services is an important way to reduce inequalities between refugee populations and host communities, to foster social cohesion and inclusive development within refugee-hosting countries, including Uganda. Therefore, understanding the availability and accessibility of SRH services to women refugees in Maratatu D Zone has the potential to enhance the provision of health services, and to inform sustainable development policies and processes that support women's empowerment in humanitarian contexts.

Refugee women are faring worse than their non-migrant counterparts in terms of reproductive health conditions, even with the global actions agreed upon. In a systematic review, Davidson et al. (2022) identified that refugee women were often faced with several barriers to their access to sexual and reproductive health services: lack of health infrastructure, lack of access to qualified healthcare providers, poor communication due to language differences, discrimination, financial constraints, cultural beliefs and limited awareness of services. Such barriers have been linked to low utilization of family planning, antenatal care, skilled delivery, postnatal care and screening services which have implications for maternal morbidity and mortality. The delivery of sexual and reproductive health (SRH) services was further impacted by the COVID-19 pandemic in many humanitarian contexts, particularly refugee women, who were affected by movement restrictions, reduced health facility operations, limited access to commodities and the diversion of health resources (Elizabeth & Stuart, 2020; Manirambona et al., 2021).

In Africa, the scattered and volatile political landscape and the prevailing state of armed conflict still results in high refugee numbers. The East and Horn of Africa are one of the regions in the world with the largest refugee populations, as witnessed in South Sudan, the Democratic Republic of Congo, Sudan, Somalia, Eritrea and the Central African Republic, which have seen multiple displacement events in the last 20 years (UNHCR, 2022a). The displacement has greatly strained neighboring countries, especially Uganda, which has one of the most progressive refugee protection policies in the world. The Uganda's Refugees Act (2006) and Refugees Regulations (2010) provide for the right to health care, education, employment, land for cultivation and free movement for refugees. This policy framework has contributed to the ability of Uganda to host refugees, in excess of 1.5 million, in a country with limited resources (Frank, 2019).

However, the surge in the number of refugees has posed significant challenges to the health sector in Uganda. The refugee-hosting districts have a higher demand for health infrastructure, skilled workers, medical equipment, medicines, and healthcare services. The Ministry of Health is developing the Health Sector Integrated Refugee Response Plan (2019-2024) to build the capacity of the health sector to provide integrated health services to refugees and host communities. However, UNHCR assessments show that women refugees still face challenges accessing reproductive health clinics related to overcrowding, staffing, issues with medicine supply, transport challenges, financial constraints, and the lack of reproductive health services (UNHCR, 2021). These challenges could affect the quality, availability, accessibility and utilization of essential SRH services.

Kyangwali Refugee Settlement is an old refugee settlement in Kikuube District in the west of Uganda, with refugees from the Democratic Republic of Congo, South Sudan, Burundi, Sudan, Ethiopia and Kenya. After repeated violence in the Great Lakes Region, the population of the settlement has grown significantly, and there is now a significant number of refugees staying in the area that continue to need ongoing health services. The Maratatu D Zone is part of this settlement and is of particular interest in the refugee women's access to SRH due to the size of the population, reliance on humanitarian-

supported health facilities, and evidence of health access challenges. While there have been several interventions from government and humanitarian agencies, there is limited empirical evidence that looks in particular at the availability and accessibility of SRH services for women refugees aged 15-49 living in Maratatu D Zone. The study was thus undertaken to produce context specific evidence to inform policy makers, humanitarian agencies, health managers and development partners to implement targeted interventions that will improve the delivery of SRH services to refugee women living in Kyangwali refugee settlement.

1.3 Statement of the Problem

Sexual and reproductive health (SRH) services play a vital role in protecting the health, rights and well-being of women of reproductive age, and are acknowledged as an important element of sustainable development, gender equality and universal health coverage. The government of Uganda's refugee policy and international humanitarian guidelines aim to provide fair and fair access to quality SRH services to refugees and host communities. But, even with these pledges, refugee women continue to lack access to needed SRH services and are at risk for unintended pregnancy, maternal morbidity and mortality, sexually transmitted infections, and other harmful reproductive health outcomes. These challenges not only impact on the health of women, but also on their social and economic involvement, which in turn reduces overall development within refugee communities.

While various studies have looked at reproductive health among refugees in Uganda, they have, in general, concentrated on general healthcare access or on refugees in general, rather than on the availability and accessibility of SRH services among female refugees aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement. This information deficit limits the capacity of policy makers, health managers and humanitarian agencies to develop context-specific interventions that meet the reproductive health needs of the refugee women. Thus, this study aims at measuring the availability and accessibility of sexual and reproductive health services among refugee women with age range of 15-49 years in Maratatu D Zone and determine the

obstacles that affect access to sexual and reproductive health services with the objective of providing evidence to support policy, service provision and development results in the refugee context.

1.4 General Objective

To assess availability and accessibility for SRH services to women refugees (15-49 years) in Maratatu D Zone, Kyangwali Refugee Settlement.

1.5 Specific Objectives

1. To assess the availability of sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement.
2. To assess the accessibility of sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement.
3. To identify the barriers affecting the availability and accessibility of sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement.

1.6 Research Questions

1. What SRH services are provided to women refugees aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement?
2. How accessible are sexual and reproductive health services for women refugees aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement?
3. What barriers affect the availability and accessibility of sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement?

1.7 Research Hypotheses

The following null hypotheses will be tested in the study at 5% level of significance:

H_{01}: It was hypothesized that there was no statistically significant relationship between sexual and reproductive health services and access to sexual and reproductive health services among female refugees (15-49 years) of Maratatu D Zone, Kyangwali Refugee Settlement.

H_{02}: Women refugees age 15-49 in Maratatu D Zone, Kyangwali Refugee Settlement have no statistically significant association between the accessibility of sexual and reproductive health services and utilization of the services.

H_{03}: For women refugees aged 15-49 years, there is no statistically significant association between barriers to SRH services and access to SRH services in Maratatu D Zone, Kyangwali Refugee Settlement.

1.8 Scope of the Study

Geographical Scope

This study was carried out in the Kyangwali Refugee Settlement, Kyangwali District, Western Uganda, where one of the zones is Maratatu D zone. Kyangwali Refugee Settlement (KRS) was purposively selected owing to being one of Uganda's oldest and largest refugee settlements with refugees mainly from the Democratic Republic of Congo (DRC), South Sudan, Burundi, Sudan, Ethiopia and other neighboring countries. Increased population growth has occurred in the settlement since the conflicts in the Great Lakes Region were ongoing and additional healthcare services, including sexual and reproductive health (SRH) services were demanded. Maratatu D Zone was chosen with a large population of women of reproductive age who rely on health facilities provided by the government and through humanitarian assistance. Beyond this, there is limited empirical evidence of the availability and accessibility of SRH services in this particular zone, although it is an important zone in terms of the settlement. The study of Maratatu D Zone is thus a source of context-specific evidence which can guide health

planning and service delivery in Kyangwali Refugee Settlement and other refugee settings in Uganda.

Content Scope

The study was conducted in Maratatu D Zone with the women refugees ranging from 15-49 years with an emphasis on availability and accessibility of sexual and reproductive health services. In particular, the study examined the accessibility of critical SRH services such as family planning, antenatal care, skilled birth attendance, postnatal care, prevention and treatment of sexually transmitted infections, HIV services, cervical cancer services, and sexual and gender-based violence (SGBV) services. The study also explored geographical access, cost, acceptability, waiting period and utilization of these services and the barriers affecting women's access to SRH services.

Time Scope

This study took place in the context of the existing refugee response in Uganda, focusing on policy and programme developments that occurred from 2019 to 2024, such as the Health Sector Integrated Refugee Response Plan (HSIRRP), the Comprehensive Refugee Response Framework (CRRF), and other humanitarian interventions to support refugee health services. This time frame was chosen because it represents the recent policy activities for improvement of integrated health service delivery for refugees and host communities and offers the right context for the study of current service availability and accessibility for SRH services.

1.9 Justification of the Study

The escalating refugee population in the world and in Uganda has led to immense public health problems, especially in relation to women's SRH services. The issue of SRH services for refugee women is exacerbated by factors specific to displacement, including heightened poverty, insecurity, sexual and gender-based violence, weakened health systems and restricted access to essential health services. While Uganda has implemented progressive refugee policies and is actively collaborating with humanitarian organizations to deliver integrated SRH services, there is ongoing

evidence of unequal access to and availability of SRH services in the refugee communities. The ability of producing context specific evidence is therefore crucial to improve reproductive health services and to ensure equal access to quality reproductive health services for refugee women.

This study aimed to fill the gap of empirical evidence regarding availability and accessibility of SRH services among women refugees aged 15-49 years in Kyangwali Refugee Settlement in Maratatu D Zone. The study presents evidence on the state of, barriers to, and opportunities for access to SRH services, which will inform interventions being designed by the Ministry of Health, the Office of the Prime Minister, UNHCR, district health authorities, and humanitarian organizations, to meet the real needs of refugee women. It also supports Uganda's SDG 3 (United Nations, 2015) which aims at achieving universal access to quality sexual and reproductive health care services and improve the health and well-being of all.

1.10 Significance of the Study

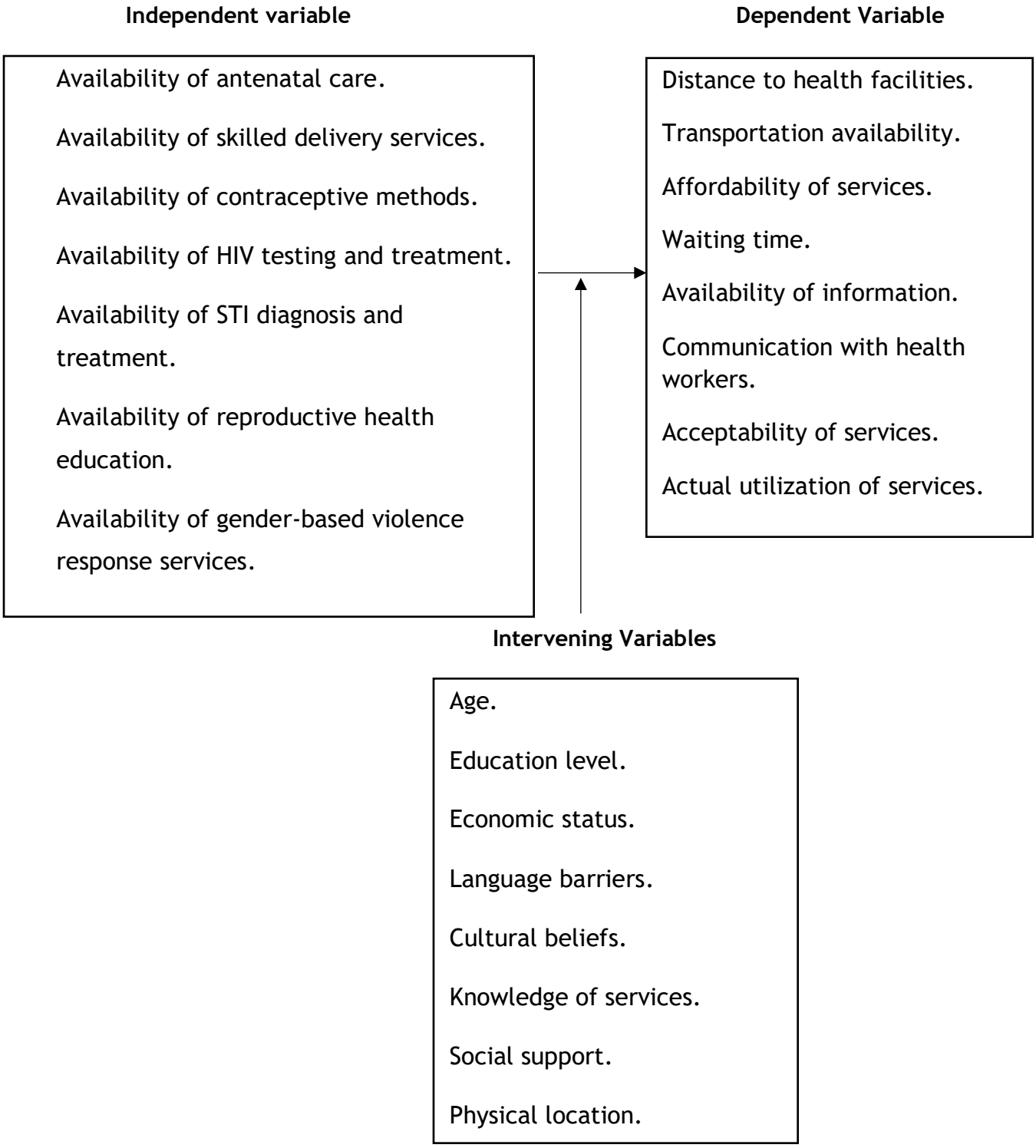
The results of this study should inform the current body of knowledge on refugee health with empirical evidence on the availability and accessibility of sexual and reproductive health services to the refugee women in the Maratatu D Zone of Kyangwali Refugee Settlement. The study will, therefore, prove to be a valuable guide for future scholars and students who are interested in refugee health, reproductive health, humanitarian assistance, and public health in refugee settings.

The findings will also benefit policy makers including Ministry of Health, Office of the Prime Minister, Kikuube District Local Government and development partners like the United Nations for Human Rights (UNHCR), and other humanitarian partners doing refugee health programmes. The evidence produced will inform evidence-based planning, resource allocation and programme implementation that will enhance the availability, accessibility and quality of SRH services in refugee settlements.

The results will offer practical information for healthcare managers and service providers in Kyangwali Refugee Settlement about the existing challenges that hinder women's access to key SRH services and suggest areas for improvement. This information can inform interventions to strengthen health infrastructure, staffing, supply of essential medicines and reproductive health commodities, increase community health education, and strengthen referral systems to increase access to services among refugee women.

Lastly, the study will help inform interventions to enhance equitable access to comprehensive sexual and reproductive health services for women refugees in Maratatu D Zone and other refugee contexts. Better access to good quality SRH services can decrease preventable maternal morbidity and mortality, ensure safer pregnancies and births, prevent STIs and unplanned pregnancies, and lead to improved reproductive outcomes and quality of life for refugee women.

Figure 1: Conceptual framework



Source: Researcher's conception (2023)

This study is based on the Penchansky and Thomas (1981) access to healthcare model that sees access as the degree of fit between health services and the populations they serve. The model suggests five dimensions of access – the Five As: availability, accessibility, affordability, accommodation, acceptability. Based on the model, healthcare services are perceived as accessible if they meet the needs, expectations and situation of the intended users. McLaughlin and Wyszewianski (2002), add that a good match between providers and clients occurs when people have access to a consistent source of healthcare and providers who provide appropriate healthcare services to meet their health needs (McLaughlin & Wyszewianski, 2002).

The variables in this study are availability and accessibility. Availability is the proportion of SRH services available in health facilities in women refugee locations. The services provided encompass family planning, antenatal, skilled delivery, postnatal, HIV and STI prevention, treatment, cervical cancer screening, sexual and gender-based violence (SGBV) prevention and management, and SRH information services. Accessibility is defined as the ability of women refugees to access these services, taking into account e.g. distance to health facilities, waiting time, affordability, opening times and ease of accessing services. In this study, it is assumed that if SRH services are accessible and available, women refugees are more likely to access and use SRH services.

The study also acknowledges that intervening factors may affect the level of SRH services availability and women's access to these services. These factors include women's age, educational status, knowledge of services available for SRH, economic status, language or communication barriers, cultural beliefs and physical distance of women from health facilities. These can be facilitating or inhibiting factors for women to access available services. The conceptual framework, therefore, visualizes how availability and accessibility of SRH services affect access to SRH services, and how intervening variables either enhance or detract from this relationship. The framework is used as a foundation to explore the interplay of these variables in the context of women refugees aged 15-49 years living in the Maratatu D Zone of Kyangwali Refugee Settlement.

1.12 Summary

Finally, Chapter 5 discusses the general background of the study which includes background to the study, statement of the problem, purpose of the study, research objectives, research questions, research hypotheses, scope of the study, Justification, and significance of the study as discussed above, and conceptual framework. Though the study is not to find out the number of women refugees, this study intends to focus on the research objectives given in line with the research topic and this paves a way for the next chapter which is the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter covers literature review on availability, accessibility and challenges of sexual and reproductive health services (SRHS) for women, refugees and internally displaced persons (IDPs) from 15–49 years. It is presented in the following order: study objectives – availability of SRHS, accessibility of SRHS, barriers to service utilisation. The maternal health, family planning, HIV/STI services, sexual and gender-based violence response, safe abortion care, cervical cancer screening, and reproductive health information reviewed. This also explores geographic, financial, informational, social and health system barriers to access. SRHS is a basic human right, and is critical for refugee women who are affected by displacement, poverty and disrupted health services. The chapter also concludes by stating the knowledge gaps that justify the need to assess the SRHS among women refugees in Kyangwali Refugee Settlement, D Zone, Maratatu.

2.1 Level of Sexual and Reproductive Health Services for Women Refugees ages 15-49

Availability of SRHS indicates the presence of adequate, appropriate and quality health services, including trained health workers, medicines, equipment and information needed to address the sexual and reproductive health needs of a population. World Health Organization (WHO, 2016) highlights that health care services must be safe, effective, timely, equitable and people-centered to enhance health outcomes. The availability of SRHS in refugee settings is largely dependent on the cooperation and collaboration between the host government, the UN agencies and humanitarian organizations responding to the health needs of refugees.

2.1.2 Key indicators for Maternal Health Services for Women Refugees

Maternal health care is one of the key elements of SRHS for women of reproductive age. Antenatal care (ANC), skilled birth attendance, emergency obstetric care and post-natal care are key interventions to be implemented to improve maternal and neonatal morbidity and mortality. UNHCR believes that pregnant refugee women should have access to appropriate ANC to detect pregnancy-related risks and to ensure prompt management of those risks. Studies in refugee settings have shown that maternal health services are in place in a number of humanitarian settings, although access and quality have been found to be inconsistent. In a study among women refugees from Syria, in Lebanon, the services of ANC were provided by humanitarian organisations based on the service of the UNHCR, the Lebanese Ministry of Health and non-governmental organisations. Financial support for the ANC visits, laboratory investigations, and ultrasound examinations was provided to the registered pregnant women. Although these interventions were implemented, only 30.7% of the pregnant refugee women who were registered attended four ANC visits, and a number of women reported receiving inadequate information about pregnancy danger signs (Benage et al., 2015). The discovery indicates that although mothers' health services were available, the quality and comprehensiveness of care was still lacking.

Likewise, Mwoma et al. (2021) found that the scarcity of trained healthcare professionals led to women refugees in Ifo Camp, Dadaab, Kenya having limited access to skilled birth attendants. This led some women to use traditional birth attendants, trusted in their communities due to their cultural knowledge and availability. While TBAs also helped with social support, there was a rise in dependence on unskilled TBAs, which can lead to preventable maternal and newborn complications. This shows that having health infrastructure is not enough without the required health manpower.

UNFPA carried out pregnancy mapping in refugee settlements in Uganda to enhance identification and follow-up of pregnant women in need of ANC and skilled delivery services. The intervention helped sensitize health workers and village health teams on the identification of pregnant women and promotion of facility birth. But the challenges for implementation, especially regarding poor network coverage in remote areas,

restricted the ability to monitor pregnant women effectively (UNFPA, 2019). This underscores that in refugee contexts, maternal health interventions may not be available due to technological and geographic constraint. In Kyangwali Refugee Settlement, women refugees were engaged in pregnancy mapping activities that involved training former Traditional Birth Attendants as community champions to sensitize women to attend ANC services, nutrition and skilled delivery. These actions have failed to stop pregnant refugee women from missing their first ANC visit and the required number of visits for pregnancy complications to be detected late (Government of Uganda & UNHCR, 2019). The results have shown that there are gaps in the utilisation of maternal health services in Kyangwali, even though there is a presence of the services.

WHO has recently recommended 8 maternal and infant health contacts instead of four ANC visits to ensure positive pregnancy experiences and better maternal and newborn outcomes (WHO, 2023). Thus, the services needed as reported in previous studies that were conducted using older standards of ANC may be underestimated. It is recommended that there should be a greater amount of research to determine if women refugee in Kyangwali are receiving maternal health services as per current recommendations.

Overall, the reviewed studies show a wide range of consensus that maternal health services are being delivered in many refugee contexts, through government–UN agency and humanitarian organisation partnerships (Benage et al., 2015; Government of Uganda & UNHCR, 2019). But the literature also shows that there is an important debate that addresses the question of whether the mere existence of services is enough for effective service delivery and better outcomes in maternal health. Previous research from Lebanon, Kenya and Uganda reveal that antenatal care, skilled delivery and postnatal care are present, but that skilled worker shortages, lack of attendance and geographical constraints during the antenatal period and gaps in continuity of care are consistent issues (Benage et al., 2015; Mwoma et al., 2021; Government of Uganda & UNHCR, 2019). The majority of these studies took place in different refugee contexts, which differs from Kyangwali Refugee Settlement in terms of health system, support

systems, and sociocultural environment (Benage et al., 2015; Mwoma et al., 2021). The results of their study cannot be directly applied to Maratatu D Zone, however, because of this, they emphasized the importance of context-specific evidence about maternal health services for women refugees aged 15-49 years.

2.1.3 Health and Social Care Services for Women Refugees

Family planning is an important aspect of SRHS as this allows women to plan their pregnancies. This is because, in humanitarian contexts, women and girls in displacement are at higher risk of unintended pregnancies, complications during pregnancy and birth, and economic vulnerability because accessing various contraceptive options is a necessity. UNHCR recommends that women refugees should be provided with various contraceptive options, including short-acting, LARC, barrier, emergency contraceptive and natural family planning methods based on their preferences (UNHCR, 2019).

Refugee settlements provide evidence that family planning services are sometimes offered, but that the use of these services varies. A study was conducted among Rohingya women refugees in Kutupalong refugee settlement to estimate the provision and use of family planning services from government organisations, UN organisations and non-governmental organisations (NGOs) in the refugee settlement. The research identified family planning outreach activities such as counselling and distribution of contraceptives were carried out by the family planning workers. But, only 48.28% of women had received visits related to family planning and around 50% of the women had used contraceptive methods, with the most commonly used ones being injectable and oral contraceptive pills (Khan et al., 2021). The results suggest that good reach of services via outreach programmes is not sufficient to achieve universal access.

Likewise, in an analysis of women refugees in Shimelba Refugee Camp, Ethiopia, contraceptive use was significantly higher for injectables and oral contraceptive pills and uptake of implants and male condoms remained low (Seyife et al., 2019). While the study found that contraceptive services were provided, the relatively low levels of

some contraceptive use indicated that there may be issues of informed choice, access to a variety of contraceptive options and preferences among refugee women.

A study of South Sudanese refugee women in Uganda (Kiryandongo and Rhino Camp) revealed that women adopted a variety of contraceptive practices including the use of injectables, oral contraceptive pills and condoms. The utilization of some methods, however, was very low, like emergency contraception and intrauterine devices (Singh et al., 2022). It indicates that family planning services are provided in refugee camps; however, the availability of complete family planning methods might be restricted. In Kyangwali Refugee Settlement, humanitarian actors have been intervening on family planning, sensitizing the community to the issue and distributing contraceptive products. UNFPA, for instance, promoted activities to encourage women refugees to use family planning methods to assist them to give birth by choice and not by chance (UNFPA, 2021). There is however, insufficient information to describe how women aged 15-49 years can access and utilise these services in the specific zones of Kyangwali (in particular Maratatu D Zone). This makes the gap in knowledge that this current study aims at addressing.

The literature reviewed shows consensus that family planning services are integrated into refugee health programmes in humanitarian settings, both in and out of camp (UNHCR, 2019; Khan et al., 2021; Singh et al., 2022). However, there is a continuing discussion on whether there is adequate commodity supply to ensure informed choice and equity of access. Despite the rise in contraceptive awareness and distribution through outreach programmes in countries like Bangladesh, Ethiopia and Uganda, there is consistent evidence of low use of some contraceptive methods, including LARC and emergency contraception (EC) (Khan et al., 2021; Seyife et al., 2019; Singh et al., 2022). The results indicate that the availability of family planning services is not equal to complete access to all family planning commodities or effective utilization, since the awareness, preferences, counselling quality, and accessibility of services all affect the utilization of family planning commodities in Kenya (Khan et al., 2021; Seyife et al., 2019). In addition, previous research has focused on either the family planning access level at settlement or at the national level, whereas only a few studies have

focused on the availability and accessibility of various family planning services among women refugees in Kyangwali Refugee Settlement in Maratatu D Zone. This study thus aims to fill this contextual void.

2.1.3 HIV Prevention and Sexually Transmitted Infection Services

HIV and other sexually transmitted infections (STIs) are important areas of SRHS for prevention, diagnosis, and treatment. Conflict-related sexual violence, lack of access to health services, poverty, and lack of access to prevention services can contribute to refugee populations being more vulnerable to HIV and STIs.HIV testing programmes reported higher rates of HIV-positive women refugees in the Rohingya community in Bangladesh. The real prevalence was, however, likely underestimated as some women did not get diagnosed because uptake of testing was low and barriers to accessing healthcare services were identified by the researchers (Khan et al., 2021). This illustrates that HIV testing programmes may not be enough if there are barriers to using HIV testing amongst refugees.

Likewise, some refugee groups were not well covered by HIV prevention programmes as South African national policies emphasized citizens (Zihindula et al., 2016). It underscores the need for inclusive health policies to meet the needs of refugees. In Uganda, the Nakivale Refugee Settlement offers services in the areas of HIV testing, counselling and distribution of condoms, and ARVs. But, O'Laughlin et al., (2021) noted that some refugees were deterred from seeking HIV services due to the fear of discrimination and stigma. This means that access to HIV services may be physical but social barriers can make access to HIV services difficult.

HIV testing, counselling, condom distribution and prevention of mother to child transmission services have been provided in Kyangwali Refugee Settlement through various organisations including African Action Help Uganda. HIV-positive pregnant women have been included in prevention programmes to minimise HIV transmission to their newborns (African Action Help Uganda, 2018). But there is little evidence on the utilisation of HIV and STI services among women refugees aged 15-49 years in Maratatu

D Zone. Evaluation of these services therefore is essential to determine if current interventions meet women's reproductive health needs.

The reviewed studies indicate that HIV prevention and STI services are generally integrated into refugee health programmes, including HIV testing, HIV counselling, antiretroviral therapy, distributing condoms, and interventions to prevent STIs (Khan et al., 2021; O'Laughlin et al., 2021; African Action Help Uganda, 2018). But there are conflicting views in the literature about the effectiveness of these services. Some research has found that increased testing and treatment programmes have led to better HIV service provision, while others show that stigma, fear of discrimination, policy restrictions and low engagement have hindered the effectiveness of HIV services (Khan et al., 2021; Zihindula et al., 2016; O'Laughlin et al., 2021). The differences also suggest that access to HIV and STI services is not sufficient to ensure equitable access or better reproductive health outcomes for refugees, as social and health systems continue to impact service access (Zihindula et al., 2016; O'Laughlin et al., 2021). Furthermore, the availability and access to HIV and STI services for refugee women in Maratatu D Zone, Kyangwali Refugee Settlement is not well documented, and this study aims to fill this gap.

2.1.4 Sexual and Gender-Based Violence Response Services

Sexual and gender-based violence (SGBV) is a major reproductive health problem of refugee women. Availability of survivor-centred healthcare, psychosocial support, legal assistance and referral systems are critical in decreasing exposure to sexual violence, exploitation, and harmful practices. UNHCR considers that addressing SGBV-related issues is a key part of refugee protection. These services typically provided are medical, psychosocial counselling, legal assistance, safety planning, and referral systems. Among the female SGBV survivors that were supported through IRC services, a study revealed that SGBV response services enhanced survivors' knowledge, confidence and capacity to seek assistance (Lilleston et al., 2018). The study, however, was conducted with a small sample and it was not generalizable to other refugee settings.

Through GBV assessments in refugee camps, in Uganda, humanitarian organizations deliver GBV prevention and response (GBV P&R) activities like psychosocial support, referral, legal and medical services. However, many cases are not reported as a result of stigma, fear and delayed reporting (Government of Uganda & World Bank, 2020). A set of referral pathways for GBV survivors have been identified in Kyangwali Refugee Settlement, but assessment indicated underreporting and need for further strengthening of capacity of service providers (Robinson, 2018). In the refugee context, GBV services have been included in the responses, but literature has mostly been concerned with reporting systems and organisational interventions, and has not investigated the refugees' experiences of accessing GBV services. This generates a gap in terms of the perceptions and utilization of available GBV related SRHS by women in Maratatu D Zone.

The literature reviewed shows that SGBV response services have been incorporated into humanitarian health responses in a number of innovative ways, including through referral pathways, medical responses, psychosocial support, legal responses and survivor-centred responses (UNHCR, 2021; Lilleston et al., 2018; Government of Uganda & World Bank, 2020). But there is uncertainty about how effective the availability of these services is in providing access and utilization among refugee women. Previous studies provide evidence of SGBV response mechanisms and their potential benefits to survivors, but they also highlight that stigma, fear of disclosure, limited awareness of services available, and providers' capacity remains a challenge (Lilleston et al., 2018; Government of Uganda & World Bank, 2020; Robinson, 2018). Moreover, the current literature tends to focus on programme implementation, institutional responses, and reporting systems, instead of refugee women lived experiences to access SGBV services (Robinson, 2018). Hence, there was few evidence that is specific to SGBV related SRHS accessibility and availability in women refugees in Kyangwali Refugee Settlement, Maratatu D Zone.

2.1.5 Safe Abortion Care and Post-Abortion Services among Women Refugees

Comprehensive SRHS encompasses safe abortion care and post-abortion services, as appropriate by law and practice. Unsafe abortion continues to be a significant driver of maternal morbidity and mortality, especially among populations experiencing displacement, conflict, and limited access to reproductive health services. Women who are refugees may be at a higher risk of unplanned pregnancies as a result of sexual violence, interruption of contraceptive use, and decreased reproductive choice. World humanitarian experience shows that safe abortion services are among the least available aspects of SRHS for refugees. Because of the experiences of sexual violence before displacement, there is a need for comprehensive abortion and post-abortion care in Bangladesh, where humanitarian organisations are already aware of this. Legal restrictions, donor priorities, and humanitarian perceptions of the complexity of providing abortion services in emergency situations, however, have restricted provision of abortion services (Fetters & Powell, 2019).

Likewise, women refugees in the Nakivale Refugee Settlement and Kampala, who had limited access to safe abortion services, used unsafe methods of terminating unplanned pregnancies which included inserting objects or substances into the uterus (Nara et al., 2019). These practices can cause complications such as infections, childlessness and maternal death. In Kyangwali Refugee Settlement, humanitarian programming has been focused on the following services: antenatal care, emergency obstetric services, newborn services, and family planning. But the available reports give scant details regarding access to safe abortion and post abortion service among the refugee women. This implies that there is a lack of awareness regarding the extent to which the women refugees' reproductive health needs are being met in the settlement.

Existing research provides valuable insights into the effects of poor access to safe abortion and post-abortion care by displaced people, including an increased likelihood of using unsafe abortion methods and associated risks of maternal complications (Fetters & Powell, 2019; Nara et al., 2019). But from the literature, there is still debate on whether these services are being provided or not, as affected by legal restrictions, cultural perceptions, humanitarian priorities, consideration of donors, and the

availability of trained health care providers (Fetters & Powell, 2019). While unsafe abortion is a reproductive health issue among refugee women, studies that exist tend to focus outside of Uganda or on refugees as a whole, rather than in Kyangwali Refugee Settlement (Fetters & Powell, 2019; Nara et al., 2019). This underscores the importance of contextually investigating the access to safe abortion and post-abortion services for women refugee in Maratatu D zone.

2.1.6 Cervical Cancer Prevention and Screening Services

Prevention of cervical cancer through human papillomavirus (HPV) vaccination, screening, early detection and treatment are significant aspects of women's reproductive health care. WHO (2022) suggests a multi-faceted strategy including primary prevention, screening for precancerous lesions, treatment and palliative care for advanced disease. Research conducted among refugee women shows that cervical cancer services can be found in health systems, but are not being fully used due to social and cultural barriers. Among Palestinian women refugees in Jerash Camp, Jordan, it was discovered that although cervical screening services were offered, some women refused to have a screening due to discomfort of being examined by men and cultural concerns about the screening process (Muhaidat et al., 2022). The results were similar among African and Middle Eastern refugee women, which showed that women's preference for female health care providers affected their willingness to do cervical screening (Ghebrendrias et al., 2021).

The evidence reviewed shows that there has been an increase in the availability of cervical cancer prevention and screening services in some refugee health programmes but that availability does not necessarily translate to utilization. Cultural beliefs, gender preferences, awareness level, discomfort with screening procedures, and perceptions of health care providers have been shown to affect women's willingness to participate in cervical cancer screening (Muhaidat et al., 2022; Ghebrendrias et al., 2021). These studies offer valuable insights and demonstrate that culturally acceptable, gender-inclusive, and attuned to women's preferences are key to improving cervical cancer prevention among refugee women. But the majority of data available comes

from refugees in countries other than Uganda, and there is little evidence to assess the provision and utilization of cervical cancer screening services in refugee camps in Uganda, including Kyangwali Refugee Settlement. This leaves women refugees in Maratatu D Zone with a context gap which calls for further research on cervical cancer prevention and screening services for women refugees in Maratatu D Zone.

2.1.7 Sexual and Reproductive Health Information and Education Services

Women have the right to access accurate SRH information to help them make informed choices about contraception, pregnancy, STI prevention and health care seeking. Limited access to information may be due to language, low literacy, cultural barriers and reduced contact with health care professionals among refugee women. In a qualitative study conducted among Syrian refugees in Lebanon, women and men were supportive of the creation of formal SRH education programmes provided by health workers, NGOs, community sessions and printed materials. But, in some families, cultural awkwardness hindered family communication about reproductive health related issues, especially between mothers and daughters (Jain et al., 2019). This illustrates how health programmes are not the only factors affecting information availability – social norms also play a role.

A study conducted in Australia and Canada in South Sudan, Sudan and Somalia refugee women revealed that women appreciated SRH education as it enhanced knowledge about their bodies, reproductive options, and health care services (Hawkey et al., 2022). The study however was conducted among resettled refugees and not women in humanitarian settings, which affects the applicability of the study to refugee camps. In Uganda, UNFPA and humanitarian partners have provided SRH education through community awareness raising, family planning awareness, and maternal health promotion. Organisations have engaged in awareness raising activities in Kyangwali Refugee Settlement for ANC attendance, uptake of family planning and skilled delivery (UNFPA, 2018). However, very limited evidence exists on the knowledge of existing women refugees in the targeted zones of Kyangwali and the impact on service utilization in Kyangwali in relation to SRHS.

A review of literature reveals that SRH information and education is critical to increasing awareness, informed decision-making and utilization of reproductive health services among refugee women (Jain et al., 2019; Hawkey et al., 2022). Research, however, shows that language barrier, cultural norms, literacy, gender norms and health system communication strategies can affect the impact of information provision (Jain et al., 2019; Hawkey et al., 2022). While humanitarian organizations have engaged in community-based sensitization and awareness raising activities, including reproductive health education in refugee settlements, there is limited evidence on if the interventions are reaching women and whether they are having an impact on service utilization (UNFPA, 2018). Moreover, most previous research on refugees has examined refugees in general or resettled refugees, but not refugees who reside in particular settlement sectors. There is therefore limited evidence of SRH information being adequate and accessible among the refugee women in the Kyangwali Refugee Settlement, Maratatu D Zone hence a gap on the level of knowledge which should be filled by this study.

2.2 Accessibility of Sexual and Reproductive Health Services for Women Refugees Aged 15–49 Years

Accessibility of health care services is the ability to receive the appropriate health services when needed, without encountering unnecessary barriers in the process. It encompasses multiple aspects such as geographical, cost, availability, acceptability and individuals' rights to informed decision making. WHO defines universal health coverage as all individuals having access to health services without facing financial hardship, particularly vulnerable groups like refugees (WHO, 2023). Accessibility of SRHS is crucial for refugee women, as their ability to access timely preventive and treatment services is frequently restricted due to displacement. While humanitarian actors have scaled-up SRHS activities in refugee settlements, there is evidence of unequal access. Although availability of health facilities, medicines and health workers may extend to the refugee women, not all of them would necessarily use health services due to social, economic, cultural and geographical barriers.

2.2.1 Geographical Accessibility and Physical Barriers to SRHS

Utilisation of SRHS among refugee women is an important factor that is determined by physical accessibility. The distance to health facilities, availability of transport services, and safety while using transport services affect women's ability to access timely reproductive health services, including during pregnancy emergencies and other health emergencies. In 2014, a study among internally displaced Syrian women in Lebanon revealed that distance and transportation issues were cited by 25.4% of respondents as a barrier to access reproductive health services (Reese Masterson et al., 2014). Likewise, an ethnographic study among Oromo women refugees in Somali and Ethiopian settlements in Kakuma refugee camp, Kenya, revealed that some women faced problems in accessing health care services, especially in cases of birth emergencies. Others had to walk several kilometers or wait for ambulance services to get them to the hospital during childbirth, thereby putting their lives at risk (Lallai et al., 2020). The results show the importance of the physical space occupied by healthcare provision on refugee women's access to healthcare.

In Uganda, a gender analysis in Bidibidi and Imvepi refugee settlements found that transportation costs and distance were among the key challenges that hinders women's access to SRHS. The study also identified that lack of financial resources to transport to health care facilities hampered access, especially for pregnant women (Laurent, 2022). The same difficulties have been documented in refugee camps in general, where services are provided by humanitarian organizations, but where geographical barriers can also not always be removed. The current literature, however, has been quite limited in scope, mostly covering larger refugee camps like Bidibidi and Kakuma, and little is known about the physical access problems experienced in Kyangwali Refugee Settlement. Within Kyangwali, some health services exist, but there is a lack of information on the ease of access of the health services to women refugees in Maratatu D Zone, especially for maternal, family planning and STI related services. Hence, the aim of the current study is to investigate the role of geographical factors in the accessibility of SRHS in the study area.

Existing research overall shows geographical accessibility is a significant factor affecting women's use of SRH services, especially in relation to accessing antenatal care and skilled delivery and other essential reproductive health services (ERHS) (Reese Masterson et al., 2014; Lallai et al., 2020; Laurent, 2022). There is, however, evidence that the impact of physical barriers varies by settlement characteristics, infrastructure, transportation options, and humanitarian support mechanisms (Lallai et al., 2020; Laurent, 2022). There has been some work that has documented the distance and transportation issues in a few refugee camps, but little work has focused on the impact on women refugees in Maratatu D Zone, Kyangwali Refugee Settlement. Hence, more research is needed to provide geographical evidence of accessibility of SRH services for women refugees age 15-49 years.

2.2.2 Financial Accessibility of Sexual and Reproductive Health Services

Financial accessibility is defined as the ability of people to access health care services without incurring financial difficulties. Economically, refugee women tend to be disadvantaged and rely on humanitarian assistance for their survival and have scant opportunities for income generation. These conditions can hinder their access to transportation, medicines or other services not adequately supported by humanitarian programmes. A survey of refugee women in the Durban, South Africa, revealed financial constraints as a barrier to SRHS. Participants described the use of public health care facilities, at times where they felt they were not welcomed because they lacked private health care facilities (Munyaneza & Mhlongo, 2019). This shows that economic vulnerability can affect the coverage and quality of healthcare services that refugees use and receive, as well as whether they use or receive them.

In Uganda, the World Bank (2019) noted that refugees were more vulnerable to financial difficulties related to healthcare compared to host communities, as a large proportion of the refugees lived below the poverty line. In Kyaka II Refugee Settlement some women faced challenges in receiving SRHS due to lack of funds for their childbirth, pregnancy care, ANC and contraceptives (A & F, 2022). Indirect costs (e.g. travel, time out of the home) can still reduce access, despite the fact that many humanitarian

organizations offer a range of services at no cost. Most of the existing studies, however, address financial barriers in a general way, rather than specifically with regard to age group of 15-49 in Kyangwali. More studies are required to see if financial difficulties affect the access to SRHS for women refugees in Maratatu D Zone.

The reviewed studies show that financial accessibility continues to be a major factor in determining refugees' use of SRHS. The available evidence has been used to gain insight into the impact of poverty, reliance on humanitarian assistance and indirect health care costs such as transport costs and cost of accessing health care services on access to reproductive health care services (Munyaneza & Mhlongo, 2019; World Bank, 2019). The literature also indicates that financial barriers are context specific, meaning that the impact of financial barriers differs depending on the presence of free health delivery services, humanitarian support structure and household's economic status (Munyaneza & Mhlongo, 2019; A & F, 2022). Previous research has highlighted the financial hardships suffered by refugees, but most of this research have focused on refugees in general or other refugee settlements, with limited evidence on the financial difficulties faced by women refugees aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement. This raises the need for context-specific evidence on the role of financial factors to access SRHS.

2.2.3 Accessibility of Family Planning and HIV Prevention Services

Accessibility of family planning empowers women to decide if and when they become pregnant and plays a crucial role in women's and children's health. Although access to contraceptive services is improved in refugee settlements, there is limited use of contraceptives. Mobile teams in Nigeria delivered family planning counselling and contraceptives in Adagom and Okende refugee camps. During the outreach period, however, only a small portion of contraceptive services was provided to the thousands of women of reproductive age who lived in the camps (Joseph Afe et al., 2021). The study identifies outreach programs as being able to enhance access but at the same time, points out, limited resources, duration and reach may be insufficient.

Reproductive Health Uganda carried out the ACCESS project where access to family planning is improved through training of healthcare workers and community health volunteers and outreach activities in Kyangwali Refugee Settlement. During its implementation period, the programme had reached thousands of beneficiaries (Reproductive Health Uganda, 2021). But the sudden closure of the project left beneficiaries with worries about the future availability of free family planning services. This shows that a short-term humanitarian project can have impacts on the sustainability of SRHS access. HIV prevention services such as access to condoms, HIV testing, counselling and treatment services are still key priorities for refugee women. Instances have been reported where stigma and fear of discrimination has been cited as a reason for not accessing HIV services, even when they are available. For instance, during a study in Nakivale Settlement, refugees were found to be not accessing HIV services due to fear of discrimination and confidentiality (O'Laughlin et al., 2021). This means that access is not just about being physically available, but also that women feel safe and accepted when accessing care.

The literature shows that the accessibility of family planning and/or HIV prevention services is more than the physical availability of contraceptive commodities, HIV prevention supplies and health care facilities. While access has been improved through various humanitarian programmes of outreach, community health workers, counselling and service integration, evidence indicates that programme sustainability, limited choice of methods, stigma, privacy concerns, and perceptions of service quality are all factors that influence utilization (Joseph Afe et al., 2021; Reproductive Health Uganda, 2021; O'Laughlin et al., 2021). These studies provide valuable insights that show that availability of services is insufficient to ensure access, as social and health system factors remain to influence refugee women's ability to access FHP. Research, however, has tended to be on a broader level of refugee population or on general settlement-level interventions in the settlement rather than on women of reproductive age in specific settlement zones. This emphasizes the need to look at the impact of these factors on the access to FP and HIV prevention services for women refugees aged 15-49 in Maratatu D Zone, Kyangwali Refugee Settlement.

2.2.4 Accessibility of SRH information and Women friendly services

Women's access to SRH information affects women's decision making and utilisation of available services. If people do not know about the services they can access, they might wait to seek health care and/or have a poor reproductive health outcome. In a study with Syrian refugee youth women in Lebanon, almost half of participants reported awareness of the location of SRH services, and the remaining part reported not knowing about the availability of SRH services (Korri et al., 2021). The study also revealed that women with a higher education level were more knowledgeable on SRH services than women with a lower education level. This suggests that education and information access has an effect on the use of reproductive health services.

In the same way, in Southern Africa, migrant women who had higher levels of knowledge about SRH services had higher likelihood of accessing them than those with low levels of knowledge (Chawhanda et al., 2022). In Northern Uganda, a study showed that refugees aged 15–24 years, with higher education level, were more likely to use SRH services as compared to those with lower education level (Bukuluki et al., 2023). There is however limited evidence on level of education, SRH awareness, and access to services among refugee women aged 15-49 years in Kyangwali Refugee Settlement. Some existing programmes like adult English classes have been tried to enhance refugees' capacity to communicate and to access services, but household responsibilities and gender expectation have affected participation rates particularly by women in Kyangwali (Refugee Law Project, 2020). Hence, accessibility of information continues to be important and worthy of further study.

The literature reviewed indicates that access to SRH information is an important pathway by which women become aware of the services available for them, acquire a reproductive health knowledge and make decisions about their health (Jain et al., 2019; Hawkey et al., 2022). Research indicates that education levels, language, cultural differences, gender norms in households, and the methods of health message dissemination have an impact on information access (Jain et al., 2019; Chawhanda et al., 2022). While health education and awareness raising initiatives among refugees have been rolled out through community sensitization, health education sessions, and

outreach, there is not yet enough evidence to determine the extent to which such efforts reach women in the refugee community, or whether the awareness created is adequate to ensure consistent uptake of SRH services (UNFPA, 2018). In addition, majority of previous studies have been conducted at the level of refugee groups or in other humanitarian contexts, offering little evidence of how SRH information is available for women refugees in particular in specific areas of Kyangwali Refugee Settlement. This gap highlights a need to explore barriers to accessing information and their impact on SRH service access in Maratatu D Zone.

2.2.5 Accessibility of Women and Girls Safe Spaces for SRH and GBV-Related Services

Safe spaces for women and girls are an important humanitarian response that enhances access to women's GBV protection, health information, psychosocial support and referral. These are safe and supportive settings where women can access information on sexual and reproductive health rights, counselling and are referred to relevant health services. In the Rohinya refugee response in Bangladesh, safe spaces for women and girls were created to provide refugee women with access to reproductive health information, psychosocial counselling services and survivor centred support services. The intervention was designed with the goal to minimize stigma, fear and lack of knowledge about the services available (CARE, 2019). Likewise, the refugees' women in the Congolese refugee settlement in Lovua, Angola, had access to reproductive health information and supportive services in safe spaces created within the settlement (UNFPA, 2022).

UNFPA and its implementing partners, including Lutheran World Federation (LWF) and International Rescue Committee (IRC), set up women and girls' safe spaces in refugee-hosting districts, including Kyangwali Refugee Settlement in Kikuube. Psosocial counselling, group therapy, and information on sexual and reproductive health rights (SRHR) were offered in these spaces (UNFPA, 2019). These are examples of humanitarian efforts to increase access to SRHS outside of the traditional health system. In the existing literature, however, the majority of research is focused on the creation and operation of safe spaces or on the women's use of safe spaces but not on

their levels of use. The data on attendance and satisfaction, and the effect of safe spaces on SRHS use among women aged 15–49 years in Maratatu D Zone is scarce. As such, more research is needed to determine if these interventions are effective in increasing women refugees' access.

As illustrated in the reviewed literature, safe spaces for women and girls have expanded the reach of SRHS services to offer women in the refugee community a confidential space for information sharing, psychosocial support, counselling and referral services (CARE, 2019; UNFPA, 2022). But most of the existing studies focus on the creation, goals and operations of these spaces and do not measure their effectiveness on the beneficiaries' point of view (CARE, 2019; UNFPA, 2022). This raises a discussion on the impact of safe spaces on the accessibility, use and empowerment of SRHS among women refugees where social, cultural and structural barriers remain in place. In Kikuube District, where Kyangwali Refugee Settlement is located, there are safe spaces for women and girls (WGS) in refugee-hosting districts, but little evidence of women's use of such safe spaces and the perceived benefits in Uganda (UNFPA, 2019). Thus, more research is needed to get a clearer picture of how safe spaces contribute to SRHS access of women refugees in Maratatu D Zone.

2.2.6 Accessibility of Sexual and Reproductive Health Services among Women Refugees in Kyangwali Refugee Settlement

Kyangwali Refugee Settlement is home to refugees from various countries and supported by government agencies, UN organisations and humanitarian partners that deliver reproductive health interventions (RHIs), protection and healthcare services (Government of Uganda & UNHCR, 2019; UNFPA, 2018). While some programmes have been put in place to enhance access to SRHS such as family planning, maternal health care, HIV prevention and community sensitization programs, evidence indicates that access to SRHS remains uneven and may differ by geographical location, individual, socio-cultural and sustainability of the humanitarian interventions (Reproductive Health Uganda, 2021; UNFPA, 2018). This suggests that not all refugee women can necessarily benefit from SRHS programmes within the settlement. Prior research,

however, has focused at settlement level and there is little evidence on how women refugees in particular zones, like Maratatu D Zone, encounter and access these services. This leads to the need to conduct a study on the availability and accessibility of SRHS for women refugees aged 15-49 years in the study area specifically.

For instance, Reproductive Health Uganda conducted the ACCESS project in Kyangwali Refugee Settlement, including provision of family planning services, community sensitization, training of health workers and village health teams and outreach. The programme helped to highlight the need for community-based strategies to increase the access to SRHS (Reproductive Health Uganda 2021). The use of this service, however, is a cautionary tale about the difficulty of sustaining access when services are reliant on external funds as much as can be. Likewise, UNFPA-supported programmes have enhanced maternal health services by providing Emergency obstetric care, midwives, reproductive health supplies, and community awareness activities. Despite this, factors like population growth, access to resources, changing humanitarian priorities, etc., can affect continuity and accessibility of services (UNFPA, 2018).

While these interventions suggest provision of SRHS in Kyangwali Refugee Settlement, the available evidence is limited and does not provide a clear picture of whether women refugees aged 15-49 years in particular zones have access to and use of SRHS as needed (UNFPA, 2018; Reproductive Health Uganda, 2021). While several literature sources have been found covering programme implementation, service delivery approaches, and humanitarian interventions, little literature has been found on lived experiences of women refugees, utilisation patterns and challenges faced when accessing care (Government of Uganda & UNHCR, 2019; Reproductive Health Uganda, 2021). Therefore, the degree of effectiveness of the current SRHS interventions to address the challenges of women refugees at community-level is not sufficiently known. This leaves a gap in contextual awareness which the current study seeks to address by analyzing the availability and accessibility of SRHS to women refugees between 15 and 49 years old in Kyangwali Refugee Settlement, Maratatu D Zone.

The literature reviewed shows that the governments, UN agencies and humanitarian actors have made concerted efforts to enhance the access to SRHS in refugee

settlements such as the inclusion of reproductive health programmes in integrated health programmes, community-based interventions, and service delivery initiatives (Government of Uganda & UNHCR, 2019; UNFPA, 2018; Reproductive Health Uganda, 2021). But it is suggested that there are several interacting factors that continue to affect access such as geographical location, financial constraints, lack of information, socio-cultural norms, stigma, and the sustainability of humanitarian interventions (Munyaneza & Mhlongo, 2019; Laurent, 2022; O'Laughlin et al., 2021). Previous studies have offered valuable insights into access to health services for refugee communities, but many have focused on particular programmes, services or refugees in general rather than refugee women's experiences in specific refugee settlement zones (Davidson et al., 2022; UNHCR, 2021). Thus, there is little empirical evidence available to understand how these factors working together affect the accessibility of SRHS for women aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement. Based on this, the present study focuses on the access of refugee women to SRHS, to provide context-specific evidence for policy, planning and humanitarian service delivery by refugee women.

2.3 Barriers to Availability and Accessibility of Sexual and Reproductive Health Services for Women Refugees Ages 15 to 49 Years

Despite the significant attempts by humanitarian actors and governments to increase access to sexual and reproductive health services for refugees, evidence shows that multiple barriers remain that hinder the provision and effective use of sexual and reproductive health services in refugee settings (Davidson et al., 2022; UNHCR, 2021). These barriers are at the individual, community, health system and policy level, affecting access to timely, acceptable, and quality SRHS for refugee women. An important debate is visible in the literature regarding the lack of association between the availability of health services and the actual uptake of services or reproductive health outcomes, with social, economic, cultural and structural factors remaining influential (WHO, 2022; UNFPA, 2019). The obstacles to SRHS are linked to displacement experiences, poverty, cultural beliefs, language barriers, lack of information, gender inequalities, stigma and vulnerabilities in healthcare systems among women refugees

aged 15-49 years (Davidson et al., 2022; O'Laughlin et al., 2021). These factors contribute to the ability of women to access services and/or reach health facilities, communicate their health needs, make informed decisions and receive appropriate reproductive health care or services. It is, therefore, important to understand these interacting barriers to create context-specific interventions to increase equitable access to SRHS among refugee women.

2.3.1 Language and Communication Barriers

Language barriers are one of the significant challenges influencing refugee women's access to SRHS, especially when refugees and health service providers speak different languages. Communication is crucial in reproductive health as women have to be able to share sensitive health issues, learn about the services offered, seek consent and make informed decisions about their reproductive health. Current evidence indicates that language barriers can impact trust between client and provider, limit understanding of health information, and hinder women's access to health services, such as contraceptive services, maternal services, HIV prevention services, and support for sexual and gender-based violence (SGBV) (Munyaneza & Mhlongo, 2019; Christopher et al., 2022; UNHCR, 2023). Thus, language accessibility is crucial not only for communicating with other people but also as a factor affecting the quality, acceptance and use of SRHS for refugee women.

In a study in Durban, South Africa, language has been identified as an issue relating to communication between refugee women and health care providers. Some challenges were noted when refugees were not exposed to health care workers' local languages, resulting in poor communication during health care visits (Munyaneza & Mhlongo, 2019). Likewise, UNHCR noted that women refugees in Turkey faced difficulties accessing SRHS because health care providers were not Arabic-speaking, impacting communication and service delivery (UNHCR, 2023). Language problems have also been cited among refugees in Uganda. Christopher et al., 2022, conducted a study among urban refugees in Kampala and found that refugees with other languages (e.g. French, Arabic, Swahili) had access difficulties to SRHS, as healthcare systems were predominantly conducted

in English and local languages in Uganda. This challenge can also be applicable in Kyangwali Refugee Settlement where Kiswahili is widely used among refugees and the health services are dominated by health providers who use English or the local languages of Uganda.

There is, however, a lack of direct study of the impact of language issues on women refugees' access to SRHS in Kyangwali Refugee Settlement. Previous studies have shown that communication problems can impact on understanding health information, confidentiality, trust and healthcare seeking behaviours (Munyaneza & Mhlongo, 2019; Christopher et al., 2022), but little focus has been placed on how these issues are experienced in specific areas of the settlement by women refugees. This study will investigate the influence of language difference on women refugees' access to SRHS in Maratatu D Zone as good communication is the core of the confidential, respectful, and quality reproductive health and services.

The refugees in Kyangwali Refugee Settlement come from various countries and are supported by the Government of Uganda, UN organisations, and partners in the humanitarian community who offer protection, reproductive health interventions and healthcare (Government of Uganda & UNHCR, 2019; UNFPA, 2018). Several programmes to enhance access to SRHS have been put in place such as family planning, maternal healthcare, HIV prevention, and community sensitization programmes, yet there is evidence that access is not consistent, and is likely to differ by geographical location and individual circumstances, as well as socio-cultural factors and the sustainability of humanitarian interventions (Reproductive Health Uganda, 2021; UNFPA 2018). This means that access of refugee women to SRHS programmes is not always equitable. But the current research interests have been mostly on settlement level and there is still not much research work on the implementation of these services and women refugee experiences and access to these services at particular zone like Maratatu D Zone. This makes it necessary to explore the availability and accessibility of SRHS for female refugees 15-49 years old in the study area in a context-specific manner.

2.3.2 Geographical and Transportation Barriers

The women refugees' access to SRHS remains an issue due to distance from health facilities and lack of access to transportation. These barriers are especially important for pregnant women who need ANC services, emergency obstetric services or delivery services. Amongst displaced Syrian women in Lebanon, distance and transportation problems were cited as significant barriers to access to reproductive health services (Reese Masterson et al., 2014). Also, some women in Kakuma Refugee Camp were stating that they had to walk long and unsafe distances to reach healthcare facilities, especially in labour emergencies. Others walked kilometre distances or waited for the ambulance service, putting their lives at risk during childbirth (Lallai et al., 2020).

The gender analysis conducted in Bidibidi and Imvepi refugee settlements in Uganda found that the challenges of transporting goods or getting to a facility and the distance were significant constraints on SRHS access. Transportation costs were an issue for many women, making it hard for them to visit health facilities regularly, particularly while pregnant (Laurent, 2022). The findings show that despite availability of services in refugee settlements, women may not be able to access services for various reasons, including geographical distance and transportation. There are health facilities and community-based health interventions within Kyangwali Refugee settlement, however, there was a lack of evidence related to the transportation challenges in the Maratatu D Zone among women refugees. This study will therefore explore distance and transport related factors to access to SRHS.

Previous research has demonstrated the relevance of geographical barriers among refugee women in terms of accessing SRHS services, such as on antenatal care attendance, skilled delivery services and family planning services (Reese Masterson et al., 2014; Lallai et al., 2020; Laurent, 2022). The literature also shows that the impact of distance and transportation difficulties is associated with the layout of settlements, the availability of referral systems, road infrastructure and humanitarian support mechanisms (Lallai et al., 2020; Laurent, 2022). The studies provide significant insights into the impact of physical constraints on refugee women's health care-seeking behaviour; however, they also illustrate the contextual nature of geographical

constraints and their non-transportability to other refugee contexts. Physical barriers have been well documented with existing studies, although some have focused on settlements outside Uganda or refugee populations in general, rather than specific settlement zones (Reese Masterson et al., 2014; Lallai et al., 2020). This leads to partial awareness of the geographical factors that affect the access to SRHS among the women refugees in the specific zones of Kyangwali Refugee Settlement specifically Maratatu D Zone.

2.3.3 Financial Barriers

The financial constraints are a major constraint that impacts refugee women's access to SRHS. While some humanitarian health services are free, refugees might incur indirect costs, such as transportation costs, medication costs and missed wages or household chores when visiting health facilities. In qualitative research among refugee women in Durban, South Africa, financial factors were cited as a reason for women to be unable to access reproductive health care services. Some of the participants reported using public health facilities due to inability to access other health facilities but at times face unkind treatment in them (Munyaneza & Mhlongo, 2019).

One of the major concerns for the refugees in Uganda is poverty. Refugees, as reported by the World Bank (2019), are also more likely to be in poverty than host communities, which puts them at a higher risk of facing financial difficulties related to health care. Some women faced challenges accessing childbirth services, ANC and contraceptives due to financial constraints as a result of a study conducted at Kyaka II Refugee Settlement (A & F, 2022). Despite some focus on the financial restrictions faced by women refugees aged 15–49 years in Kyangwali, however, the previous literature has been primarily concerned with the general refugee population. The knowledge of these challenges is crucial when developing an intervention based on an application of improved equitable access to SRHS.

Although there have been initiatives at the humanitarian level to provide free medical care to refugees, the reviewed literature indicates that financial constraints are preventing refugee women from accessing available SRHS. Previous research provides

valuable insights into the direct and indirect costs (including poverty, costs of transportation and prescription drugs) that reduce utilization of reproductive healthcare services among refugee women (Munyaneza & Mhlongo, 2019; World Bank, 2019; A & F, 2022). The literature also indicates that other vulnerabilities such as unemployment, gender inequalities, household responsibilities and reliance on humanitarian assistance are interconnected with financial constraints that affect women's uptake and continuation of using SRHS (Munyaneza & Mhlongo, 2019; World Bank, 2019). Improving access is more than removing the direct cost of services, as it is the wider socio-economic environment which influences women's ability to access available services. There are few studies available on the financial situation faced by women refugees aged 15-49 in SRHS access in Kyangwali Refugee Settlement in Maratatu D Zone. Hence, additional research is needed to provide context-specific evidence of the impact of financial factors on SRHS access in the study area.

2.3.4 Limited Awareness and Knowledge of SRHS

Even if available services exist, limited knowledge about services available may make it difficult to encourage refugees' women to seek care. Awareness affects the decisions made about seeking health care, informed decisions, and the time taken to utilize preventive and treatment services. A study of Syrian refugee young women in Lebanon revealed that some were not aware of the services available for SRH, and lower levels of knowledge were linked to lower educational status (Korri et al., 2021). In a comparable study in Southern Africa, women who knew more about the SRHS were more likely to access the services provided than women who knew less about the SRHS (Chawhanda et al., 2022).

In Northern Uganda, refugee education level was correlated with refugee utilisation of SRH services, with those with higher education reporting greater uptake of SRH services than those with lower education levels (Bukuluki et al., 2023). The results show that health education and information sharing is important to enhance uptake of services. Advocacy/Adult education has been conducted to enhance refugees' communication and information access capacities in Kyangwali Refugee Settlement. Participation of

women, however, has been influenced by the domestic duties and gender roles of women (Refugee Law Project, 2020). Thus, poor education and access to information may still have a bearing on women's access to available SRHS.

SRHS literature shows that the knowledge of the SRHS is a key pathway between service availability and utilization, because awareness can help women identify services available, make informed health decisions and access timely services (Jain et al., 2019; Hawkey et al., 2022). The literature also highlights the importance of education and community sensitization activities in raising awareness and improving health seeking behaviour among refugees, while noting that access to information on SRH is affected by factors such as language, education level, cultural norms, gender relations and social context (Jain et al., 2019; Chawhanda et al., 2022). This raises the question of whether, without structural and social changes, women would take the necessary steps to utilise the health information provided, when there are still structural and social barriers to them doing so. SRHS knowledge among refugees in Maratatu D Zone is however, limited on whether they have adequate knowledge of available SRHS and how these impacts on their use thereof. The current study aims to fill an important gap in context.

2.3.5 Cultural and Gender-Related Barriers

The ability of women refugees to access and have access to SRHR is affected by cultural beliefs, gender norms and social expectations. Women's family structure, community norms and beliefs, and women's autonomy also influence reproductive health choices. Talking about contraception, sexuality, pregnancy, and sexually transmitted diseases (STD) could be sensitive in certain refugee groups, and may make women less willing to seek information or services. In a qualitative study among Syrian refugees in Lebanon, women and men were supportive of formal education programmes on SRH, but cultural norms restricted discussions of sexual and reproductive health and particularly between parents and adolescents. There were some mothers who were not comfortable discussing topics of SRH with their daughters, which limited opportunities for young women to receive accurate information (Jain et al., 2019). This indicates that cultural beliefs can affect the access to and use of SRH information.

Likewise, in refugee women from various culture backgrounds studies have indicated that preferences for healthcare providers can influence the use of reproductive health care services. For instance, some refugee females refused to be screened for cervical cancer due to their discomfort with being examined by a male health care worker (Muhaidat et al., 2022). It indicates that culturally sensitive and culturally appropriate health care delivery is important in enhancing women's access to SRHS.Women may also be constrained in their reproductive health choices due to gender inequalities. Women may not be able to access health facilities or contraceptives due to their limited decision-making authority, reliance on male partners and household obligations. Women had limited participation in the adult education programmes as they had domestic responsibilities in Kyangwali Refugee Settlement (RLP, 2020). This suggests that gender roles can act as a barrier to women accessing health information and services, indirectly.

But the current studies offer only partial insights regarding the role of culture and gender specifically in the access to SRHS for women refugees in Maratatu D Zone. While social norms, gender roles, and cultural beliefs have been shown to affect women's decision making, healthcare-seeking, and their inclination to use reproductive health services (RHS) in general, little research has investigated their impact on access in the context of refugee settlements. Thus, they must be analysed to shed light on the social context that affects women refugees' utilisation of reproductive health services in Kyangwali Refugee Settlement, D Zone, Maratau.

2.3.6 Age-Related Barriers and Limited Attention to Women Throughout the Reproductive Age Group

SRHS access may be affected by age, as access decisions for humanitarian responses may prioritise certain groups, for example, adolescents, pregnant women or survivors of sexual violence. Attention given to these groups is necessary but could be exclusive to particular groups of focus, and prevent broader attention to the reproductive health needs of women of reproductive age (15–49 years). Adolescent refugees' research underscores the need for SRHS for youth. In Bidibidi Refugee Settlement, Uganda, the

provision of SRH information to adolescent refugees resulted in a delay in risky sexual behaviours and better decision-making (Bukuluki et al., 2021). In the same way, Windle International Uganda (2022) did research on the issue of teenage pregnancies among adolescent mothers in Kyangwali and Palabek refugee settlements and identified the need for social and behavioral change communication to combat the problem.

While adolescent SRH programmes are essential to support adolescents' reproductive health needs, the heightened focus on adolescent-specific interventions could lead to some neglect of other women of reproductive age who also have comprehensive needs, such as family planning, STI prevention and treatment, cervical cancer screening, and maternal health services (Bukuluki et al., 2021; UNFPA, 2019). While past studies on adolescent refugees provide useful evidence of the relevance of SRH information, youth-friendly services and behavioral interventions, their findings might not apply to the wider reproductive age group of 15–49.Previous research on adolescent refugees offers valuable evidence of the importance of SRH information, youth-friendly services and behavioral interventions, but may not reflect the experiences and needs of women in the broader reproductive age group of 15–49 years (Bukuluki et al., 2021). This raises the question of whether there is an appropriate level of attention paid to the broader reproductive health concerns of refugee women through targeted activities for particular age groups. In addition, there is little evidence available on the relationship between age and men's and women's access to and use of SRHS in Kyangwali Refugee Settlement in the age group of 15-49 years. This current study will close this gap, focusing on the access to SRHS at the level of women in the reproductive age group and not in only one of these groups.

The findings reviewed suggest that cultural and gender-related factors are complex determinants of SRHS accessibility as they affect women's autonomy, decision-making power, health-seeking behaviour and willingness to seek health care (Jain et al, 2019; Muhaidat et al, 2022). Preliminary findings provided by previous studies are also relevant to provide insights regarding how cultural beliefs, gender norms and social expectations influence other reproductive health behaviours, such as use of contraceptive, accessing screening services, and accessing reproductive health

information. Yet the literature also indicates that these forces are meaningful only in a specific context and are differential between refugee communities based on social structures, cultural backgrounds, gender relations and the organisation of health services (Jain et al., 2019; Muhaidat et al., 2022). The majority of the studies found have focused on refugee populations in other countries and/or broader settlement contexts, which has limited their understanding of such dynamics in relation to women refugees in Kyangwali Refugee Settlement. Thus, further studies should be conducted to explore the effects of cultural and gender on access to SRHS among women refugees at Maratatu D Zone.

2.3.7 Health System and Humanitarian Response Barriers

The accessibility and availability of SRHS for refugee women may be influenced by factors within the health system. They range from a lack of health workers, funding lapses, lack of supplies, poor infrastructure, and reliance on humanitarian organisations. While humanitarian actors are key providers of SRHS in refugee contexts, they can have an impact on the sustainability of the SRHS when these interventions are based on short-term projects. When the Reproductive Health Uganda ACCESS project was closed in Kyangwali Refugee Settlement, for instance, beneficiaries began to express concerns about the provision of free family planning services (Reproductive Health Uganda, 2021). This shows that external financing programs can provide short term access, but not necessarily sustainable solutions.

Likewise, in refugee camps, the lack of qualified health care personnel has had an impact on health services. Due to limited numbers of trained health workers, some refugee women in Dadaab Refugee Camp found themselves dependent on TBAs (Mwoma et al., 2021). These shortages can impact on quality of care and prompt reproductive health issues that need to be managed in a timely manner. Additionally, the type of SRHS provided may be based on humanitarian priorities. Research in various refugee settings indicates that some services have been given less attention, including comprehensive reproductive health counselling and safe abortion care, as compared to maternal health in emergencies and disease prevention services. Research in different

refugee settings reveals that specific services were not given the same attention as some services in the area of maternal health in emergencies and disease prevention, such as comprehensive reproductive health counselling and safe abortion care. This leaves large areas of the SRHS provision missing.

Overall, it was found that the literature reviewed suggests that the barriers to access to SRHS for refugee women are multidimensional, complex and interrelated with individual, social, economic and health system factors. Previous studies have provided valuable contributions by highlighting communication challenges, geographical barriers, financial constraints, lack of knowledge, cultural differences, age differences and capacity of the health system (Munyaneza & Mhlongo, 2019; Jain et al., 2019; Bukuluki et al., 2021; World Bank, 2019). However, it is also noted from the literature that many of the studies focus on the individual or separate barriers, and do not analyze how these factors, in their multiple combinations, operate in specific refugee contexts to impact women's access to SRHS. Furthermore, the current evidence comes from refugee groups in other countries or from settlement level analyses, which only partially applies to the refugee women in Maratatu D Zone of Kyangwali Refugee Settlement. Hence, the aim of this study is to produce context-specific evidence of the interconnected barriers faced by women refugees (15-49 years) in the study area in relation to the availability and accessibility of SRHS.

Several reproductive health interventions targeting access to SRHS in Kyangwali Refugee Settlement such as maternal health, family planning, HIV prevention, and community-based health promotion have been implemented by humanitarian agencies (UNFPA, 2018; Reproductive Health Uganda, 2021). Current evidence, however, is largely limited to evidence on the implementation of programmes and service delivery outcomes, with little focus on whether current health system capacity, such as staffing, commodities, infrastructure and continuity of services is sufficient to address the reproductive health needs of women aged 15-49 years. This brings up an interesting question on whether humanitarian interventions have contributed to a long-term, equitable and quality access to SRHS. Identification of these health system factors in

Maratatu D Zone is therefore important to know the gaps and suggest the strategies to improve reproductive health system delivery for women refugees.

2.4 Summary of Literature Review and Research Gap

The literature reviewed in this study shows that sexual and reproductive health services are fundamental in ensuring the health and wellbeing of women refugees aged 15-49 years. Previous research demonstrates that governments, humanitarian organisations and non-governmental organisations (NGOs) have played a crucial role in a number of interventions, including maternal health services, family planning, HIV prevention and treatment, STI management, GBV response, SRH education, and reproductive health outreach programmes (UNFPA, 2019; UNHCR, 2021). There is, however, a significant discussion in the literature about whether the creation of SRHS automatically translates to access and/or better reproductive health results. Evidence suggests that although services are provided, they are often limited by weak human resources in health care institutions, fragmented funding, lack of access to all SRH components, lack of commodities and weak humanitarian health systems (Davidson et al., 2022; UNHCR, 2021). In the same way, social, economic, geographical and cultural determinants are interdependent and continue to affect accessibility, such as distance from health facilities, transport problems, poverty, language difficulties, lack of awareness, stigma, cultural beliefs and gender inequity (Jain et al., 2019; Munyaneza & Mhlongo, 2019). The results indicate that the improvement of SRHS among refugee women does not only depend on the availability of services but also on the overall structural and social context for women's ability to access services.

Although considerable research has been carried out on refugee SRHS around the world, there are still gaps in knowledge. While previous studies have made valuable contributions to evidence on reproductive health challenges faced by refugee populations, much of this evidence comes from refugee groups outside Uganda such as those from Syria in the Middle East and Rohingya refugees in Asia, whose health systems, humanitarian responses and sociocultural contexts vary from Ugandan refugee settlements. Therefore, the applicability of these results to the context in Uganda is

limited. Moreover, previous studies often focus on one of the several components of SRHS, such as maternal health services, family planning, HIV prevention, or others, without a holistic view of the availability and accessibility of multiple services among women refugees. Furthermore, much of the evidence available is of national or settlement-wide level, with little consideration of the nuances that may exist within zones in refugee settlements. There is limited empirical evidence on the availability of comprehensive SRHS for women refugees aged 15-49 years in Maratatu D Zone in the event of need, despite a number of SRH interventions that have been implemented by government and humanitarian actors in Kyangwali Refugee Settlement. Further, the unique social, economic, cultural and health system issues that impact on service access within this local context have not been adequately considered. The aim of this study is thus to fill these gaps by providing context-specific evidence of the availability, accessibility and barriers to SRHS among women refugees in Maratatu D Zone, Kyangwali Refugee Settlement.

Thus, with this knowledge gap this study aims to provide context specific evidence on availability and access to SRHS for women refugees aged 15–49 years in Maratatu D Zone of Kyangwali Refugee Settlement. It specifically looks at availability of essential SRH services, factors that influence women's access to the services, and social, economic, cultural and health system barriers to effective utilisation. The findings will inform evidence-based planning and impact efforts to improve equitable and responsive SRH interventions for refugee women by government agencies, humanitarian organisations and health service providers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter outlines the methodology used in conducting the study on availability and accessibility of sexual and reproductive health services for women refugees aged between 15-49, in Maratatu D Zone, Kyangwali Refugee Settlement. It outlines the methods and techniques that can be used to collect, transform and interpret information to address the research questions.

The research design, study area, sources of information, study population, sample size determination, sampling procedure, study variables, data collection methods and instruments, data quality assurance procedures, data analysis techniques, ethical considerations, and anticipated methodological limitations and mitigation measures are explained in the chapter.

The methodology aimed at providing quantitative data about the availability, accessibility, and utilization of sexual and reproductive health services by women refugees, as well as qualitative data on institutional, social, cultural, and contextual factors that can affect access to these services.

3.1 Research Design

The study used a mixed methods approach that incorporated both quantitative and qualitative methods. The decision for a mixed-methods design was informed by the type of research problem, which included the measurement of availability and accessibility of sexual and reproductive health services and understanding women's refugee experiences and contextual factors that affect the utilization of sexual and reproductive health services.

The design for quantitative data was cross sectional survey. This allowed the researcher to gather quantitative data from women refugees (15-49 years old) at one time. The approach was suitable as the study aimed to identify the proportion of women who

knew of sexual and reproductive health services, women who had accessed sexual and reproductive health services, and the barriers to sexual and reproductive health services use. The quantitative methods yielded measurable indicators which could be statistically analyzed to draw relationships between availability, accessibility, utilization and barriers.

The qualitative aspect consisted of key informant interviews with persons first-hand involved with refugee health service deliveries and community structures. This was chosen because there are some issues relating to accessibility of sexual and reproductive health services which are not adequately captured in numerical data such as cultural beliefs, community perceptions, institutional challenges, resource availability and implementation experiences. The combination of the two approaches enabled methodological triangulation. Qualitative explanations from service providers and community representatives were supported by quantitative findings from women refugees. This enhanced determination of results by making the results more meaningful and providing rationales for any observed patterns.

3.2 Area of Study

This study was carried out in Kyangwali Refugee Settlement in Kikuube District, Western Uganda. The settlement is located close to the border of the Democratic Republic of Congo (DRC) and has received refugees from various countries, including the Democratic Republic of Congo, South Sudan, Burundi, Rwanda, Somalia and Kenya.

The Government of Uganda, under the Office of the Prime Minister (OPM) is the administering authority of Kyangwali Refugee Settlement in partnership with the United Nations High Commissioner for Refugees (UNHCR) and other humanitarian organizations. They are organizations that offer protection, health services, livelihood support and other humanitarian services. The study was specifically targeted at Maratatu D Zone, one of the zones of Kyangwali Refugee Settlement. The zone was chosen due to the fact that it hosts a high number of refugees and is one of the densely populated areas in the settlement. The estimated settlement population size of

Maratatu D Zone based on population records in the settlement is about 15,075 people from 15 households.

The age of women refugees (15-49 years) was selected as the focus of this study because it is the reproductive age group, which has an increased need for sexual and reproductive health services. They encompass a range of services such as family planning, antenatal care, skilled delivery, HIV prevention and treatment, STI services, cervical cancer screening, gender-based violence response services, and reproductive health information. The choice of Maratatu D Zone was appropriate to address the aim of assessing the accessibility and responsiveness of sexual and reproductive health services to the needs of women refugees in refugee humanitarian programmes.

3.3 Sources of Information

The study used primary and secondary sources of information.

3.3.1 Primary Sources

Primary data was obtained from women refugees aged 15-49 years, and selected key informants.

Women refugees gave numerical data on:

- knowledge of sex and reproduction health services
- accessibility of services in the settlement
- performance of reproductive health functions and
- transitions in the health-care system and
- barriers affecting access

Qualitative information was gathered from key informants about:

- sexual and reproductive health services in the settlement
- service delivery processes
- access to health facilities and health services and

- challenges affecting access
- actions taken to increase usage of services

3.3.2 Secondary Sources

Secondary data was gathered from the literature and documents available on refugee health and sexual and reproductive health services.

These included:

- peer-reviewed journal articles

The Government of Uganda states;

- National and provincial newsletters and magazines and
- UNHCR reports
- UNFPA reports
- WHO documents
- humanitarian organization reports
- policy documents

The literature review was supplemented by secondary sources, which were used to compare findings of the studies with the existing literature.

3.4 Study Population

The study population comprised of women refugees aged 15-49 years living at Kyangwali Refugee Settlement in Maratatu D Zone. Women in this age group were chosen because they are considered to be in the reproductive age group and are likely to seek sexual and reproductive health services at various stages of their reproductive life cycle.

Key informants were also included in the study, who had knowledge and experience of refugee health services. These included representatives from health workers, humanitarian organisations, government officials, and refugees' community leaders.

Incorporating the voices of service users and providers allowed the study to gain insights from both perspectives: views of women refugee clients seeking services and the perspectives of the service providers.

3.5 Sample Size Determination

The quantitative sample size was calculated with a SurveyMonkey sample size calculator.

The calculation considered:

- study population: 5,064 households
- confidence level: 90%
- margin of error: 5%

Using these parameters, the sample size was calculated as 259 women refugees in the age range of 15-49 years.

This sample size was deemed adequate to allow for information about women refugees in Maratatu D Zone to be gathered and was believed to be manageable for the resources made available for the research. The purposive sampling technique was employed in selecting the key informants for the qualitative component. Enough information was collected by targeting about 15-20 participants, with knowledge and involvement in sexual and reproductive health service provision.

3.6 Sampling Techniques

The study was done using both probability and non-probability sampling methods.

3.6.1 Simple Random Sampling

Women refugees who were involved in the quantitative survey were selected by simple random sampling.

A household listing obtained from settlement structures was used as the sampling frame. Numbers were given to eligible households and participants were randomly

selected to ensure equal opportunity for the participation of all eligible women refugees. If there was more than one eligible female present in a household, a random selection process was used to determine which participant would be selected.

This approach minimized selection bias and enhanced representativeness of quantitative results.

3.6.2 Purposive Sampling

For qualitative interviews, the key informants were selected by purposive sampling techniques.

The participants were chosen on their basis of roles, knowledge and direct involvement in refugee health services.

The categories selected were:

- Healthcare providers for refugees (3)
- humanitarian organization staff(4)
- government refugee officials (1)
- community health workers (3)
- refugee leadership representatives (2)
- women representatives (2)

Total of 15 key informants

Purposive sampling was suitable as the study aimed to obtain detailed information from those who knew their way around sexual and reproductive health services in the refugee settlement.

3.7 Study Variables and Measurement.

The study included the independent, dependent and intervening variables in three categories.

3.7.1 Independent Variable: Accessibility of SRH services

Availability was the independent variable and was defined as the presence of sexual and reproductive health services in the refugee settlement.

Measures were taken using indicators such as:

- access to birth preparedness and
- skilled delivery services and
- availability of contraceptive methods
- health care provider recommendation
- use of STI diagnosis and treatment and
- access to reproductive health information and
- the use of methodology for gender and gender-based violence service provision and
- availability of cervical cancer screening

Women refugees were questioned on their awareness of these services, availability of such services, and its utilization.

3.7.2 Dependent Variable: Accessibility of SRH Services

Dependent variable was accessibility defined as the ability of women refugees to access and utilize available sexual and reproductive health services as needed.

Accessibility was gauged by:

- access to transport and
- transportation availability
- affordability of services
- waiting time

- availability of information
- counselling on health, hygiene and nutrition; and
- acceptability of services

Use of services (as actually used).

3.7.3 Intervening Variables

Factors potentially affecting the relationship between service availability and accessibility were used as intervening variables.

These included:

- age
- education level
- economic status
- language barriers
- cultural beliefs
- knowledge of services
- social support
- physical location

The intent of these variables is to consider those that were examined because the availability of services does not necessarily equate with access or utilization.

3.8 Data Collection Methods

Both qualitative and quantitative data collection were used to provide information for the purposes of the study. The data collection methods used were quantitative and qualitative, which are used to gather measurable data from women refugees and detailed explanation of the service provision, accessibility issues and contextual factors that affect sexual and reproductive health services from key informants.

3.8.1 Questionnaire Survey Method

Structured questionnaires were used to gather quantitative data from 259 women refugees aged 15-49 years in Maratatu D Zone.

The questionnaire was chosen because it allowed the researcher to gather standardized data from a relatively large sample of subjects in a relatively short time. It also enabled the responses to be measured and statistically analysed to identify trends and patterns in the study variables.

This questionnaire consisted of four main sections:

Section B: Cultural factors, time and nutrition. Section C: Health and hygiene, sanitation.

This section collected information about participants:

- age
- marital status
- education level
- nationality
- household characteristics

These characteristics were important as they could affect knowledge, availability, accessibility, and use of sexual and reproductive health services.

B: Sexual and reproductive health services accessible (SRHS)

This section aimed to determine if women refugees knew about and had access to services.

Questions focused on:

- the presence of a doctor or midwife at home and
- line of credit and

HIV testing and treatment services (HITS);

- Advocacy and outreach around and within the STI system and
- sex education and
- gender-based violence services
- cervical cancer screening

Section C: Accessibility and utilization of services

Questions assessed:

- whether respondents had ever used sexual and reproductive health services
- the amount of care used and
- availability and quality of health facilities and
- transportation challenges
- waiting time
- expenses of accessing services
- Satisfaction of received services.

D Barriers to access

In this section, factors that might affect access were evaluated, such as:

- financial constraints
- language barriers
- cultural beliefs
- fear of stigma
- lack of information
- attitudes of the healthcare providers towards patients, which are unfriendly

- geographical barriers

Most of the questions in the questionnaire were closed-ended, such as multiple-choice questions and statements with a Likert scale, to enable statistical analysis.

A key informant interview method has been utilized to gather information from the key informants.

Semi-structured key informant interviews were conducted to collect qualitative data.

Interviews were chosen as one method for gaining further insights into topics that were not fully captured in the survey responses. The information was gathered from key informants, whose roles and experiences in refugee health service delivery were used as the basis for providing information.

The interview guide focused on:

- The type of sexual and reproductive health services/welfare being provided in Kyangwali Refugee Settlement
- supply of healthcare workers, medicines, equipment and supplies
- interventions and services to enhance women refugees' access to services
- challenges faced by the service providers
- social and cultural factors leading to the use or non-use of services
- recommendations for improving sexual and reproductive health services

Key informants included:

The categories selected were:

- Healthcare providers for refugees (3)
- humanitarian organization staff(4)
- government refugee officials (1)
- community health workers (3)

- refugee leadership representatives (2)
- women representatives (2)

Total of 15 key informants

Interviews produced qualitative data which complemented the findings obtained through the quantitative data collection from the women refugees.

3.8.3 Documentary Review Method

Document review was used as a supplementary method of data collection.

The researcher scanned the available documents on refugee health and sexual and reproductive health services such as:

- UNHCR reports
- UNHCR Uganda reports and
- General thumb rules and
- humanitarian organization reports
- academic publications

Background information and support for interpretation of primary findings were provided through document review.

3.9 Data Collection Instruments

The study used three main instruments:

1. Structured questionnaire
2. Guide for conducting key informant interviews
3. Document review checklist

3.9.1 Structured Questionnaire

The questionnaire had been designed in accordance with the study objectives, study questions and literature reviewed.

It was given to women refugees (15-49) to gather quantitative data on:

- sexually and reproductive health services available
- accessibility of services
- utilization patterns
- barriers affecting access

Questionnaire administered by the researcher, with the help of a trained interpreter if needed.

The Key Informant Interview Guide is provided in this section.

The qualitative information was collected from selected key informants using a semi-structured interview guide.

The guide included open-ended questions which enabled the participants to share their experiences, observations and recommendations about sexual and reproductive health services. The researcher asked probing questions to gain further clarification if required.

3.9.3 Document Review Checklist

A checklist was created to assist in extracting the relevant information from reports, policies and publications.

The checklist was centred on:

- sexually and reproductive health services
- refugee health programmes
- barriers affecting access

- previous interventions

Assess data collection and interpretation in terms of their language.

English and languages commonly understood by the refugees in Kyangwali Refugee Settlement (KRS), mainly Kiswahili and the appropriate Congolese languages, were used for data collection. Some of the participants were not very fluent in English so a trained interpreter was recruited to help during the administration of questionnaires and interviews.

The interpreter was chosen for the following:

- understanding of refugee needs and humanitarian issues
- ability to communicate in local refugee languages

Comprehension of confidentiality guidelines.

The researcher received training from the interpreter regarding:

- maintaining confidentiality
- translating questions accurately
- Not conditioning the participants' answers

Interview-administered questionnaires were used to assist participants that couldn't read or write. The researcher asked the questions orally and wrote down the answers for the participants. All the respondents were informed of the purpose of the study and given informed consent prior to taking part in the study.

3.11 Data Quality Assurance

The information collected was subject to quality assurance to ensure it was valid, reliable and accurate.

3.11.1 Validity

Validity is a validation of research instruments with regard to measuring what is being measured.

Validity was ensured through:

- measuring and quantifying the problem and
- reviewing relevant literature
- asking for expert and supervisor feedback
- revising unclear questions

Pre-testing of the questionnaire prior to the data collection.

The pre-test was useful in identifying some questions that were not clear, language barriers and issues with questionnaire administration.

3.11.2 Reliability

Reliability is the consistency of research measurements.

The following measures were taken to improve the reliability:

- using standardized questionnaires
- training the interpreter
- ensuring the same data collection procedures are adhered to
- Promptly delivering completed questionnaires or reports and
- complete collection of information

3.12 Data Processing and Analysis

The student will process and analyze quantitative data.

Data was gathered quantitatively using questionnaires which were completed, coded, entered, checked, cleaned and analyzed using the SPSS software.

Descriptive statistics including:

- frequencies
- percentages
- tables
- graphs and charts

Findings were summarized using . . .

Relationships between variables and the test of the study hypotheses were determined using inferential statistical tests.

The following hypotheses were tested:

Hypothesis One

H_{01}: In Maratatu D Zone, the availability of sexual and reproductive health services is not associated with the availability of these services for women refugees aged 15-49 years.

To decide if there was a significant association between availability of services and accessibility, a Chi square test of association was performed.

Hypothesis Two

The alternative hypothesis (H_{02}): There is no statistically significant relationship between accessibility of sexual and reproductive health services and utilization of sexual and reproductive health services among women refugees aged 15-49 years.

The test of association Chi-square was used to find out whether there was an association between accessibility factors and utilization of sexual and reproductive health services.

Hypothesis Three

H_{03}: Barriers to sexual and reproductive health services do not have a statistically significant association with access to sexual and reproductive health services among women refugees aged 15-49 years.

A Chi-square test was used to assess for statistical association of distance, cost, language and cultural differences with access.

The significance level used for making decisions was $p < 0.05$.

The analysis and processing of qualitative data can be expressed at three levels: 3.12.2 Qualitative Data Processing and Analysis.

Thematic analysis was used to analyse the qualitative data obtained from key informant interviews.

The process involved:

1. Transcribing interviews
2. Reading transcripts carefully
3. Developing initial codes
4. Classifying codes into themes
5. Clearly identifying themes in accordance with study goals

Major themes included:

- sexual and reproductive health services available
- accessibility challenges
- barriers affecting utilization

Recommendations on how services can be improved.

Qualitative findings were incorporated with quantitative findings in the interpretation.

3.13 Ethical Considerations

The study was conducted after getting ethical approval and appropriate permissions.

The researcher secured ethical clearance from his/her university research ethics committee and permission from the relevant refugee authorities.

The following ethical principles were respected:

Confidentiality

All participants' information was kept confidential. The names were not written on questionnaires or on the transcripts of the interviews. Data stored in a secure manner and only for academic purposes.

Informed Consent

The participants were given information on:

- the research objective and
- procedures involved
- their rights
- possible risks and benefits

The participation was voluntary, and the subjects gave their consent to participate before they were asked to engage in it.

Voluntary Participation

Consenting participants were told they could withdraw from the study or refuse at any point without any penalties.

Avoidance of Harm

As sexual and reproductive health concerns are a sensitive issue, interviews were done with respect. Participants could refuse to answer any uncomfortable questions.

Privacy

Questionnaires and interviews were administered in an area of privacy to the participants.

The following factors limit the scope of this study and will be addressed in its mitigation:

The study was deemed to have several methodological constraints which might have influenced the data collection and data interpretation of the findings. But appropriate steps were taken to minimise their potential impact.

The expected constraint was the potential language barrier between the researcher and some of the women refugees, especially those who had not been very fluent in English. The researcher faced this challenge by using a trained interpreter who was familiar with the common languages spoken in Kyangwali Refugee Settlement such as Kiswahili and other refugee community languages. The interpreter aided in conveying research questions and responses from the participants while ensuring accuracy and confidentiality.

Another constraint was the potential for low literacy levels of some female refugees, which may have influenced their ability to fill in the questionnaires themselves. To overcome this problem, questionnaires were given orally, explaining the question clearly and taking note of the answers in place of the participants during face-to-face interviews. This method helped to take into account also the women who are unable to read and write and can be included equally in the study.

Another expected potential limitation was the sensitivity of sexual and reproductive health issues. Participants may have been hesitant to share information about contraception, pregnancy, sexual health or experiences of gender-based violence. To overcome this, the researcher used a series of interviews in private locations and obtained informed consent from the participants, ensured their confidentiality and provided a non-judgmental atmosphere where participants could speak freely without fear of judgment.

The study also expected difficulties with availability of the key informants given their workload. In an attempt to reduce this limitation, the timing of the interviews was arranged to be as convenient as possible to the participants and adequate advance was made to enable adequate planning.

Further, the study acknowledged the potential for social desirability bias, which is the tendency for respondents to provide answers that they believed were socially desirable, especially since sexual and reproductive health is an important topic. To minimize this bias, the researcher explained the purpose of the study, informed the participants that their responses would remain confidential, and let them know that there were no right or wrong answers. These measures facilitated truthful responses and enhance the reliability of the collected data to improve.

3.15 Chapter Summary

The methodology of the study used to investigate the availability and accessibility of sexual and reproductive health services among women refugees aged 15-49 years in Maratatu D Zone, Kyangwali Refugee Settlement was presented in this chapter.

A mixed methods research approach was used, which entails both qualitative interviews with key stakeholders and quantitative surveys with female refugees. The methodology allowed the study to produce measurable results whilst also being able to look at the contextual explanation of service availability and accessibility and barriers.

The findings of the study based on the collected and analysed data according the objectives of the study are presented in the next chapter.

CHAPTER FOUR

PRESENTATION, ANALYSIS, INTERPRETATION AND DISCUSSION OF RESULTS

4.0 INTRODUCTION

This chapter presents the analysis and interpretation of results of the data collected. The presentation and analysis begin with the response rate, demographic characteristics and the findings on the research objectives.

4.1 Response rate

The participants in the sample demonstrated a high level of cooperation, with the majority readily providing the requested information. A total of 259 questionnaires were distributed to the selected study sample. Out of these, 258 questionnaires were completed, returned, and subsequently validated, resulting in a response rate of 99.6%. This substantial response rate is considered highly representative of the sample, a perspective that is line with the recommendation of Amin (2005) on deeming an appropriate response rate.

Table 1: Showing response rate

Response rate	Frequency	Percent
Response	258	99.6
Non-response	1	0.4
Total	**259**	**100.0**

Source: Primary Data

4.2 Background characteristics of the respondents

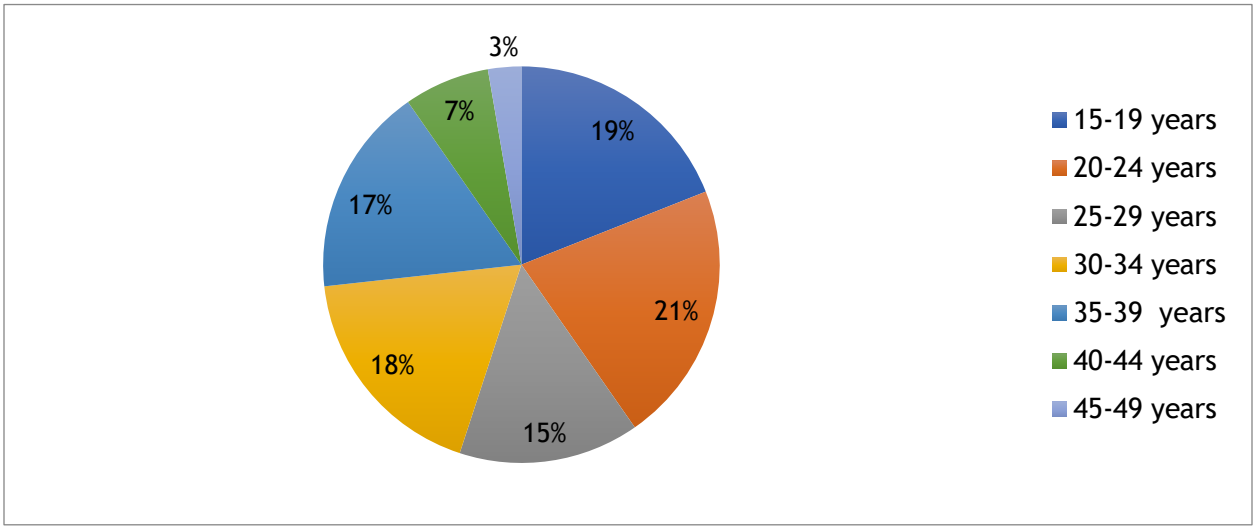
In this research, self-administered questionnaires were employed to collect data regarding various demographic attributes of the respondents, including their age, highest level of education, country of origin, marital status, and religion. The purpose

of gathering this demographic data was to better understand the profile of the respondents and assess how this background characteristics may influence their access to and utilization of sexual reproductive health services as refugees in the Kyangwali Refugee Settlement.

4.2.1 Age of the respondents

Respondents were requested to specify their age brackets. The results are summarized in *Figure 2* below:

Figure 2: Showing age of respondents



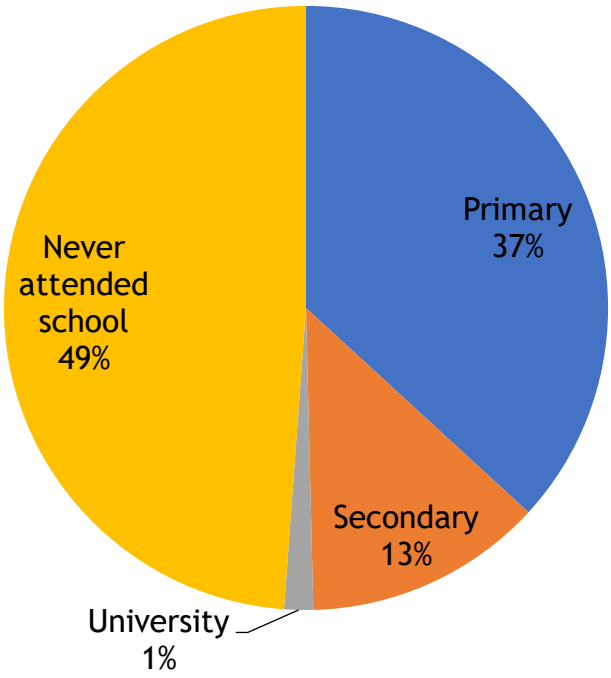
Source: primary data

The results concerning the age distribution of respondents reveal that the various age groups were represented in the sample as follows: 15-19 years (19.0%), 20-24 years (21.3%), 25-29 years (14.7%), 30-34 years (18.2%), 35-39 years (17.1%), 40-44 years (7.0%), and 45-49 years (2.7%). *Figure 1* illustrates that the largest proportion of female respondents in Kyangwali refugee settlement, Maratatu D zone (21%), falls within the 20 – 24 years age group. This indicates that the responses in this study predominantly come from a youthful age group. Conversely, a small minority (3%) belong to the 45-49 years age group, reinforcing the observation that the refugee settlement is primarily inhabited by younger women.

4.2.2 Highest level of education

The research inquired about the highest level of education attained by the respondents, and the results are presented below:

Figure 3: Level of education of respondents



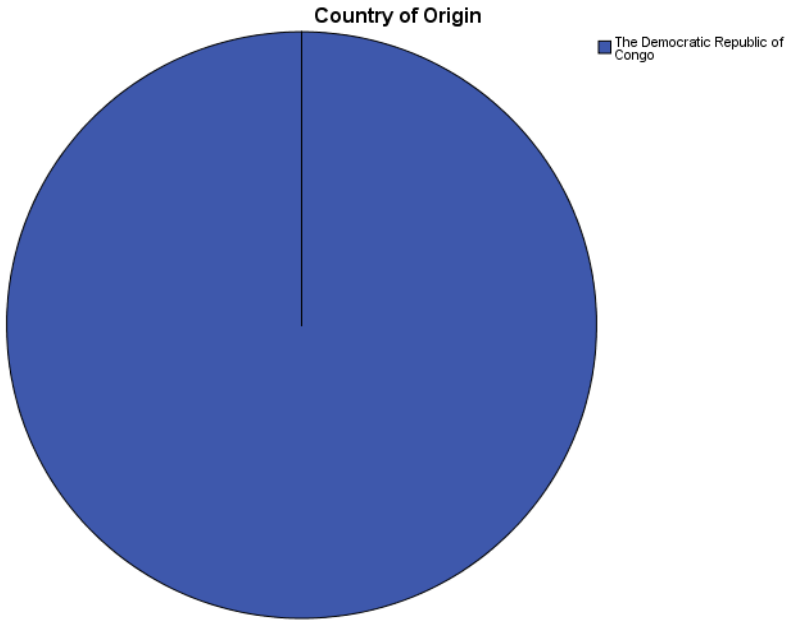
Source: primary data

In *Figure 3* above, the majority of respondents (49%) reported that they had never attended school. This was followed by individuals at the secondary level (13%), those with a primary education (37%), and a minority who had reached the university level (1%). These findings highlight that a significant portion of the respondents had limited or no formal education. Consequently, the researcher had to engage in more detailed, individualized data collection, ensuring each questionnaire item was thoroughly explained to the respondents due to their varying levels of education.

4.2.3 Country of origin

Respondents were requested to specify their country of origin before arriving at the Ugandan-based refugee settlement. The results are summarized in the *Figure 4* below:

Figure 4: Country of origin



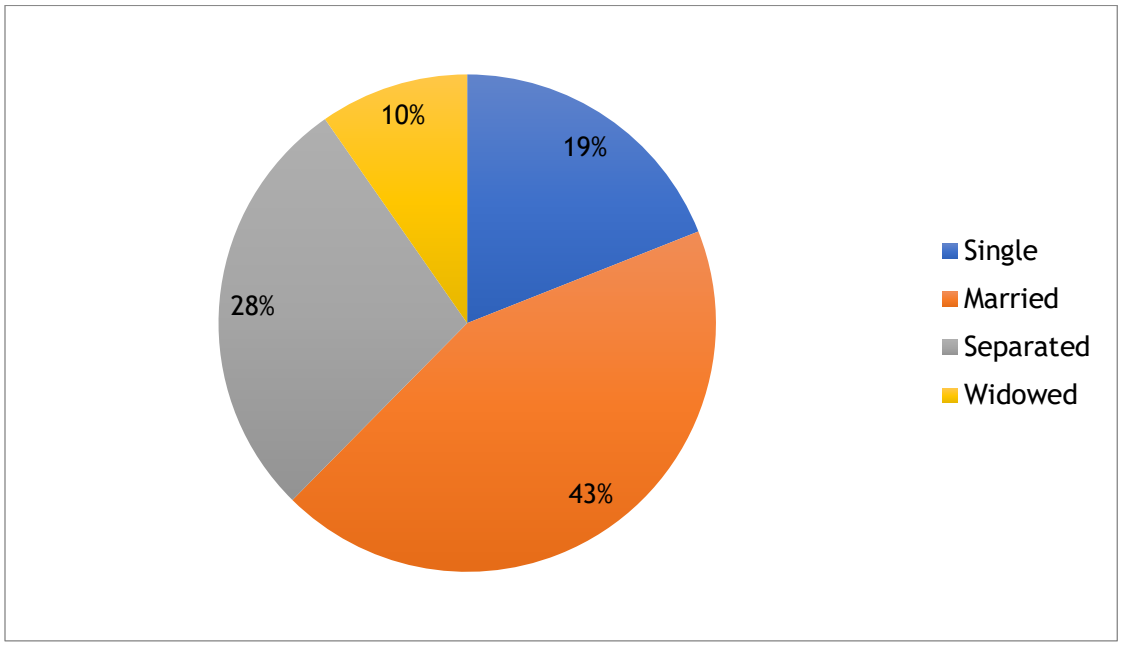
Source: primary data

In *Figure 4* above, it is evident that all of the respondents (100%) reported their country of origin as the Democratic Republic of Congo. This finding implies that the study is predominantly composed of respondents originating from a single country, namely the DRC.

4.2.4 Marital status of respondents

The study also aimed to ascertain the marital status of the respondents, and the results are presented below:

Figure 5: Marital status of respondents



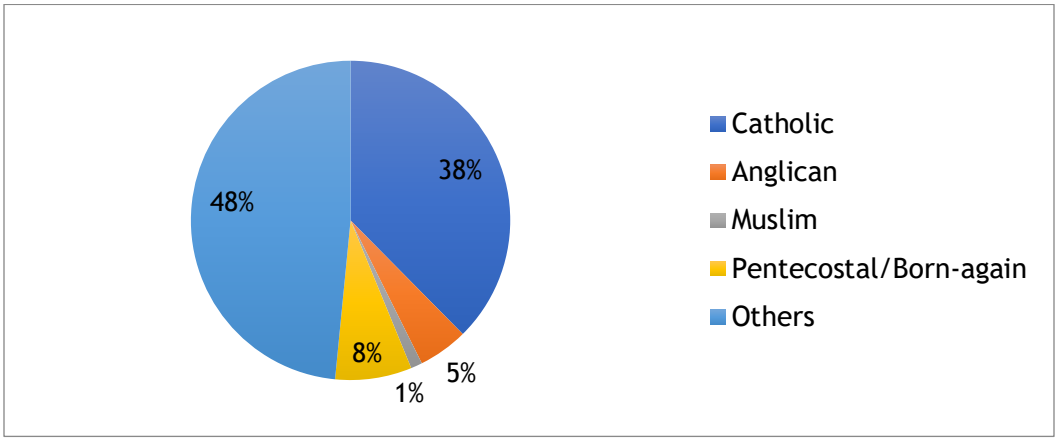
Source: primary data

As demonstrated in *Figure 5* above, 19% of the respondents reported being single, 43% indicated they were married, 28% had separated from their husbands, and 10% were widows. In summary, the largest proportion of respondents (43%) was in a married status. This suggests that a significant portion of the respondents had marital responsibilities, signifying their maturity and capability to provide meaningful responses to the questionnaire.

4.2.5 Religion

The study also examined the religious affiliations of the respondents, as illustrated below:

Figure 6: Religion of respondents



Source: primary data

As depicted in *Figure 6*, 38% of the respondents identified as Catholics, 5% as Anglicans, 1% as Muslims, and 8% as Pentecostal/Born-again. A significant portion, comprising 48%, reported belonging to various other religious groups, including Jehovah Witnesses, IC, African Spirituality, and more. Consequently, the results indicate that the majority of respondents (48%) belonged to diverse religious affiliations, reflecting the study's representation from various religious denominations.

4.3 Study Findings

This study aimed to ascertain the availability and accessibility of sexual and reproductive health services among women refugees residing in the Maratatu D zone of the Kyangwali Refugee Settlement. A questionnaire was administered to 259 women refugees, and key informants were interviewed using semi-structured guides. The respondents who participated in the key informant interview were selected based on their involvement in providing sexual and reproductive health services and refugee health in general. The quantitative results of this study were expressed in percentages and frequencies. The qualitative results from the key informants were thematically analysed and reported to provide an in-depth understanding of the research issue.

The discussion below follows the research objectives of this study. The first part of the discussion presents the availability of sexual and reproductive health services as reported by the study participants. The second part highlights the accessibility of these

services based on the responses obtained from the women refugees. The last segment of the discussion segment expounds on the barriers to accessing sexual and reproductive health services encountered by the women refugees.

4.3.1 Availability of Sexual and Reproductive Health Services among Women Refugees in Maratatu D, Kyangwali Refugee Settlement

The first objective of this study was to determine the availability of sexual and reproductive health services among the women refugees residing in Maratatu D Zone. In this study, availability was defined as whether the respondents knew or had ever used any of the sexual and reproductive health services provided within the Maratatu D Refugee Settlement. The following sexual and reproductive health services were enquired about: maternal care, family planning, HIV testing and counselling, sexually transmitted infection (STI) treatment, sexual and reproductive health education, cervical cancer screening, gender-based violence services, and abortion.

Table 2: Availability of Sexual and Reproductive Health Services Reported by Key Informants

Sexual and Reproductive Health Service	Available (Yes/No)	Main Providers	Source of Information
Antenatal care services	Yes	Government health facilities, NGOs	Key informant interviews
Skilled birth attendance	Yes	Health workers, midwives	Key informant interviews
Postnatal care services	Yes	Health facilities, community outreach	Key informant interviews
Family planning services	Yes	Health facilities, NGOs, VHTs	Key informant interviews
Barrier methods (male/female condoms)	Yes	Health facilities, implementing partners	Key informant interviews

Short-acting contraceptive methods	Yes	Health facilities and outreach programmes	Key informant interviews
Long-acting reversible contraceptive methods	Yes	Trained health providers	Key informant interviews
HIV testing and counselling	Yes	Health facilities and outreach programmes	Key informant interviews
STI diagnosis and treatment	Yes	Health facilities	Key informant interviews
Cervical cancer screening	Yes	Health facilities and partners	Key informant interviews
Gender-based violence response services	Yes	NGOs, health facilities, protection actors	Key informant interviews
Psychosocial counselling services	Yes	Safe spaces and implementing partners	Key informant interviews
SRH health education	Yes	VHTs, safe spaces, health workers	Key informant interviews

Source: Key Informant Interviews (2024)

Availability of Maternal Health Services

Concerning the availability of maternal health services, respondents were asked whether midwives provide the recommended eight antenatal care contacts for a positive pregnancy outcome. Responses revealed that 107 (41.5%) respondents agreed and 21 (8.1%) strongly agreed that midwives provide eight antenatal care contacts for a positive pregnancy outcome. On the other hand, 87 (33.7%) respondents neither agreed nor disagreed, while 43 (16.7%) respondents disagreed or strongly disagreed.

Overall, close to half of the respondents indicated that they experienced or knew that midwives provide eight antenatal care contacts for a positive pregnancy outcome. At the same time, a significant proportion of respondents neither agreed nor disagreed with the statement. This could mean that some women refugees were unaware of the recommended number of antenatal care visits or had no direct experience with maternal health services. Information from key informants confirmed that maternal health services were available in the settlement. The respondent health worker noted that antenatal care, skilled attendance, and referrals were available in the form of health facilities for the refugees. On the other hand, the key informants explained that the utilization of these services depended on the awareness of the refugees, their access to the facilities, and their willingness to use the services.

The availability of maternal health services was in line with humanitarian health action recommendations for the provision of skilled maternal care, antenatal services, and referrals. However, the study findings reveal that the mere availability of these services does not necessarily mean that all women refugees accessed or utilized them.

Availability of Family Planning Services

The study evaluated the availability of family planning services by assessing the respondents' knowledge of the different family planning methods available to the refugees. Family planning methods include barrier methods, short-acting methods, and long-acting reversible contraceptive methods. Concerning the availability of barrier methods, 129 (50.0%) respondents agreed and 4 (1.6%) strongly agreed that refugee stakeholders provide barrier methods. However, 67 (26.0%) respondents disagreed, while 56 (21.7%) respondents neither agreed nor disagreed.

Regarding the availability of short-acting family planning methods, 149 (57.8%) respondents agreed and 12 (4.7%) strongly agreed that short-acting methods such as injectables and pills were available. In addition, 158 (61.2%) respondents agreed and 5 (1.9%) strongly agreed that long-acting reversible contraceptive methods were available. Overall, the findings reveal that most respondents knew that different family planning methods were available in the settlement. However, some respondents were

unsure or had no direct experience with family planning services. Key informants confirmed that the availability of family planning methods was mainly through the health facilities and outreach services provided by the implementing partners. The key informants highlighted the following contraceptive methods available to the refugees: condoms, injectables, implants, and family planning counselling. The key informants explained that the use of these methods was limited by the refugees' inadequate knowledge and negative perceptions, such as the belief that these methods caused infertility. Furthermore, male partners' involvement in family planning decisions was minimal. Overall, while the study found that most family planning methods were available in Maratatu D Zone, the utilization of these methods was limited by several factors.

4.3.2 Level of Access to Available Sexual and Reproductive Health Services among Women Refugees in Maratatu D Zone, Kyangwali Refugee Settlement

The second objective of this study was to determine the level of access to available sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement. This study evaluated the level of access to sexual and reproductive health services based on women refugees' reports of their experience accessing the services rather than their mere availability. The following indicators were used to evaluate the level of access to sexual and reproductive health services: access to maternal healthcare services, access to contraceptive services through outreach services, access to female condoms, access to sexual and reproductive health information through safe spaces, and access to psychosocial counselling services.

The findings presented below were generated using the questionnaire administered to the women refugee respondents. The findings were supplemented by the responses of key informants who provided sexual and reproductive health services to the refugees. The quantitative results are presented using percentages and frequencies, while the qualitative results provide an explanation of the statistical data.

The findings are presented in Table 3 below.

Table 3: Comparison between Reported Availability of SRH Services by Women Refugees and Confirmation by Key Informants

Sexual and Reproductive Health Service	Women Refugees Reporting Availability (%)	Key Informant Confirmation	Interpretation
Maternal health services	75.6% (65.9% agreed + 9.7% strongly agreed)	Confirmed	Services available through health facilities and referral systems; maternal health was among the most accessible SRH services assessed.
Family planning / contraceptive services	42.6% (42.2% agreed + 0.4% strongly agreed)	Confirmed	Various contraceptive methods provided through health facilities and outreach programmes, but access through outreach was mixed.
HIV testing and counselling	Not provided in the data	Confirmed	Available through health facilities. Percentage requires survey results on HIV testing and counselling availability.
STI treatment services	Not provided in the data	Confirmed	Available through health facilities. Percentage requires survey results on STI treatment availability.
Cervical cancer screening	Not provided in the data	Confirmed but limited coverage	Available but may require strengthening. Percentage requires survey results on screening access.

Female condoms	29.9% (29.1% agreed + 0.8% strongly agreed)	Available but limited utilization	Access was limited, with low awareness, supply challenges, and lower demand compared with other contraceptive methods.
GBV support services	Not provided in the data	Confirmed	Provided through referral and protection systems. Percentage requires survey results on access to GBV services.
Psychosocial counselling	23.6% (18.2% agreed + 5.4% strongly agreed)	Confirmed but limited awareness	Services available through humanitarian and protection programmes, but awareness and uptake remain low.

Source: Primary Data (2024) and Key Informant Interviews (2024)

Access to Maternal Health Services

In relation to women refugees' ability to obtain maternal healthcare services when needed, 170 (65.9%) respondents agreed and 25 (9.7%) strongly agreed that they were able to access maternal health interventions. On the other hand, 22 (8.5%) disagreed whereas 41 (15.9%) neither agreed nor disagreed. These findings indicate that most women refugees accessed maternal health services in the settlement. In addition to the positive responses, the study results suggest that maternal health services were among the most accessible SRH services in the settlement. Nevertheless, the large number of respondents who indicated no agreement may signify lack of access with respect to some aspects of maternal healthcare services or that some women did not need such services during the period of stay.

Key informants revealed that health facilities in the settlement provided maternal care services including antenatal and skilled attendance as well as referral services in case

of complications. According to a healthcare worker, women are advised to seek antenatal service and have children attended by skilled births. However, key informants revealed that women's attendance of antenatal services and skilled birth depended on several factors including awareness, distance to health facilities and women's personal circumstances. In general, the findings demonstrate that maternal healthcare services were relatively easily accessible to women refugees as compared to some of the other SRH services assessed in the study. Nonetheless, access to maternal healthcare services is limited by several factors including lack of sensitization and timely referrals as well as other individual circumstances. There is a need to promote community sensitization and ensure timely referrals to appropriate maternal health services for better accessibility.

Access to Contraceptive Services through Outreach Programmes

The study assessed women refugees' ability to access contraceptive services through outreach programs within their settlement. The results indicate that 109 (42.2%) respondents agreed whereas 1 (0.4%) strongly agreed that they accessed contraception through outreach programmes. On the other hand, 116 (45.0%) disagreed and 1 (0.4%) strongly disagreed with 31 (12.0%) respondents remaining undecided.

The results illustrate that women refugees accessed contraceptive outreach services however some of the respondents had limited access to these programmes. In fact, the number of respondents who disagreed was nearly equal to those who agreed. This could suggest disparity in the level of access to female condoms between different groups of women refugees.

Key informants reported that community outreach services in relation to contraceptive use were provided through health facility services and outreach programmes. According to key informants, community health workers conducted outreach services to ensure effective contraceptive use among women refugees who found it difficult to access contraceptive services at health facilities. However, key informants identified gaps in access to these services due to a number of challenges including limited resources, time and community misconceptions. As a result, although outreach programmes contribute

to the accessibility of contraceptive services, addressing such limitations by promoting community mobilization and outreach efforts will improve access to family planning services.

Access to Female Condoms

The study evaluated women refugees' access to female condoms by determining if they could obtain female condoms at health centres when needed. The results indicate that 75 (29.1%) respondents agreed and 2 (0.8%) strongly agreed that health centres provided female condoms. However, 106 (41.1%) disagreed and 5 (1.9%) strongly disagreed with 70 (27.1%) respondents being undecided.

The results demonstrate that female condoms were relatively inaccessible to women refugees. The large percentage of respondents who disagreed shows that few women refugees accessed female condoms. This could be attributed to low demand, limited supply or low awareness of female condoms in the settlement. According to key informants, the low use of female condoms can be related to a number of factors including limited supply, low awareness as well as limited community demand for this particular type of contraception. A healthcare worker noted that women refugees opted for other contraceptive methods since they were more familiar with them. The results reveal the significance of ensuring that women refugees have access to female condoms as well as other contraceptive methods based on their individual needs.

Access to Sexual and Reproductive Health Information through Safe Spaces

The study also aimed to establish whether women refugees accessed SRH information through safe spaces. The results indicate that 41 (15.9%) respondents agreed and 28 (10.9%) strongly agreed that they accessed SRH information through safe spaces. However, 110 (42.6%) disagreed whereas 77 (29.8%) remained undecided.

These results suggest that the presence of safe spaces in the settlement did not guarantee access to SRH information by the majority of respondents. Although safe spaces were accessible to women refugees, key informants as well as respondents indicated that these safe spaces were not easily accessible to most women in the

settlement. Key informants revealed that the safe spaces provided an avenue for sharing SRH information, discussing health issues and accessing services within a safe and encouraging environment. Nonetheless, key informants acknowledged challenges associated with encouraging women refugees to use safe spaces in order to obtain SRH information. Lack of knowledge about the existence of safe spaces, limited attendance due to inconvenient schedules or lack of time and other personal commitments affected women's ability to attend and benefit from the services provided in these safe spaces.

Access to Psychological Counselling Services

In relation to psychological counselling services through safe spaces, 47 (18.2%) respondents agreed and 14 (5.4%) strongly agreed that they accessed psychological counselling services. In contrast, 114 (44.2%) disagreed and 3 (1.2%) strongly disagreed with 80 (31.0%) respondents being undecided. The results indicate that women refugees accessed psychological counselling to a limited extent. The relatively large number of respondents who disagreed suggests that some of the women refugees never accessed these services whereas others were not aware of their existence.

Key informants reported that although services such as psychological counselling were provided through humanitarian agencies and protection programmes the services were limited by lack of awareness amongst women refugees. Key informants revealed that stigma surrounding mental health and other psychosocial problems as well as lack of time prevented women refugees from accessing such services. In summary, the findings illustrate that women refugees faced several barriers to accessing psychological counselling services.

Summary of Findings

The study findings demonstrate the fact that the majority of women refugees accessed maternal healthcare services within their settlement. The respondents revealed that maternal healthcare services were amongst the most accessible SRH services in the settlement. Although the majority of respondents indicated that they accessed maternal healthcare services, a significant number of women responded that they did

not access these services. This could be attributed to individual circumstances or lack of access to health facilities due to distance. Moreover, key informants reported that maternal healthcare services depend on women's individual circumstances including personal preferences, level of awareness and proximity to health facilities.

Although maternal healthcare services were largely accessible, the study identified marked disparities in relation to women refugees' access to other SRH services including contraception, female condoms, SRH information through safe spaces and psychological counselling. In regards to contraceptive services, outreach programmes helped improve access to contraceptive services but the limited number of participants in community outreach activities limited the extent to which these programmes improved women access to contraceptive services.

The study found that female condoms were relatively inaccessible as compared to other contraceptive methods due to limited supply and demand for this particular type of contraception. In addition to the limited access to female condoms, women refugees also faced limited access to SRH information through safe spaces. The study found that although safe spaces were present in the settlement, they were not as easily accessible as health facilities.

Although some of the safe spaces such as community-based initiatives offered psychosocial support services, these services were limited due to inadequate awareness and stigmatization surrounding mental health problems. Therefore, the study findings indicate that although maternal healthcare services and contraceptive services were largely accessible to women refugees, access to female condoms through health centres and SRH information through safe spaces, and psychological counselling services within safe spaces was relatively limited.

4.3.2 Level of Access to Available Sexual and Reproductive Health Services by Women Refugees at Maratatu D Zone, Kyangwali Refugee Settlement

The second objective of the study was to assess the level of access to available sexual and reproductive health services among women aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement. Unlike the previous section that evaluated the

availability of sexual and reproductive health services, this section focuses on the extent to which women refugees accessed the services. Access to sexual and reproductive health services was measured using indicators on maternal health services, contraceptive outreach services, availability of female condoms, access to sexual and reproductive health information in safe spaces, and access to psychosocial counseling services.

The quantitative results presented below were generated using women's responses to the questions. At the same time, qualitative results from key informants were used to expound on the reasons for the levels of access displayed by the respondents. The results are presented in Table 3 below.

Table 4: Summary of Access Indicators for Sexual and Reproductive Health Services

Access Indicator	Agree f (%)	Strongly Agree f (%)	Disagree f (%)	Strongly Disagree f (%)	Neutral f (%)
Access to maternal interventions contributes to reducing maternal deaths	170 (65.9)	25 (9.7)	22 (8.5)	0 (0.0)	41 (15.9)
Access contraceptives through outreach programmes	109 (42.2)	1 (0.4)	116 (45.0)	1 (0.4)	31 (12.0)
Health centres distribute female condoms	75 (29.1)	2 (0.8)	106 (41.1)	5 (1.9)	70 (27.1)
Access SRH information through safe spaces	41 (15.9)	28 (10.9)	110 (42.6)	2 (0.8)	77 (29.8)
Access psychological counselling through safe spaces	47 (18.2)	14 (5.4)	114 (44.2)	3 (1.2)	80 (31.0)

Source: Primary Data (2024)

Access to Maternal Health Interventions

The results demonstrated that most of the respondents assessed positively the access to maternal health interventions. In particular, 65.9% and 9.7% of the women refugees agreed and strongly agreed, respectively, that access to maternal health interventions is essential in reducing maternal mortality. At the same time, 8.5% disagreed, and 15.9% neither agreed nor disagreed. The results suggest that the majority of women refugees understand the role of maternal health interventions such as antenatal care, skilled attendance at birth, and pregnant-related interventions. The results also suggest that the respondents mainly provided general knowledge on the role of maternal health interventions in improving health outcomes rather than a direct measurement of maternal mortality.

The information obtained from the key informants confirmed the availability of maternal health interventions in the settlement. According to the respondents, pregnant women are advised to seek antenatal care early, which plays a critical role in managing pregnancies, especially those at risk. One key informant stated that 'seeking ante-natal care services early in pregnancy is crucial to have a healthy pregnancy.' Moreover, if additional care is required, the pregnant woman is referred to higher-level facilities such as Kituti Health Centre and Kyangwali Health Centre.

The results suggest that maternal health interventions are available through the health system, community health workers, and referrals. However, there is a need to increase community engagement to ensure that women understand the importance of maternal health services and adhere to them accordingly.

Access to Contraceptive Services through Community Outreach Programmes

The results showed that women refugees had a different understanding of accessing contraceptive services through community outreach programs. In particular, 42.2% of the respondents agreed that they accessed contraceptive services through community outreach programs, while 0.4% strongly agreed. At the same time, 45.0% disagreed, and 12.0% neither agreed nor disagreed. The results demonstrate that community outreach programs are available for women refugees; however, they are not easily accessible to

all women. As a result, the interpretation of the results should be done with caution, considering the diverse perceptions of the respondents.

According to the key informants, community outreach programs are conducted to ensure women access contraceptive information, advice, and services. In particular, they stated that various contraceptive methods are available through community-based outreach services, including village health teams, and health facilities. However, the informants noted that it is not always easy to monitor the number of women reached by the outreach services.

The results suggest that women refugees reported limited accessibility to contraceptive services despite their availability. Therefore, there is a need to increase community outreach programs while providing more information to women refugees about contraceptive methods.

Access to Female Condoms

The results demonstrated that the majority of the respondents neither agreed nor accessed female condoms as a contraceptive method available in the settlement. In particular, 29.1% agreed, and 0.8% strongly agreed that health centres provide female condoms. At the same time, 41.1% disagreed, while 27.1% neither agreed nor disagreed. The results suggest that female condoms are less accessible to women refugees and might not be well promoted within the settlement. On the other hand, the results might not be entirely accurate since some of the respondents might have limited knowledge about female condoms.

The key informants noted that female condoms are less preferred compared to male condoms and might, therefore, be unavailable in some health facilities. They added that female condoms can be acquired from implementing partners and are available at health facilities, antenatal clinics, and community health workers. The results suggest that women refugees should be counseled about the different contraceptive methods available, including female condoms.

Access to Sexual and Reproductive Health Information through Safe Spaces

The results showed that women refugees accessed sexual and reproductive health information through safe spaces limitedly. In particular, 15.9% agreed, and 10.9% strongly agreed that they accessed sexual and reproductive health information through safe spaces. At the same time, 42.6% disagreed, while 29.8% neither agreed nor disagreed. The results suggest that safe spaces are available; however, the majority of the women refugees might not have sufficient information on accessing them.

According to the key informants, women safe spaces offer health education on family planning, prevention and treatment of sexually transmitted infections, and menstrual hygiene. However, the informants added that the attendance of these safe spaces is optional, and the number of women who access them is not monitored. The results suggest that women refugees need more awareness about the benefits of safe spaces and how to access them.

Access to Psychological Counselling Services

The results illustrated the limited accessibility to psychological counselling services through safe spaces by women refugees. In particular, 18.2% of the respondents agreed, and 5.4% strongly agreed that they accessed psychosocial support services through safe spaces. At the same time, 44.2% disagreed, while 31.0% neither agreed nor disagreed. The results suggest that counselling services are available through safe spaces; however, they might not be easily accessible to all women refugees. As noted in the results section, the negative responses might have been provided because some of the women refugees might not have been aware of the services.

The key informants explained that women safe spaces provide psychosocial support services such as grief counselling and family planning services. Moreover, they added that women refugees need to know that these services are available to them, particularly when seeking help.

Overall, the results suggest that the majority of the women refugees assessed positively the opportunities for accessing maternal health services and indicated that most of the services are available to them. However, there are disparities in the accessibility of

some services, including contraceptive services, female condoms, sexual reproductive health information, and psychosocial support.

4.3.3 Barriers Influencing Access to Available Sexual and Reproductive Health Services among Women Refugees in Maratatu D Zone, Kyangwali Refugee Settlement

The third objective of the study was to determine the barriers influencing the access to the available sexual and reproductive health services among women refugees aged 15–49 years in Maratatu D Zone, Kyangwali Refugee Settlement. In particular, the study assessed whether language, distance to health facilities, transportation, economic costs, education, knowledge of available services, and age contribute to the low utilization of sexual and reproductive health services.

The results presented below are based on the responses provided by the women refugees. The key informant interviews were conducted to provide additional information and clarify the experiences and circumstances under which the women refugees access sexual and reproductive health services. The results demonstrate that most of the barriers listed above were not considered applicable by the majority of the respondents. However, the key informant responses identified several influencing factors, including the impact of crises, limited access to commodities, and specific influencing factors for women refugees with special needs.

Table 5: Summary of Barriers Affecting Access to SRH Services among Women Refugees

Potential Barrier	Agree/Strongly Agree (%)	Disagree/Strongly Disagree (%)	Interpretation
Language difficulties	10.5	82.6	Not a major barrier
Distance to health facilities	22.5	77.6	Not a major barrier

Transportation challenges	27.1	70.5	Not a major barrier for most women
Economic costs	29.0	69.8	Limited influence
Educational status	9.0	86.9	Not a major barrier
Lack of knowledge of SRH services	5.8	87.6	Not a major barrier
Age-related factors	10.1	79.4	Not a major barrier

Source: Primary Data (2024)

Language Difficulties in Accessing Sexual and Reproductive Health Services

The results indicate that language difficulties were generally not identified as a significant barrier to accessing sexual and reproductive health services. Moreover, there was a low percentage of participants who indicated agreement with the idea that limited proficiency affects their service access. Specifically, 9.7% of respondents indicated agreement, while 0.8% showed strong agreement. On the other hand, 10.5% disagreed, while 72.1% strongly disagreed with the statement, with 7.0% indicating neutrality. This information suggests that language was generally not a limiting factor for women refugees when seeking sexual and reproductive health services. This might be attributed to the provision of interpretation services in the settlement.

This was supported by the key informants who affirmed that interpretation services were available and utilized within the setting to facilitate effective communication. They added that the interpretation services were offered through community interpreters and health workers to ensure that women refugees accessed information, counselling, and treatment effectively. Despite the fact that language was not identified as a significant barrier to accessing sexual and reproductive health services, interpretation services should continue to be utilized to ensure confidentiality and effective disclosure of information.

Distance to Health Facilities

According to the results, distance was generally not identified as a significant barrier to accessing sexual and reproductive health services by the respondents. Indeed, the majority of participants indicated disagreement with the notion that distance is a limitation to accessing services in the settlement. 73.3% of women refugees indicated disagreement, while 4.3% showed strong disagreement with the statement. On the other hand, 21.7% of respondents indicated agreement, while 0.8% showed strong agreement. This information suggests that the proximity of health facilities is not a major limitation to accessing sexual and reproductive health services for most women refugees. This can be attributed to the fact that most health facilities are found within the settlement. However, it is significant to note that this might not be the case for those living in the far parts of the settlement and those requiring special care.

The key informants responded that sexual and reproductive health services are available and accessed from Maratatu D Zone Health Centre, while outreach services are utilized by the community to facilitate service accessibility. Thus, it can be concluded that despite the fact that distance was not identified as a major barrier to accessing sexual and reproductive health services by most respondents, service availability should be decentralized to ensure confidentiality and easy access to services.

Transportation Challenges Affecting Access to Health Services

According to the results, transportation was generally not identified as a significant barrier to accessing sexual and reproductive health services by the respondents. The majority of participants indicated disagreement with the statement, with 64.7% indicating disagreement, while 5.8% indicated strong disagreement. On the other hand, 23.6% of respondents indicated agreement, while 3.5% showed strong agreement with the idea that transportation is a limiting factor to accessing services. This suggests that transportation is not a major limitation to accessing sexual and reproductive health services for most women refugees. However, key informants noted that transportation can often become a major limitation to accessing services in emergency situations,

especially during referrals. They added that most emergencies occur among pregnant women who require special care during transportation.

Key informants responded that emergency transport is organized and accessible within the settlement to facilitate emergency referrals to health facilities. However, such services can become limiting in instances where timely access to transportation is difficult. Thus, it can be concluded that while transportation was not identified as a major factor influencing sexual and reproductive health service access by most respondents, it should continue to be promoted due to its potential limitations during emergency situations.

Economic Costs Associated with Accessing Sexual and Reproductive Health Services

According to the results, economic costs were generally not identified as a major barrier to accessing sexual and reproductive health services by the respondents. Most participants indicated that financial limitations did not affect their ability to access reproductive health services in the settlement. Indeed, 65.9% of refugees showed disagreement, while 3.9% showed strong disagreement with the statement. On the other hand, 27.1% indicated agreement, while 1.9% showed strong agreement with the notion that economic cost influences service accessibility. This suggests that despite the fact that most refugees do not identify financial limitations as a major factor limiting service accessibility in Maratatu D , there are still those who find it difficult to pay for services, especially medication.

This was supported by the feedback provided by key informants who responded that most women can access free health services from the government, which reduces the influence of economic factors on service accessibility. However, key informants and respondents showed that indirect costs such as medication, transportation to and from health facilities, and several other expenses can become rather expensive and limit service accessibility, especially among those living in poverty. Thus, it can be concluded that despite the fact that economic costs were not identified as a major barrier to accessing sexual and reproductive health services by most respondents, it remains a

major concern that should continue to be addressed to ensure service accessibility among those living in poverty.

Educational Status and Access to Sexual and Reproductive Health Services

According to the results obtained from the women refugees, educational status was generally not identified as a major barrier to accessing sexual and reproductive health services. Most respondents indicated disagreement with the notion that educational status influences service accessibility. Indeed, 82.2% of the participants indicated disagreement, while 4.7% showed strong disagreement with the statement. On the other hand, 7.8% of respondents indicated agreement, while 1.2% showed strong agreement with the view that education affects service access to sexual and reproductive health services in the settlement. This suggests that the majority of women refugees do not perceive education as a major barrier to accessing sexual and reproductive health services. This might be attributed to the fact that services are provided through approaches that consider the literacy levels of the refugees.

This information was supported by the key informants who responded that health workers offer services using approaches that are easy to understand by most women refugees. However, it is significant to note that educational status can influence the ease with which women refugees learn about sexual and reproductive health issues. Thus, it can be concluded that despite the fact that educational status was not identified as a significant factor influencing sexual and reproductive health service access by most respondents, health education should continue to be promoted to enable women refugees to access and utilize services appropriately.

Knowledge of Sexual and Reproductive Health Services

The results indicate that knowledge was generally not identified as a major barrier to accessing sexual and reproductive health services by the women refugees. According to the results, most respondents indicated disagreement with the notion that limited knowledge about sexual and reproductive health influences service accessibility in the settlement. Indeed, 86.0 % of the women refugees indicated disagreement, while 5.0% showed strong disagreement with the statement. On the other hand, only 1.9%

indicated agreement, while 0.8% showed strong agreement with the view that knowledge affects service access to sexual and reproductive health services. This suggests that women refugees do not perceive knowledge about sexual and reproductive health services as a major barrier to accessing services.

This was supported by the feedback provided by the key informants regarding the utilization of community health workers and outreach services in Maratatu D to sensitize the community about available health services. However, the majority of respondents indicated that knowledge about the services is insufficient, limiting their ability to access services. Nevertheless, many respondents stated that the majority of available services are well known within the community. Therefore, it can be concluded that despite the fact that knowledge about sexual and reproductive health services was not identified as a significant barrier to accessing services by most respondents, it should continue to be promoted to ensure service accessibility among women refugees who might lack such information.

Age-Related Factors Affecting Access

The results indicate that age was generally not identified as a major factor limiting access to sexual and reproductive health services by the respondents. According to the results, most women refugees indicated disagreement with the notion that age affects service accessibility in Maratatu D. Indeed, 77.5% of respondents indicated disagreement, while 1.9% showed strong disagreement with the statement. On the other hand, 9.7% of participants indicated agreement, while 0.4% showed strong agreement with the view that age influences service access to sexual reproductive health services. This information suggests that the majority of women refugees do not perceive age as a major barrier to accessing sexual and reproductive health services. This can be attributed to the fact that services are available to women of all ages.

This was supported by the key informants who responded that health services are offered to women refugees of all ages, with special attention being paid to adolescents and older women. However, key informants noted that age can be a major limitation to accessing services due to differences in social interactions among various age groups.

Thus, it can be concluded that despite the fact that age was not identified as a significant factor influencing sexual and reproductive health service access by most respondents, special attention should be paid to different age groups to ensure service accessibility.

Conclusion Regarding Factors Influencing Access to SRH Services

In summary, it can be concluded that the majority of women refugees do not perceive the commonly anticipated structural barriers as major limitations to accessing sexual and reproductive health services in Maratatu D. Indeed, language difficulties, distance, transportation, economic factors, educational status, knowledge, and age were all indicated as factors that do not significantly affect service accessibility. However, key informants identified several challenges affecting refugees' access to sexual and reproductive health services. According to the informants, the challenges include shortages of contraceptive pills and other related commodities, limited awareness about most sexual and reproductive health services, insufficient emergency transport, and several other social factors that affect service accessibility. Therefore, it can be concluded that despite the fact that most of the commonly anticipated structural barriers were not identified as major limitations to accessing sexual and reproductive health services by women refugees, several accessibility challenges still need to be addressed.

4.3.4 Contribution of Key Informants' Perspectives to the Availability and Accessibility of Sexual and Reproductive Health Services

Context and Participants

To supplement the information obtained from women refugees regarding their access to sexual and reproductive health services, qualitative inquiries were conducted among 15 key informants associated with refugee health service delivery and community development activities in Maratatu D and Kyangwali Refugee Settlement. The key informants included health personnel, government representatives, humanitarian organization members, Village Health Team members, and community leaders and workers.

Interviews were conducted to obtain information about the availability of sexual and reproductive health services, mechanisms utilized to promote service accessibility, existing challenges affecting service utilization, and possible interventions that could be implemented to address the challenges.

Availability of Sexual and Reproductive Health Services within Maratatu D Zone

Key informants reported that several sexual and reproductive health services are available to women refugees within Maratatu D. Specifically, maternal healthcare, family planning services, and HIV testing and counselling are accessible to the women. Other services include the management of sexually transmitted infections, cancer screening, gender-based violence response services and education, and sexual and reproductive health education. According to the key informants, the services are offered through health facilities as well as community-based methods.

Health workers revealed that maternal health services are offered through community-based and facility approaches within the settlement. Moreover, antenatal care, skilled Birth Attendance, postnatal care, and referral services are available to pregnant women seeking maternal health services at Maratatu D Clinic. According to one of the key informants:

> "Accessing antenatal care services in the first trimester is critical for a healthy pregnancy."

Referral systems are utilized to facilitate access to specialized maternal care, particularly for those with high-risk pregnancies. The key informants added that women refugees with special care needs can be referred to Kituti Health Centre and Kyangwali Health Centre for additional maternal health services. Key informants noted that family planning services are available to women refugees through the distribution of various contraceptive methods. According to the key informants, most women choose the contraceptive methods based on their needs and preferences.

The key informants added that the services are offered through community-based activities, targeting diverse social and economic groups. Although most refugees have

access to a wide range of SRH services, they utilize the services according to their preferences and needs. On the other hand, key informants identified social factors that affect the utilization of sexual and reproductive health services by the respondents, noting that some services are utilized less due to cultural beliefs.

Key informants also revealed that several humanitarian organizations contribute to the delivery of sexual and reproductive health services within the settlement. For instance, UNHCR, CARE, Medical Teams International, and many other humanitarian agencies support diverse aspects of refugee health, including family planning, HIV prevention and treatment, gender-based violence response services, screening programs, menstrual hygiene management, and sexual and reproductive health education. According to one of the key informants:

> "These organizations provide critical services such as family planning methods, cervical cancer screening, SGBV services, postnatal care, and health education."

Therefore, the qualitative data gathered from key informants supplement the quantitative data gathered from women refugees in identifying sexual and reproductive health services available to women refugees.

Mechanisms Supporting Access to Available Sexual and Reproductive Health Services

The key informants identified several mechanisms utilized to facilitate access to SRH services in Maratatu D. According to them, services are offered from Maratatu D Health Centre, while community-based approaches are utilized to supplement the services. In addition, women safe spaces, outreach services, and referral systems are utilized to facilitate service accessibility. The key informants identified Women Safe Spaces as a valuable approach that offers a forum for women refugees to discuss their health needs, particularly sexual and reproductive health concerns. According to the informants, the safe spaces provide a platform for women refugees to receive information about menstrual health, family planning, and prevention and management of sexually transmitted infections and gender-based violence.

However, the utilization of the safe spaces varies, with some women having limited access due to several factors. According to the key informants, it is difficult to document the exact number of women who attend the safe space activities on a weekly basis.

"Women refugees access safe spaces to get free information on family planning, STIs, menstrual health, and prevention and management of gender-based violence," said one key informant.

"Although many women attend the meetings, the actual number is difficult to say with certainty."

Challenges Affecting Access to Sexual and Reproductive Health Services

While most of the women refugees did not report structural factors as a problem, key informants revealed various contextual barriers affecting access to sexual and reproductive health services by specific categories of women.

One of the key informants mentioned lack of knowledge about some sexual and reproductive health services as a limiting factor. The key informants noted that services such as screening for cervical cancer, psychosocial services and gender-based violence services are available but some women are not aware of where and how to access them.

The key informants also noted challenges with regard to contraceptives as a major issue. According to the key informants, while the settlement provides a wide range of contraceptive methods, there are times when there are stocks deficits for some contraceptive methods which then affect the access to those methods by the refugees. Other than the intermittent stock deficits, cultural beliefs also affect the use of contraceptives among the refugee women. The key informants noted that some women are unable to make decisions regarding family planning matters due to societal expectations, their partners' expectations as well as misconceptions regarding the use of contraceptives.

Although the quantitative study did not reveal language as a major barrier to accessing sexual and reproductive health services, the key informants revealed that interpretation services are essential, especially for newly arrived refugees and those who are not as proficient in the local dialects.

The lack of transportation was not identified as a major barrier by the quantitative study. The key informants agreed that transportation is not a major hindrance to accessing sexual and reproductive health services except in emergency situations, where transportation is required to ensure that pregnant women reach the health facilities in time.

Strategies used to increase access to Sexual and Reproductive Health Services

The key informants identified various strategies that have been deployed to increase access to sexual and reproductive health services for the refugees by targeting specific areas of intervention, which include: sensitization, involvement of the village health teams, interpretation services, engagement of men and community leaders and promotion of reproductive health education.

Community meetings, health talks and radio jingles have been used as effective ways of promoting awareness of sexual and reproductive health services among the refugees. The key informants revealed that engagement of men is an important strategy as it increases the likelihood of women accessing family planning services due to husbands' support. Increasing the allocation and distribution of family planning commodities and promoting outreach services have also been revealed as important strategies by the key informants.

It is evident from both the quantitative and qualitative study that the refugees in Maratatu D zone have access to sexual and reproductive health services. This is demonstrated by the fact that most of the women refugees did not report any of the structural factors as a major hindrance to accessing sexual and reproductive health services. From the quantitative study, refugees in Maratatu D zone report low levels of

satisfaction with regard to language, distance, transportation, education and age as limiting factors to accessing sexual and reproductive health services.

On the other hand, the qualitative study brings out more insight into the access to sexual and reproductive health services for the refugees in Maratatu D zone. Although most of the refugees have access to sexual and reproductive health services, there are still several barriers that need to be addressed. Some of these barriers include the lack of knowledge about some sexual and reproductive health services and availability of most contraceptive methods, intermittent stocks of some family planning commodities, the need for transportation in emergencies and community beliefs about sexual and reproductive health issues.

Therefore, the recommendations for promoting sexual and reproductive health services in Maratatu D zone include: ensuring that services are available to the refugees as well as promoting community engagement and sensitization, ensuring that essential commodities are continuously available, having effective referral systems and addressing the various social, cultural and economic determinants for increasing access to reproductive health services by the refugees in Maratatu D zone.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter contains the summary of findings, conclusion and recommendations, limitations of the study and areas of further research. The chapter follows the objectives which guided the study on availability and accessibility of sexual and reproductive health services among women refugees aged 15 – 49 years in Maratatu D Zone Kyangwali Refugee Settlement. The conclusions drawn are based on the results of this study which demonstrate to what extent the research objectives and questions were met.

5.1 Summary of Findings

The study aimed to determine the availability and accessibility of sexual and reproductive health services among women refugees aged 15 – 49 years in Maratatu D Zone Kyangwali Refugee Settlement. The study objectives included: to establish the sexuality and reproductive health services available, assess the level of access to available sexual and reproductive health (SRH) services and identify barriers to availability and accessibility of SRH services among women refugees in Maratatu D Zone Kyangwali Refugee Settlement. Below is a summary of findings based on the objectives.

5.1.1 To establish the available sexual and reproductive health services among women refugees in Maratatu D Zone Kyangwali Refugee Settlement

The study established that women refugees in Maratatu D Zone, Kyangwali Refugee Settlement, are provided with a wide range of sexual and reproductive health services by government-designated health facilities and humanitarian organizations. The services include maternity, family planning, HIV testing counseling, sexually transmitted infections treatment, sexual and reproductive health education, and gender-based violence support services. The evidence shows that the collaboration between the Government and various humanitarian organizations facilitates the

implementation of sexual and reproductive health services in the refugee settlement. Similar findings were reported by the World Health Organization (WHO, 2022) and the United Nations High Commissioner for Refugees (UNHCR, 2023) regarding the role of partnerships in responding to sexual and reproductive health needs in humanitarian settings.

This study adds to the growing evidence on the effectiveness of refugee health programs in addressing the various sexual and reproductive health needs of the displaced persons in the Kyangwali Refugee Settlement. It illustrates how the progressive policies of the Government of Uganda, in collaboration with nongovernmental organizations, meet the basic free health needs of refugees and the host communities (Government of Uganda, 2006; Government of Uganda & UNHCR, 2018). The finding connects to the Uganda Refugee Response Policy whose health sector aim is to ensure effective, efficient, and equitable health service delivery to both nationals and refugees by considering the former as partners in development and health issues (UNHCR, 2023). Similar reports by WHO (2022) and Spiegel et al. (2018) emphasize the importance of building cohesive health systems by strengthening the health programs of the host countries to ensure continuous care to both nationals and refugees.

The study highlights the gap in providing cervical cancer screening, female condoms, psychosocial support, and reproductive health information despite the availability of maternity services, family planning, HIV counseling/testing, and treatment of STIs and gender-based violence. The finding connects to similar research done by Casey et al. (2015) and McGinn et al. (2019) on the challenges of providing comprehensive sex and reproductive healthcare in emergency situations. The gap illustrates how the essential maternal health component overshadows other reproductive health components such as cervical cancer screening and psychosocial support, especially in low-resource settings like Kyangwali Refugee Settlement. Lack of resources, skilled personnel, and time limits make it difficult for health workers to address refugees' multiple sexual and reproductive health needs during emergencies. Additionally, the scarcity of female condoms and psychosocial support services is worrying given the high risks of gender-based violence, sexual assault, and reproductive health complications in refugee camps

(UNFPA, 2023). Similar findings were reported by UNHCR (2023) on the lack of appropriate mental health and psychosocial support for refugees in different humanitarian settings globally.

The study's findings connect to the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations requirements for integrated health services among refugees. MISP advocates for comprehensive reproductive healthcare services beyond the essential maternal health component, including family planning, prevention and treatment of STIs, clinical management of rape, psychosocial support, cervical cancer screening, and community mobilization and education on reproductive health during emergencies (Inter-Agency Working Group on Reproductive Health in Crises, 2018; Sphere Association, 2018). Thus, the study achieved its first objective of assessing the availability of sexual and reproductive health services to women refugees in Maratatu D Zone, Kyangwali Refugee Settlement, Uganda. The study found that most sexual and reproductive health services, including maternity, family planning, HIV counseling/testing, STIs treatment, and GBV support services, were available. However, it revealed a gap in addressing other critical reproductive health components like psychosocial support, cancer screening, and community education on reproductive health.

5.1.2 To assess the level of access to available sexual and reproductive health services among women refugees in Maratatu D Zone Kyangwali Refugee Settlement.

The study established that women refugees in Maratatu D Zone, Kyangwali Refugee Settlement, have access to sexual and reproductive health services including antenatal care, skilled birth attendance, and referral maternal health services. This implies that the humanitarian health response in the settlement has contributed to increasing the availability of key maternal and reproductive health services (UNDP, 2016). Similar findings were reported in other humanitarian settings where the availability of primary health care facilities and the Minimum Initial Service Package (MISP) contributed to the improvement of maternal and reproductive health services among the displaced

population (Inter-Agency Working Group [IAWG], 2020; World Health Organization [WHO], 2022).

However, the study also established that although the women refugees have access to most sexual and reproductive health services, several barriers hinder access to some essential services. This conclusion is based on the fact that although contraceptive services are available in most health facilities, the women refugees face several challenges accessing them as discussed in the following section. Therefore, the study agrees with the assertion that the mere availability of essential reproductive health services is not sufficient to ensure accessibility and utilization (UNHCR, 2022; WHO, 2022). Availability of essential commodities, human resources, community engagement, and demand generation are required to ensure accessibility and utilization of sexual and reproductive health services (UNHCR, 2022; WHO, 2022). Similar findings were reported by Casey et al. (2015) in concluding that the stock-out of contraceptive pills, lack of community engagement, and sociocultural factors contribute to the low utilization of reproductive health services by the displaced population despite their availability.

The findings of this study align with those of previous studies conducted among the displaced population to establish the accessibility of health services. The study by World Health Organization (2016) and McGinn et al. (2019) concluded that the accessibility of health services to the displaced population is determined by availability, physical accessibility, administrative and cultural acceptability, quality of care, information availability, and social support. Similarly, UNFPA (2023) asserts that engaging the community, promoting health education, ensuring the availability of essential commodities, and providing culturally competent services are critical factors that must be considered to enhance the utilization of sexual and reproductive health services by the displaced population. Therefore, this study achieved its second objective of determining the level of access to the available sexual and reproductive health services by women refugees in Maratatu D Zone, Kyangwali Refugee Settlement. The findings established that the women refugees have access to most sexual and

reproductive health services, but several barriers hinder their ability to utilize the available services consistently and equally.

5.1.3 To identify barriers influencing the availability and accessibility of sexual and reproductive health services among women refugees in Maratatu D Zone Kyangwali Refugee Settlement.

The study established that barriers to sexual and reproductive health services, including language, distance to health facilities, accessibility, cost of services, level of education and age of the refugees, were not significant predictors of availability and accessibility of sexual and reproductive health services. This indicates that the refugee health sector in Kyangwali Refugee Settlement has successfully addressed most of the barriers that were traditionally associated with limited access to health services in the past. This was achieved by providing health facilities inside the settlement, providing interpretation services and free healthcare services in the settlement. Similar findings were made in other humanitarian health service studies that addressed barriers to health services among refugees (World Health Organization [WHO], 2022; United Nations High Commissioner for Refugees [UNHCR], 2023). Studies have shown that decentralizing health services and eliminating charges for services increased accessibility to maternal and reproductive health services for displaced persons (Inter Agency Working Group [IAWG], 2020; Tanabe et al., 2017).

The study also established that other underlying barriers to sexual reproductive health services continued to affect the utilization and demand for services among women refugees. This was evident from the qualitative findings that showed that knowledge of some services was limited, some essential commodities for motherhood were regularly unavailable, safe spaces were not utilized fully due to various reasons and negative community attitudes towards sexual reproductive health services were a barrier to accessing services. This is in line with various studies that argue that increasing physical availability of health services alone is insufficient to increase utilization due to lack of information, beliefs and poor health systems (McGinn et al., 2019; Casey, Chynoweth, Cornier, & Gallagher, 2015). Studies conducted among refugees also show that negative

perceptions of sexual reproductive health services, stigma around family planning and unavailability of key commodities such as family planning items continue to impede utilization of sexual reproductive health services (UNFPA, 2023; Singh et al., 2018).

Therefore, the study meets its third objective of establishing barriers to the availability and accessibility of sexual reproductive health services by showing that although most of the conventional barriers to accessing health services had been eliminated, some barriers such as poor community engagement, intermittent commodity supply and utilization of safe spaces continued to affect the availability and accessibility of sexual reproductive health services among the women refugees. This is an indication that although most of the physical barriers to accessing health services among the refugees in Maratatu D Zone had been addressed, most of the social barriers still persisted. Therefore, the study recommends increased community mobilization efforts and addressing the social barriers to increasing the long-term utilization of sexual reproductive health services (WHO, 2022; Sphere Association, 2018; UNHCR, 2023).

5.2 Conclusion

Based on the research findings, this paper concludes that sexual reproductive health services are available to women refugees in Maratatu D Zone, Kyangwali Refugee Settlement. The study established the availability of maternity services, family planning, HIV treatment and support, sexually transmitted infection management and sexual reproductive health education in the study area which indicates that the government and non-governmental organizations have met their mandate of providing health services to the refugees. However, the study also concludes that although sexual reproductive health services are available, they are not accessible due to the lack of key services such as screening for cancer, psychosocial support, female condoms and sexual reproductive health information from safe spaces. Therefore, based on the study, it is concluded that sexual reproductive health services need to be improved so that they are comprehensive and accessible to all women refugees.

The study further concludes that the barriers to the availability and accessibility of sexual reproductive health services among the women refugees were not significant predictors of availability and accessibility of maternal health services except for lack of community engagement, intermittent supply of reproductive health commodities, effective outreach follow up and social factors influencing utilization of sexual reproductive health services in Maratatu D Zone, Kyangwali Refugee Settlement. Overall, this study concludes that the objectives of demonstrating availability and accessibility of sexual reproductive health services were met.

5.3 Recommendations

5.3.1 Recommendation to improve availability of comprehensive SRH services

It is recommended that the Ministry of Health, Office of the Prime Minister, UNHCR and partners increase the investment in providing comprehensive sexual reproductive health services in Maratatu D Zone Kyangwali Refugee Settlement. The key components of sexual reproductive health services to be prioritized in Maratatu D Zone Kyangwali Refugee Settlement include: cervical cancer screening, psychosocial support services and gender-based violence support services.

5.3.2 Recommendation to improve access to family planning services

The study recommends that health facilities and implementing partners increase investment in community sensitization on family planning services and ensure that contraceptives are available at the facilities. It is also recommended that implementing partners provide better counselling to increase demand for family planning services and address family planning related challenges including myths, side effects and social stigma around the use of contraceptives.

5.3.3 Recommendation to strengthen SRH information and safe space services

The study recommends that the implementing partners increase community awareness on the availability of women safe spaces and utilise Village Health Teams, community leaders to sensitize the community and refugee population on various aspects of sexual reproductive health in addition to providing sexual reproductive health information. Moreover, Women Safe Spaces should continue to play a key role in providing sexual reproductive health information, counselling services and psychosocial support to the women refugees.

5.3.4 Recommendation for stakeholder coordination

This study recommends that the government agencies, humanitarian organisations and community-based structures strengthen coordination to ensure continuous monitoring of availability and accessibility of sexual reproductive health services to the women refugees and respond to the identified gaps based on commodity shortages, information and support needs.

5.4 Study Limitations

This study had several limitations which must be considered when interpreting the results. Firstly, this study relied on self-reported data. Secondly, some respondents were interrupted while providing information by family members which may have hindered free expression of opinions on intimate aspects of sexual and reproductive health services. Thirdly, the study was conducted among women refugees aged 15 – 49 years which may have excluded the views of men, adolescents aged below 15 years, community members and medical personnel. Further, the study focused on Maratatu D zone Kyangwali Refugee Settlement and the results may not represent the situation in other zones. Finally, the study used a cross-sectional design which limited an in-depth exploration of the availability and accessibility of reproductive health services.

5.5 Areas of Further Research

Further studies can focus on exploring the experiences of male refugees, adolescents and community leaders with sexual and reproductive health services to understand how their experiences influence sexual and reproductive health decision making among refugees. Additionally, further research can focus on exploring community perceptions to increase understanding of some of the community attitudes which affect utilisation of sexual and reproductive health services by refugees. Lastly, further research can be done to assess availability and accessibility of sexual and reproductive health services over a period of time to determine changes and response strategies.

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APPENDICES

APPENDIX 1: INFORMED CONSENT FORM

TOPIC: Availability and Accessibility of sexual reproductive health services for women refugees (15-49). a case study of Maratatu D zone: Kyangwali refugee settlement, Kikuube district, Uganda

Principal investigator and contacts: Inno Daphine

Telephone contacts; 0751172658 and 0777619467

Email; daphineinno4@gmail.com

Institution: Uganda Christian University Mukono

INTRODUCTION

I Inno Daphine, a student doing research under the supervision of Lino Bukenya, a senior lecturer in the School of Social Sciences at Uganda Christian University to fulfill the requirements for the award of a Masters in Development Studies.

This informed consent document basically explains the nature of the study to you. In case you have any questions, they will be answered after the study has been explained to you. If you decide to participate in the study, you will be asked to sign a consent document and a copy of which you will be given to keep.

The study is sponsored by the researcher (Inno Daphine)

PURPOSE OF STUDY

The purpose of this study is to examine availability and accessibility of sexual reproductive health services for women refugees (15-49) years in Maratatu D zone, Kyangwali refugee settlement.

STUDY PROCEDURES

Your participation in this study will involve a questionnaire for women refugees to obtain your opinions regarding the study being conducted and the interview with the Key informant participants that will be recording by the phone for documentary purposes. Both will last about 30 to 45 minutes. These transcripts, audios will be transcribed later for verification, and coding purposes and both the data collection instruments (questionnaire, interviews) will be scheduled based on your availability in the zone.

WHO WILL PARTICIPATE IN THE STUDY?

The study will comprise of Public Health Assistant for Maratatu D zone, Settlement commandment OPM, enrolled midwife (2), Kyangwali refugee settlement HIV/Reproductive Health Officer from MTI, Public Health Officer for UNHCR Kyangwali, GBV Officer with Alight Organization, Focal person of Community Based worker, Sexual Reproductive and Maternity Officer from CARE, Lead mother of Maratatu D zone (chairperson), Head of health under Refugee Welfare Council 3, Women Representative under Refugee Welfare Council 3, Woman Representative from the VHT, VHT Coordinator for Maratatu D zone, Focal Person for Peer Educator for Maratatu D zone and 259 women refugees (15-49) years of Maratatu D zone.

RISKS

This study poses no risks to you personally or the refugee settlement except for the risk of inconvenience of your time during the interview.

BENEFITS

There will be no direct benefit to you for your participation in this study. However, the researcher, hopes that the information obtained from this study may help Maratatu D zone to improve sexual reproductive health services to boost women health status of the reproductive age and the settlement at large. The refugee stakeholders may request a copy of the final report for reference and in agreement with the principal investigator to aid knowledge sharing sessions on the concerned problem under investigation.

CONFIDENTIALITY

For the purposes of this research study, your comments will be anonymous. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all research notes and documents.

- Keeping notes, interview transcriptions, audios, photos and any other identifying participant information in a locked file cabinet in the personal possession of the researcher.

Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

CONTACT INFORMATION OR QUESTIONS

If you have questions at any time about this study, or you experience adverse effects as the result of participating in this study, you may contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the Primary Investigator, please contact the Uganda Christian University Research Board on Tel:+256(0)772 405357, Email: pwaiswa@musph.ac.ug and the secretary on Tel:+256(0)775737627, Email: oahimbisibwe@ucu.ac.ug

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After signing the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

STATEMENT OF CONSENT

I……. have agreed to take part in the study. I have understood the purpose and the methods to be used in the study and agreed without being forced.

The information I share can be freely used by the researcher provided that my privacy will be protected. I understand that by signing this form, I do not waive off my legal rights but merely indicate that I have been informed about the research study in which I am voluntarily agreeing to participate.

A copy of this will be provided to me.

Participant's Participation Number…….

Participant's Signature…….

Start time……...End time……

Date of Interview…….

Researcher's Name: Inno Daphine Researcher's Signature……..

Date……

APPENDIX 2: QUESTIONNAIRE

Topic: Availability and Accessibility of sexual reproductive health services for women refugees (15-49): A case study of Maratatu D zone; Kyangwali refugee settlement, Kikuube district.

Section A: Background Information

1. Participants participation Number ……..……

2. Age bracket (a) 15-19 ☐ (b) 20-24 ☐ (c) 25-29 ☐ (d) 30-34 ☐ (e) 35-39

(f) 40-44 ☐) 45-49 ☐

3. Marital status.

(a) Single ☐ b) Married ☐ (c) Separated ☐ (d). Widowed ☐

4. Number of Children……

5. Level of Education.

(a) Primary ☐ (b) Secondary ☐ (c) Tertiary ☐ (d) University ☐ (e) Never attended school ☐

5. Country of Origin.

(a) The Democratic Republic of Congo ☐ (b) South Sudan ☐ (c) Somali ☐

(d)Kenya ☐ (e) others ☐

6. Religion

(a) Catholic ☐ (b) Anglican ☐ (c) Muslim ☐ (d) Pentecostal/Born-again ☐ (e) Others ☐

8. Source of livelihood ……

To what extent do you agree with the following statements in each section of the study? The researcher will read a statement and let the respondent score it according to her opinion. On a scale of 1=Agree, 2=strongly agree, 3=Disagree, 4=Strongly disagree, 5=Neither agree nor Disagree (Please tick one).

Section B: The available sexual reproductive health services for women refugee (15-49) years in Maratatu D zone, Kyangwali refugee settlement.

Statement	Agree	Strongly agree	Disagree	Strongly disagree	Neither agree or disagree
Mid-wives provide eight contacts for a positive pregnancy experience.					
Refugee stakeholders offer barrier family planning methods to avoid pregnancy.					
Refugee stakeholders offer short-acting family planning to avoid pregnancy.					
Refugee stakeholders offer long-acting reversible family method to avoid pregnancy.					

Free HIV testing and counselling services as a preventive measure					
There is STI/STDs treatment when we have STIs/STDs symptoms.					
Attendance to sensitization programs to create awareness about SRHS					
Female health practitioners provide screening for cervical cancer					
Refugee stakeholders provide immediate support services for Gender or sexual-based violence victims					
Non-government organizations provide Safe-abortion as a medical necessity.					

Section C: The level of access to available sexual reproductive health services by women refugees in Maratatu D zone, Kyangwali Refugee Settlement

Statement	Agree	Strongly agree	Disagree	Strongly Disagree	Neither agree nor disagree
Access to maternal interventions leads to less maternal deaths					
Access to contraceptives through conducted outreaches					
Health centres distribute female condoms to practice safe sex life					
Access to SRH information from established Safe spaces					
Access to psychological counselling from established safe spaces					

Section D: Factors influencing availability and accessibility of sexual reproductive health services for women refugees (15-49) years of Marartatu D zone, kyangwali refugee settlement.

Statement	Agree	Strongly agree	Disagree	Strongly disagree	Neither agree or disagree
Language difficulties when accessing available services					
Long distances to the health centres.					
Difficulties in means of transportation to the health centres					
Economic costs when accessing available SRHS					
Educational status affects access to available SRHS					
Knowledge to SRHS limits they access to available SRHS					
Age affects our access available SHRS					

APPENDIX 3: INTERVIEW GUIDE

Key Informant Interview Guide

1. What are the Sexual Reproductive Health Services provided by the Government of Uganda for women refugees (15-49) years in Maratatu D zone, Kyangwali refugee settlement?
2. What are the Sexual Reproductive Health Services provided by UN refugee agency and other Non-Government Organizations for women refugees (15-49) years in Maratatu D zone, Kyangwali refugee settlement?
3. Where are the Sexual Reproductive Health Services for women refugees (15-49) years located in Maratatu D zone, Kyangwali refugee settlement?
4. What maternal interventions are accessed by women refugees (15-49) years to decrease maternal mortality rates in Maratatu D zone, Kyangwali refugee settlement?
5. What services are offered during community outreaches on contraceptives and how many women refugees (15-49) years in Maratatu D zone, Kyangwali refugee settlement are being reached out.
6. How many female condoms are supplied annually and how do women refugees (15-49) years access them in Maratatu D zone, Kyangwali refugee settlement.
7. What SRHS are being offered in women safe spaces and how many women refugees (15-49) years utilize the women safe spaces to access SHRS on a daily basis in Maratatu D zone, Kyangwali refugee settlement?
8. What are the barriers women refugees (15-49) years face when accessing the available Sexual Reproductive Health Services in Maratatu D zone, Kyangwali refugee settlement?
9. What mitigation strategies are there for such barriers in Maratatu zone, Kyangwali refugee settlement?

Thank you for cooperation.

APPENDIX 4: WORKPLAN

A RESEARCH WORKPLAN

ACTIVITIES	TIMELINE	EXPECTED OUTCOME
Writing up the concept paper Choose the research topic	September 2019	Comments and allocated supervisor.
Continuous working with the supervisor Presented a Research Proposal	March 2022	Proposal
Working on the recommendations and suggestions from the panel	June, July 2022	A revised proposal of three chapters
Forming research instruments Questionnaires Key informant interviews	August 2022	Forming appropriate instruments
Submission to the Research Ethics Committee	September 2022	Comments and approved proposal
Data collection process Giving out questionnaires And Key informant interviews Coding, analysis, and interpretation of the collected raw data	November 2022	Visiting Kyangwali refugee settlement to achieve Reliable, valid information on the research topic. Teamwork with a local researcher from the settlement

Submission	November 2022	Comments from the Ethics Committee in the month of December
Corrections/ Resubmission to the Ethics Committee	January to May, 2023	Revised research proposal

Therefore, the student will take full responsibility for all the mentioned research activities under the guidance of a research supervisor to produce a satisfying research dissertation in order to attain a master's degree in development studies at Uganda Christian University Mukono.

APPENDIX 5: APPROVAL NOTICE

UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

17th May, 2023

Inno Daphine
Uganda Christian University
P.O Box 4, Mukono
+256 751172658
Email: daphineinno4@gmail.com

UG-REC-026 APPROVAL NOTICE

To: Inno Daphine, Principal Investigator

Re: UCU-REC Application titled; **Availability and Accessibility of Health Services for Women Refugees: A case study of Kyangwali refugee settlement, Kikuube District Uganda.**

Application Number: **UCUREC-2022-407**

Version: 4.0

UGANDA CHRISTIAN UNIVERSITY APPROVED UNTIL 08 DEC 2023 RESEARCH ETHICS COMMITTEE

Type: [ ] Initial Review
[ ] Protocol Amendment
[ ] Letter of Amendment (LOA)
[ ] Continuing Review
[ ] Material Transfer Agreement
[ ] Other, Specify:

I am please to inform you that the **UG-REC-026;** UCUREC approved the above referenced application.

Approval of the research is for the period from 8th December 2022, to 8th December, 2023.

This research is considered minimal risk category.
As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.

2. Changes, amendments, and additions to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes. The REC application number assigned to the research should be cited in any correspondence.

3. Reports of unanticipated problems involving risks to participants or other must be submitted to the REC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for REC review.

4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the REC eight weeks prior to the above expiration date of 8th December, 2023 in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. Your research details have been shared with the Executive secretary of Uganda National Council for Science and Technology (UNCST) and you are **not** required to get clearance since you are a Masters Degree research. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6(e).

The following is the list of all documents approved in this application by **UG-REC _026:**

	Document Title	Language	Version	Version Date
1.	**Protocol**	**English**	1.0	2022-11-04
2.	Data collection tools	English	1.0	2022-11-04
3.	Informed Consent forms	English	1.0	2022-11-04
4.	Wok plan	English	1.0	2022-11-04
5.				

Signed and Stamped

.....

Prof. Peter Waiswa.
UCUREC Chairperson,
pwaiswa@musph.ac.ug

UGANDA CHRISTIAN UNIVERSITY
APPROVED
UNTIL
08 DEC 2023
RESEARCH ETHICS COMMITTEE

APPENDIX 6: RESEARCH INTRODUCTORY LETTER

UGANDA CHRISTIAN UNIVERSITY
A Centre of Excellence in the Heart of Africa

May 18th, 2023

TO WHOM IT MAY CONCERN

Dear Sir/Madam

Re: **INTRODUCTORY LETTER FOR RESEARCH**

This is to introduce to you **INNO Daphine** Registration number **S19M13/113**, a student of Uganda Christian University, pursuing a Master's degree in Development Studies. She is expected to carry out research in the final year under the guidance of a university supervisor in partial fulfillment for the requirements of the above mentioned award.

Topic: **"Availability and Accessibility of Sexual Reproductive Health Services for Women Refugees (15-49) of Mararatu D Zone: A Case of Kyangwali Refugee Settlement."**

The purpose of this communication is to request your office to allow her collect data from your organization. Any assistance rendered to her will be highly appreciated.

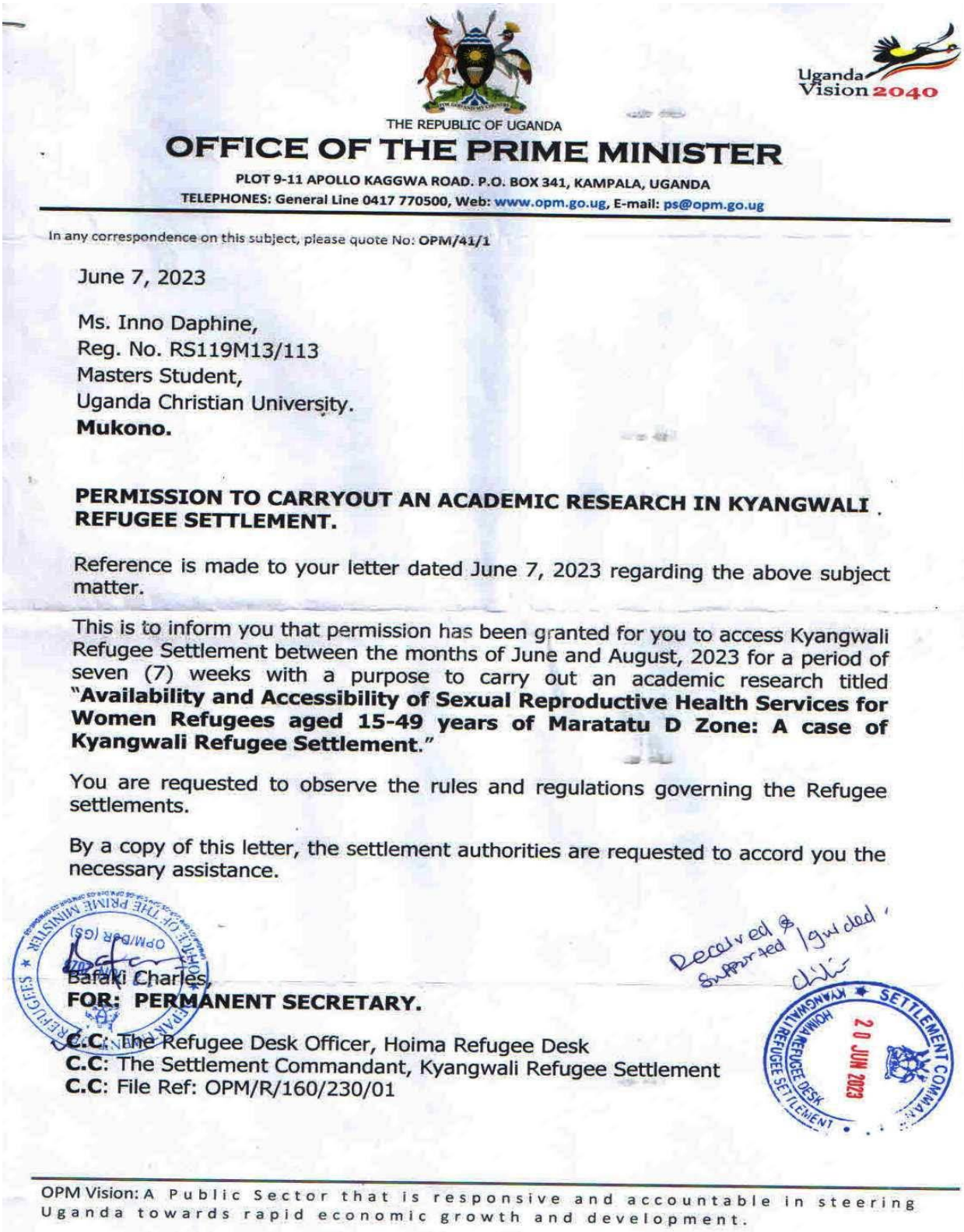
UGANDA CHRISTIAN UNIVERSITY
18 MAY 2023
H.O.D RESEARCH & POSTGRADUATE STUDIES
SCHOOL OF SOCIAL SCIENCES

Yours faithfully,

.....

Dr. Jeremy Waiswa
HoD, Post Graduate Studies & Research Department
Tel: 0752319951
Email:jwaiswa@ucu.ac.ug

APPENDIX 7: ACCEPTANCE LETTER FOR RESEARCH



THE REPUBLIC OF UGANDA

OFFICE OF THE PRIME MINISTER

PLOT 9-11 APOLLO KAGGWA ROAD. P.O. BOX 341, KAMPALA, UGANDA
TELEPHONES: General Line 0417 770500, Web: www.opm.go.ug, E-mail: ps@opm.go.ug

In any correspondence on this subject, please quote No: **OPM/41/1**

June 7, 2023

Ms. Inno Daphine,
Reg. No. RS119M13/113
Masters Student,
Uganda Christian University.
Mukono.

PERMISSION TO CARRYOUT AN ACADEMIC RESEARCH IN KYANGWALI REFUGEE SETTLEMENT.

Reference is made to your letter dated June 7, 2023 regarding the above subject matter.

This is to inform you that permission has been granted for you to access Kyangwali Refugee Settlement between the months of June and August, 2023 for a period of seven (7) weeks with a purpose to carry out an academic research titled **"Availability and Accessibility of Sexual Reproductive Health Services for Women Refugees aged 15-49 years of Maratatu D Zone: A case of Kyangwali Refugee Settlement."**

You are requested to observe the rules and regulations governing the Refugee settlements.

By a copy of this letter, the settlement authorities are requested to accord you the necessary assistance.

Received & supported / guided

Bafaki Charles,
FOR: PERMANENT SECRETARY.

C.C: The Refugee Desk Officer, Hoima Refugee Desk
C.C: The Settlement Commandant, Kyangwali Refugee Settlement
C.C: File Ref: OPM/R/160/230/01

KYANGWALI SETTLEMENT COMMANDANT HOIMA REFUGEE DESK REFUGEE SETTLEMENT 20 JUN 2023

OPM Vision: A Public Sector that is responsive and accountable in steering Uganda towards rapid economic growth and development.

APPENDIX 8: DISSERTATION CORRECTION COMPLIANCE FORM (POST VIVA FORM)

UGANDA CHRISTIAN UNIVERSITY

A Centre of Excellence in the Heart of Africa

DIRECTORATE OF POSTGRADUATE STUDIES DISSERTATION CORRECTION COMPLIANCE FORM (POST VIVA FORM)

Date: 11th July 2026

Name of Candidate: **INNO DAPHINE** Reg. No: **RS19M13/113**

Title of Dissertation: **Availability and Accessibility of Sexual Reproductive Health Services for Women Refugees: A case of Kyangwali Refugee Settlement, Maratatu D Zone**

S/N	COMMENTS For internal examiner	ACTION TAKEN	INDICATOR
1	Overall structure and presentation: The dissertation followed the recommended university structure, but the abstract was too long, contained repetitions, had grammatical errors, and referencing was not in the required APA style.	The abstract was shortened by removing unnecessary explanations and repetitions. The dissertation was edited for grammar and clarity. In-text citations and references were revised to follow APA 7th edition guidelines.	Improved abstract length and clarity; grammatical corrections made throughout the dissertation; references and citations formatted according to APA style.
2	Chapter One: Introduction: The introduction was poorly written, the research gap was unclear, the problem	The introduction was rewritten to clearly explain the research gap, justification of the study, and relevance of sexual reproductive	Clear research gap identified; objectives linked to the problem statement; improved justification of

	statement lacked justification, objectives were not linked to the identified gap, and the study location was not sufficiently justified. The conceptual framework also required improvement.	health services among women refugees. The problem statement and objectives were aligned. The rationale for selecting Kyangwali Refugee Settlement was added, and the conceptual framework was revised and explained.	study area; revised conceptual framework.
3	Chapter Two: Literature Review: . The literature review was not sufficiently evaluative and had grammatical challenges.	The literature review was reorganized and rewritten using relevant scholarly sources. Studies were critically reviewed by comparing findings, identifying gaps, and relating them to the current study. Language and flow were improved.	Literature review demonstrates critical engagement with previous studies; improved organisation and academic writing style.
4	Chapter Three: Methodology: The mixed-methods design was not adequately justified. Data collection procedures were unclear, tools and participants were not well described, language considerations were missing, and hypothesis testing procedures were not explained.	The methodology chapter was revised to provide justification for the mixed-methods approach. Data collection methods, tools, participants, languages used, translation/interpreter processes, and quantitative and qualitative data procedures were clearly described. Hypotheses were reviewed and appropriate analysis procedures were explained.	Clear justification of research design; detailed description of data collection tools and procedures; clarified analysis methods.
5	Chapter Four: Presentation and Analysis of Data: Findings were not clearly presented, interpretation was	The results chapter was rewritten according to the objectives. Findings from key informants were integrated with quantitative	Findings clearly aligned with objectives; improved interpretation of results; qualitative and quantitative

	sometimes unsupported, and there was confusion between availability, accessibility, and perceptions of services. Key informant findings were presented separately instead of being integrated. Hypothesis results were missing.	results. Interpretation was revised to avoid unsupported conclusions. Availability, accessibility, and perceptions were clearly distinguished. Hypothesis testing results were included where applicable or removed were inappropriate.	findings integrated; hypotheses appropriately addressed.
6	Chapter Six: Conclusion and Recommendations: The conclusion repeated findings instead of presenting overall conclusions. Recommendations included issues not strongly supported by findings, and limitations were missing.	The conclusion was rewritten to highlight the main discoveries of the study and demonstrate whether objectives were achieved. Recommendations were revised based on study findings. Study limitations were added.	Clear overall conclusions provided; recommendations linked to evidence; limitations of the study included.
7	References and Appendices: References contained formatting errors and did not consistently follow APA style.	All references and citations were reviewed and corrected according to APA 7th edition requirements. Errors from reference management software were manually corrected.	Proper APA formatting achieved; improved accuracy and consistency of references.
8	General Dissertation Quality: The major concern was poor grammar, readability issues, weak presentation of results, and inadequate	The entire dissertation was edited for language, coherence, academic tone, and logical flow. Additional review was conducted with guidance from the supervisor.	Improved readability, academic presentation, and overall quality of the dissertation.

	demonstration of research writing skills.		
S/N	**Comments from External Examiner**	**Action Taken**	**Indicator**
1	The dissertation is well structured and written, but chapter introductions are too brief.	Expanded all chapter introductions to provide context, purpose, and linkage to subsequent sections, replacing one-sentence introductions with comprehensive introductory paragraphs.	Revised chapter introductions (e.g., Chapter Two.
2	The dissertation title is good but can be more concise.	Revised the title to: **"Availability and Accessibility of Sexual and Reproductive Health Services for Women Refugees: A Case of Kyangwali Refugee Settlement, Maratatu D Zone."**	Revised title page.
3	The study should be situated within broader development debates.	Incorporated discussions on development theories and debates relating to refugee livelihoods, gender, equity, human rights, and access to health services in the background and literature review.	Background (Chapter One) and Literature Review (Chapter Two) revised.
4	The background is comprehensive but needs stronger linkage to development debates.	Strengthened the background by integrating current development discourse on refugee protection, sustainable development, and	Chapter One revised.

		universal access to Sexual and Reproductive Health Services (SRHS).	
5	The problem statement is not sufficiently streamlined and reads like findings from different studies.	Rewrote the problem statement to make it concise, coherent, and focused on the specific research gap and justification for the study.	Revised Problem Statement.
6	Objectives and research questions are well stated and researchable.	No major revisions required. Minor editorial improvements were made for consistency with the revised title.	Objectives and research questions retained with minor edits.
7	The conceptual framework is well conceived.	No substantive changes were required. The conceptual framework was retained, with improved explanation of the relationships among variables.	Conceptual framework description enhanced.
8	Literature review is comprehensive but requires stronger engagement with debates, contributions, and gaps.	Revised the literature review to critically compare previous studies, highlight scholarly debates, identify methodological and contextual gaps, and clearly demonstrate the study's contribution.	Literature Review revised (Chapter Two).
9	The methodology is comprehensive and scientifically sound.	No substantive revisions required. Minor language and formatting	Methodology chapter edited.

		improvements were made to enhance clarity.	
10	In Chapter Four, relate variables such as age and education more explicitly to access to SRHS.	Expanded data analysis by discussing how respondents' age, education level, and other socio-demographic characteristics influenced access to SRHS, supported by both qualitative and quantitative evidence.	Chapter Four analysis strengthened.
11	The mixed-methods approach is well utilized.	No major changes required. Additional explanations were added to demonstrate integration of qualitative and quantitative findings.	Chapter Four revised.
12	Discussion of results is coherent.	Minor revisions were made to strengthen connections between findings and existing literature.	Discussion chapter enhanced.
13	Findings and conclusions flow well from the results.	Minor editorial refinements were made to improve clarity and coherence.	Findings and Conclusion revised.
14	Conclusions and recommendations are good and flow from the findings.	Recommendations were refined to align more explicitly with the study objectives and findings, including practical policy implications.	Conclusion and Recommendations revised.

15	References require refinement; some citations are missing from the reference list.	Reviewed the entire reference list, corrected formatting to conform to the required referencing style, ensured consistency between in-text citations and references, and added all missing references.	Reference list updated and cross-checked.
16	Final Verdict: The dissertation is worthy of the award of a Master's Degree.	The dissertation was comprehensively revised in line with all recommendations to further improve its scholarly quality before final submission.	Final revised dissertation submitted.
S/N	**Comments from Viva Panel Examiners**	**Action Taken**	**Indicator**
1	Incorporate relevant national and international policy frameworks governing refugees and sexual and reproductive health (SRH) services.	Reviewed and incorporated relevant international and national policy frameworks, including refugee and SRH policies, in the literature review and discussion chapters.	Chapter Two (Literature Review); Chapter Five (Discussion).
2	Demonstrate how these policies address maternal health and SRH needs among refugee women.	Explained the provisions of each policy and linked them to maternal health and SRH service delivery for refugee women.	Chapter Two; Chapter Five.
3	Integrate policy discussions throughout the study rather	Integrated policy discussions within the literature review,	Chapters Two, Five, and Six.

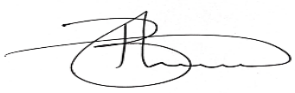
	than presenting them in isolation.	discussion of findings, and recommendations.	
4	Revise the first and second objectives to focus on the availability and accessibility of SRH services.	Revised Objectives One and Two to explicitly assess the availability and accessibility of SRH services among refugee women.	Chapter One (Research Objectives).
5	Clearly define and distinguish availability and accessibility and apply them consistently throughout the study.	Added conceptual and operational definitions of availability and accessibility and applied the concepts consistently throughout the dissertation.	Chapters One and Two.
6	Justify why availability and accessibility are the central focus of the research.	Strengthened the study rationale by explaining the importance of assessing both availability and accessibility for improving SRH service utilization.	Chapter One (Background and Justification).
7	Strengthen the problem statement using current statistics on the study population and the magnitude of the problem in Kyangwali Refugee Settlement.	Updated the problem statement with recent statistics and evidence on refugee demographics and SRH challenges from credible sources.	Chapter One (Problem Statement).
8	Support all arguments with recent and credible empirical evidence.	Reviewed and incorporated recent peer-reviewed studies and reports from reputable organizations.	Chapters One, Two, and Five.

9	Clearly specify whether the study adopts a qualitative or quantitative approach and ensure consistency throughout the dissertation.	Clarified the study design and ensured methodological consistency across all chapters.	Chapters One and Three.
10	Ensure all tables and figures are clearly labelled, well-organized, and aligned with the study objectives.	Revised all tables and figures by numbering them, improving titles, and aligning them with the research objectives.	Chapter Four.
11	Present findings on availability and accessibility logically to enhance readability and interpretation.	Reorganized the presentation of findings according to each study objective, beginning with availability followed by accessibility.	Chapter Four.
12	Discuss the major barriers affecting the availability and accessibility of SRH services among refugee women.	Expanded the discussion to include major barriers identified during the study and their implications.	Chapter Five.
13	Relate the findings to existing literature and relevant policy frameworks.	Compared study findings with previous studies and relevant policy frameworks to strengthen the discussion.	Chapter Five.
14	Highlight the implications of the findings for improving	Included practical, policy, and programmatic implications for	Chapter Five (Discussion and Implications); Chapter Six (Recommendations).

	refugee health services in Uganda.	strengthening refugee SRH service delivery.	
15	Summarize the major findings concisely and ensure that all conclusions are evidence-based.	Revised the conclusion to provide a concise summary of findings based solely on the study evidence.	Chapter Six (Conclusion).

INNO DAPHINE

Candidate's Name Signature



MR. LINO BUKENYA

Supervisor's Name Signature