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Perceived Needs and Barriers to Accessing Sexual Reproductive Health (SRH) Services Among the Ik Community, Kaabong District, Uganda

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Abstract

Background: The Ik are minority group of people in Kaabong district, Uganda. They are the most marginalized. In addition, little is known about their perceived SRH needs and barriers to accessing SRH services.

Objective: To determine perceived needs and barriers to accessing SRH services by the Ik community.

Material and Methods: A cross-sectional analytical design with analytical was used, both quantitative and qualitative (mixed methods). Data was collected using key informant interviews, focus group discussions and semi-structured questionnaires. Sample of 345 participants selected randomly and purposively. Qualitative analysis was thematic whereas Statistical Package for Social Scientists (SPSS) was for quantitative analysis.

Results: Perceived SRH needs of the Ik were; limited access to SRH information, lack of protection from gender-based violence and lack of access to comprehensive safe motherhood programs. Access to SRH services was limited mainly by poverty, limited range of available RH services, long distances to health facilities, poor attitudes of health workers, culture, poor road networks and language barriers. Individual factors; period in marriage **(p=0.047)**, number of sex partners **(p=0.041)**, type of house structure one lived in **(p=0.039)**, economic activity **(p=0.009)** were significantly associated with access of SRH services.

Conclusion: SRH needs of the Ik community is still wanting

Keywords: perceived needs, sexual reproductive health services, barriers, Wakiso district

1. Introduction

1.1 Background of the Study

The global burden of premature death due to SRH continues to grow despite global efforts to deter the occurrence. In 2017, about 75000 women had premature death due to pregnancy and child birth related complications. 94% of these deaths occurred in resource limited settings and most could have been prevented (WHO, 2019). Despite sizeable gains steps in promoting access to SRH services; more than 120 million couples have unmet need for modern contraception, 80 million women have unintended pregnancies, 45 million pregnancies end in abortion and kill more than half a million women annually and leave about 210 million women with disabilities (Anon., 2007). This cumulatively contributes to the high maternal mortality ratio (MMR) of 216 deaths per 100000 live births (UNICEF, 2015; WHO, 2019). Apparently, 340 million new STI cases and 5 million new HIV infections occur annually. Violence against women contributes significantly to these SRH problems as the victims are often unable to make choices hence the high risks of unwanted pregnancy and STIs (Anon. 2007). The sustainable development goal (SDG): Goal 3. Target 3.7: To ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030 (WHO, 2016). Through such global commitments, Great gains have been achieved and impacted the individual SRH indicators.

However, Sub-Saharan Africa (SSA) continues to lag behind the rest of the world despite progress on SRH indicators globally. It constitutes only 15% of women of reproductive age (WRA) in developing regions (WHO,

2020), yet in 202 it accounted for two thirds (196000) of all maternal mortalities and 89% of HIV mother to child transmissions (WHO, 2019). Each year, about 50 million women get infected with at least one of the four curable STIs - chlamydia, gonorrhoea, syphilis or trichomoniasis (UNFPA & Guttmacher institute, 2014). In 2014, over 55 million women who wanted to avoid a pregnancy did not use an effective modern contraceptive which accounted for over 93% of unintended pregnancies (UNFPA & Guttmacher institute, 2014). If maternal health is to be improved, quality services must be provided to all women and children at the WHO recommended standards. In addition, all barriers that limit access to quality maternal health services must be identified and addressed at both health system and societal levels to realise benefits in the short and long term (WHO, 2019).

Uganda's total fertility, maternal mortality, teenage pregnancy rates continue to be among the highest globally despite its international commitments to universal healthcare coverage. Even with the glaring improvements in different SRH indicators, more efforts have to be implemented to attain the global goal (MoH, 2018). Fertility remains at 5.4 births per woman and high among rural women compared to the urban women (UBOS, 2014). Contraceptive prevalence rate (CPR) is at 39% and the unmet need soars high at 10% without considering unmarried women who are the majority population which includes the adolescents (UBOS, 2014).

Karamoja region has unique features that are very important to the trends of the SRH indicators and SRH needs of its population. The average age of its population is 15 years, has the highest total fertility rate of 8 children per woman and 61% of its 1.2 million population is the least socially and economically developed (UNFPA, 2018). It has a high MMR of 750 deaths per 100000 live births compared to the national value of 438 (UNICEF, 2015). In Kaabong, Fertility rate is at 7.9 and it's among the districts with the highest fertility rates in the Country (UBOS & UNFPA, 2017). In addition, only 6.7% births are attended to by a skilled birth attendant, there's virtually no transport for transporting mothers to facilities for delivery in case of referrals and mothers are more likely to attend antenatal than deliver at a health facility (UNFPA, 2017). These facts are of significant importance to the understanding of the sexual and reproductive health among the Ik of Kaabong district.

1.2 The Study Area

The Ik are a minority group of people located at Ik County along the north eastern Uganda-Kenya border in Kaabong district. It is hilly with semi-arid bush and a few forests (Speke Uganda Holidays, 2020). The Ik people keep bees, gather white ants and practice agriculture involving subsistence farming of maize, sorghum, millet, finger millet, beans, cabbage, pumpkins and mill their grains by grinding on grindstones (Speke Uganda Holidays, 2010). They prefer to live in isolation and have no urgency with what the rest of the world calls development (Blanc, 2019; Bainemigisha, 2013). They are considered to be the most marginalized of all tribes in Karamoja region due to their geographical location and the uniqueness of their language (Bainemigisha, 2013). Kaabong has a total of 167879 people of which 409 live in Ik County (UBOS, 2017). There are only two HCIIs (Timu HCII and Kamion HCII) in the whole of Ik County. 73% of the Ik have no access to public health facilities; Ik County has only two HCIIs; less than 0.3% of the Ik community has piped water; over 99.9% of the population don't live in a descent dwelling (UBOS, 2017). There's no doubt that the Ik contribute heavily to the poor SRH indicators of Kaabong district and Karamoja region.

1.3 Problem Statement

The trend of global efforts for Sexual and reproductive health indicate a consensus that reaching the sustainable development goals (SDGs) particularly target 3.7 and 5.6 demand for increasing access to and utilization of comprehensive health services to all populations including the hard to reach groups (Thongmixay, et al., 2019). Unlimited access to SRH services by the hard to reach populations is essential to improving their quality of life and developing communities to which they belong. There's better grouping of populations with regards to HIV/AIDS, poverty, substance abuse compared to other aspects of sexual and reproductive health. For example, multiple studies conducted in HIV/AIDs have categorized female sex workers, long distance drivers, men having sex with men, fishing communities and injecting drug users as the key populations and there's evidence of efforts to estimate the size of these key populations (Braeken & Rondinelli, 2012; Doshi, et al., 2019). This is not the case for the Ik people and they continue to experience violation, discrimination and exclusion by policy makers, the health system and their surrounding communities.

The problem is the very low uptake of SRH services especially family planning (0.4%) which is among the lowest in the country (UBOS, 2017); and low facility-based deliveries among minority groups in Kaabong district like the Ik. Despite numerous efforts by government and implementing partners, the SRH indicators have not improved as expected. What must be put into perspective are the perceptions about SRH for the Ik including the perceived needs, pathways they take while seeking SRH services and the barriers they face along that pathway of seeking SRH services.

1.4 Broad Objective

The main aim of this study was to contribute to the understanding of the perceived needs regarding sexual reproductive health and the barriers to accessing SRH services among the Ik Community of Kaabong district, Karamoja region, Northern Uganda.

1.5 Specific Objectives

1) To identify the perceived Sexual and Reproductive health (SRH) needs of the Ik community
2) To identify the individual and community barriers to accessing SRH services among the Ik community
3) To determine the individual factors associated with access to family planning or SRH Services among the Ik community
4) To identify the institutional barriers to accessing SRH services among the Ik community

2. Materials and Methods

2.1 Study Design

The study design was analytical and descriptive, cross-sectional and applied both qualitative and quantitative methods of data collection (Creswell, 2003).

2.2 Study Population

The study population was the men and women of reproductive age 15 to 49 years of the Ik tribe from the Ik County of Kaabong district in north eastern Uganda.

2.3 Study Unit

The unit of study was a man or woman aged 15 to 49 years of the Ik tribe in Ik county of Kaabong district.

2.4 Sample Size

The sample size was calculated using Yamane's formula since the population size was known, level of precision at 5% and a confidence interval of 95% (Yamane, 1967).

$$n = \frac{N}{1+N(e)^2} = \frac{4023}{1+4023(0.05)^2} = \frac{4023}{11.0575} = 363$$

Where **"n"** was the sample size, "**N"** was the proportion size and "**e"** was the level of precision.

For a population of key population such as the Ik (Doshi, et al., 2019), certain techniques were required to arrive at the right sample.

2.5 Sampling Techniques

All participants were selected using random sampling technique. Four participants were selected using purposive sampling to give an in-depth information as key informants.These were; the area local chairman, the in charge of Timu Health center, the area member of parliament and the district representative for the Ik.

2.6 Data Collection Tools

Key Informant Interviews (KIIs)

Key informant interviews targeted policy makers and local leaders that are well versed with the lifestyle and SRH needs of the Ik people. The KIIs gleaned information on perceptions about SRH, the perceived SRH needs; enablers and barriers to accessing the SRH services.

Focus Group Discussions (FGDs)

FGDs aimed at understanding the shared views on SRH services, policies and programs in the larger Ik community, and mitigating factors, such as stigma and discrimination, human-rights-related barriers to accessing and the reasons for non-use and discontinuation of FP, norms and service availability. Each FGD had 6-12 participants. Similar to other data collection methods, maximum variation purposive sampling was used to select FGDs taking into account the different categories of the Ik people. (25,26). Four FGDs were conducted.

Questionnaire

These were used to collect quantitative data from participants. Questions were administered in Ik language with the help of an interpreter.

2.7 Data Analysis

All interviews were audio recorded and transcribed. Transcribed data was analyzed and arising themes categorized according to the study objectives. All quantitative data was entered into SPSS version 20.0 and analyzed. The P-value of 0.05 was taken for statistical significance. The association between the binary outcome [usage of family planning services (yes or no)] and the independent categorical variables was determined. Results were presented in form of analyses and tables. Data related to this study has been published in a public repository (Omona, 2021).

2.8 Ethical Consideration

Ethical approval for the study was granted by responsible Institutional Review Board of the university. Administrative clearance was sought and granted by the office of the District health officer (DHO) for Kaabong district. Verbal consent was obtained before conducting the key informant interviews, focus group discussions or answering the questionnaire. Each participant was informed of the objectives of the study, anticipated risks and issues related to confidentially prior to obtaining his or her consent. Interview transcripts were given identifiers that cannot be linked to the participants.

3. Results

3.1 Background Characteristics of Respondents

A total of 345 respondents were interviewed in this study and their socio demographic characteristics were profiled in Table 1 below:

Table 1. Socio-demographic characteristics of respondents

Characteristics			**Frequency (n=345)**	**Percentage (%)**
1)	Age category	15 to 19 years	96	27.8
		20 to 30 years	161	46.7
		31 to 49 years	88	25.5
2)	Gender	Male	113	32.8
		Female	232	67.2
3)	Marital status	Married	281	81.4
		Not Married	64	18.6
4)	How long have you been Married	Less than 1 year	53	15.4
		More than 1 year	282	81.7
		not applicable	10	2.9
5)	Number of sex partners	None	64	18.6
		One sex partner	267	77.4
		More than one sex partner	14	4.1
6)	Religion	Christian (Catholic, Anglican, Pentecostal, adventist)	345	100.0
7)	Highest level of education achieved	Completed Primary school	38	11.0
		Never Completed Primary School	307	89.0
8)	Economic activity	Formally employed	8	2.3
		Not formally employed	337	97.7
9)	Monthly Income	Less than 50000	320	92.8
		More than 50000	25	7.2
10)	Locality	Rural	341	98.8

	Urban	2	.6
	Nomadic	2	.6
11) Type of house of residence	Permanent structure	2	.6
	Temporary structure (Manyata)	343	99.4
12) Distance from health centre	Less than 5 Kms	71	20.6
	More than 5 Kms	274	79.4
	Total	345	100.0

According to table 1 above; Most 161(46.7%) of the respondents were aged between 20 and 30 years and the average age was between 20 and 30 years. Most of the participants were female 232 (67.2%) and of a Christian based religion. Majority were married 281 (81.4%), had been married for more than one year 282 (81.7%) and had one sex partner 267 (77.4%). The respondents had predominantly never completed primary school 307 (89.0%), were unemployed 337 (97.7%) and were very poor earning less than 50000 shillings a month 320 (92.8%). They were predominantly in a rural setting 341 (98.8%), lived in temporary structures 343 (99.4%) that were more than 5 Kms from a health facility 274 (79.4%).

3.2 Perceived Sexual and Reproductive Health Needs of the Ik

Theme 1a: Lack of Protection from Sexual and Gender-Based Violence

Participants talked about women and girls being raped and murdered by the Dodoth neighbors and the Turkana from Kenya. Participants identified the men in uniform (Soldiers) who are deployed to protect the rights of girls and women as the main perpetrators.

They also sighted teachers as being responsible for violence against some of the girls.

> *"[…] there's an issue of rape of girls and women when they go to look for vegetation in the forest by our neighbors the Dodoth and the Turkana. This is common when these neighbors come here to cultivate and rear animals. The result is HIV, STIs and also murder of our women […]"* **(KII- Respondent I, 18th/6/2019)**

> *"[…] there have been cases of sexual violence against the Ik, the main perpetrators have been the men in uniform that have been deployed to guard their rights, and the teachers have also been sighted among the perpetrators of sexual offense against the girls […]"* **(KII- Respondent II, 19th/6/2019)**

Although sexual violence against women was mentioned as the most common form of violence, physical violence especially against women was also reported by few participants for example female genital mutilation.

> *"[…] SGBV against women is not common but there are cases of FGM and domestic violence […]"* **(FGD-Woman aged 24 years, 19/6/2019)**

Theme 2a: Limited Access to Information on Sexual Reproductive Health and Available Reproductive Health Services

Participants identified significant gaps in access to information related to sexual and reproductive health as well as basic health information. They mentioned that all Information Education and Communication (IEC) health materials are produced in English and Karamojong languages yet majority of the participants expressed their inability to read and write. Secondly those who can read and write, can only try to understand materials that are written in the Ik language. This makes it very difficult for majority if the Ik community to understand the few IEC materials because they are exclusively written in Karamojong or English languages.

> *"[…] we need education services because most of us did not even go to school. We do not know how to read and write […]"* **(FGD – A Man aged 34 years, 20/6/2019)**

> *"[….] all posters and health materials are written in English; some are in Karamojong languages and none is in the Ik language. So, you find the materials are there but even when they give them to you, you cannot read anything […]"* **(FGD – A Man aged 42 years, 20/6/2019)**

Participants also talked about the need to access information on health services available in their community but of critical importance is education and information on the importance of accessing these reproductive health services. They expressed an urgent need for sensitization of the community on the importance of accessing the available reproductive health services.

> *"[…] they need serious sensitization because that is where they are lagging behind. They need to know the dangers of these killer diseases so that if someone is infected, he should actually seek health services […]"* **(FGD – Woman aged 24 years, 19/6/2019).**
>
> *"[…] most of these people in the Ik County are not aware of the services. They need to be sensitized on the importance of assessing at the health facility […]"* **(FGD - Woman aged 30 years, 19/6/2019)**

Theme 3a: Limited Access to Diagnostic Laboratory Services

The study discovered that one of the determinants for the Ik people to seek for a health service from a health center is the availability of a comprehensive package which includes laboratory investigations for diagnostic purposes before treatment can be given. For the few health facilities at the Ik community, the respondents expressed the absence of these laboratory services and the need for them to be available.

> *"[…] going to health center doesn't mean that you get all the services that you want. First of all, you will inquire that I would like to do my blood test which actually you will not get it unless they will refer you either to the clinic or the gov't health facility in Kaabong […]"* **(FGD woman aged 22 years, 19/6/2019)**

Theme 4a: Limited Access to Counselling, Testing and Treatment of Sexually Transmitted Infections including HIV/AIDS

Participants pointed out concerns about the Ik have being exposed to the outside world (meaning outside the Ik community). This has come with the exposure of some Ik children to education, the cattle rustling activities by the neighboring tribes of the Dodoth and Turkana together with the different tourism and trade activities between the Ik and the neighbors. Some of these neighbors take advantage of the primitive nature of the Ik people and engage them into commercial sex, consensual sex or even rape and defilement. As a result, this has exposed some of their people to HIV/ AIDS. They talked about the need of HIV counselling, testing and treatment services in their community. These services are perceived as reproductive health needs for this community.

> *"[...] just like the other parts of Karamoja they have been exposed to the outside world and some of them have even already been exposed to HIV/AIDs, some of them now go to school, institutions, universities and secondary schools [...]"* **(KII- Respondent III, 22/6/2019)**

Theme 5a: Limited Access to Quality Maternity Services

The study discovered that maternity services including antenatal, delivery under the care of a health worker and postnatal services were perceived reproductive health needs of the Ik people. These maternity services were mentioned by all participants as being necessary and one of the major reasons why especially pregnant mothers visit the available health centres.

> *"[…] of course, you can't talk about reproductive health and you don't mention maternity. Our pregnant women need to deliver at a hospital […]"* **(KII- Respondent III, 22/6/2019)**
>
> *"[…] we come here to attend antenatal services and also to ensure that we have safe deliveries with help of the nurses […]"* **(FGD – Woman aged 26 years, 19/6/2019)**
>
> *"[…] majority of women here go to the traditional birth attendants because there are no health workers closer to them when they need to deliver and they are used to going to the traditional birth attendants for a long time because there are no hospitals here […]"* **(KII- Respondent IV, 10/6/2019)**

3.3 Individual and Community Barriers to Accessing Sexual and Reproductive Health Services Among the Ik

Theme 1b: Poverty

Participants confessed that they are poor because they don't have livestock which is the measure of wealth in their community. They further informed us that due to the levels of poverty, a greater number of Ik people could not afford all costs related to a referral to Kaabong for further management.

> *"[…] they are very poor, they lack livestock and they depend on gathering wild fruits and honey […]"* **(KII- Respondent III, 22/6/2019)**

> *"[…] people are very poor so even when referred they don't go to Kaabong. If you refer someone to Kaabong, they say how will I survive from there and then they don't go […]"* **(FGD-A Man aged 10 years, 20/6/2019)**
>
> *"[….] because many people come to the facilities without a book many are turned away when they are asked to buy a book……. they can't afford a book where to write their details […]"* **(KII- Respondent II, 19/6/2019)**

Theme 2b: Lack of Trust in Available Reproductive Health Services

There's a major gap in the trust of available reproductive health services by the Ik community. This is evident in many statements made by the participants during our discussions. When asked why they would not choose to go for a service at the health center during the FGDs, most participants reported lack of medicines in the health facility as one of the major reasons. They alleged that there are no medicines at the health centers and the few drugs at the health centers are of poor quality. However, my interaction with one of the health workers revealed that the medicines were actually always available but people did not want to go to the facility.

> *"[…] going to health centre doesn't mean that you get all the services that you want. First of all you will inquire that I would like to do my blood test which actually you will not get it unless they will refer you either to the clinic or the government health facility in Kaabong […]"* **(FGD woman aged 22 years, 19/6/2019)**
>
> *"[…] the services are poor because you go there when you are feeling headache and they give you amoxicillin, it doesn't help […]"* **(FGD- A man aged 20 years, 20/6/2019).**
>
> *"[…] the drugs are available but people do not come to the clinic and the stores are always full. The medicines are there of which we have the Panadol, Coartem, Amoxil […]"* **(KII-Respondent II, 19/6/2019)**

Theme 3b: Cultural Beliefs and Practices

Participants talked about different aspects of their culture as factors that influence their decisions to seek for sexual and reproductive health services. They explained that their culture promotes use of traditional medicine first for all health needs including STIs, during pregnancy and delivery. One participant informed us that all modern SRH services are new to the Ik community.

> *"[…] all those things you are saying are new things to the Ik. They have been delivering with help of traditional healers close to them and you ask them to go to a central point where there's a stranger […]"***(FGD-A Man aged 40 years, 20/6/2019)**
>
> *"[…] they take their herbs which help them and they believe that they are strong so they don't need to be helped at the health facility……they have their TBAs in the community […]"* **(FGD-A Man aged 24 years, 20/6/2019)**

In addition, participants informed us that their culture puts a total abomination on abortion. If a woman gets an unwanted pregnant, she should get married to the responsible man. It's reported that some girls try to abort but they face adverse effects.

> *"[…] the Ik don't support abortion, they say it's satanic and dangerous. In the past you would be killed for doing abortion … if you get pregnant you get married to that man […."* **(FGD-Woman aged 10 years, 19/6/2019)**

Participants informed us of a lack of balance of authority in a home and the view at number of children as a measure of wealth. This encourages big families and limits the use of family planning.

> *"[…] yes, children are a measure of wealth. Another thing is the women themselves might prefer to have a small family because they are the ones who bear the burden from being pregnant, labour pain, take care of the children, so they might prefer to have a small family but the head of the family is not in for such […]"* **(FGD-A Man aged 45 years, 20/6/2019)**

Theme 4b: Language Barrier Between the Ik Community and Health Workers

The study discovered that majority of the health workers that are recruited in the health facilities in the Ik County are not of Ik origin. This is because majority of the Ik people are illiterate. With the uniqueness of the Ik language, the Ik people are unable to communicate effectively with the health workers at the facilities. This makes interpretation of complaints difficult for the health workers and affects the quality of health services provided in their health centers.

"[…] it's because of language barrier; the doctors don't know our language […]" **(FGD-Women # 6, 19/6/2019)**

3.4 Individual Factors Associated With Access to Family Planning or SRH Services Among the Ik

A bivariate analysis of the individual factors of participants using the binary outcome of have you ever used a family planning method (Yes, No) using chi-squared test was done and the results are shown in Table 2 below.

Table 2. Socio-demographic factors at bivariate analysis with access to family planning

Socio-demographic factors		**Have you or your partner ever used any FP method or SRH Service?**		**Total**	**Chi-Square**	**p-values**
		YES	**NO**			
1) Age of respondent	15-19 years	46(13.3%)	50(14.5%)	96	21.589[a]	**0.000****
	20-30 years	51(14.8%)	110(31.9%)	161	df=2	
	31-49 years	14(4.1%)	74(21.4%)	88		
2) Gender	Male	33(9.6%)	80(23.2%)	113	0.679[a]	0.410
	Female	78(22.6%)	154(44.6%)	232	df=1	
3) Marital status	Married	91(26.4%)	190(55.1%)	281	0.031[a]	0.861
	Not Married	20(5.8%)	44(12.8%)	64	df=1	
4) If Married, for how long have you been married?	Less than 1 year	21(6.1%)	32(9.3%)	53	6.1	**0.047***
	More than 1 year	90(26.1%)	192(55.7%)	282	df=2	
	not applicable	0(0.0%)	10(2.9%)	10		
5) Number of sexual partners	None	28(8.1%)	36(10.4%)	64	6.396[b]	**0.041***
	One sex partner	81(23.5%)	186(53.9%)	267	df=2	
	More than one sex partner	2(0.6%)	12(3.5%)	14		
6) Highest level of education	Completed Primary school	28(8.1%)	10(2.9%)	38	33.719[a]	**0.000****
	Never Completed Primary School	83(24.1%)	224(64.9%)	307	df=1	
7) Economic activity	Formally employed	6(1.7%)	2(0.6%)	8	6.883[b]	**0.009****
	Not formally employed	105(30.4%)	232(67.2%)	337	df=1	
8) Monthly income (Ug. Shs)	Less than 50000	92(26.7%)	228(66.1%)	320	23.723[a]	**0.000****
	More than 50000	19(5.5%)	6(1.7%)	25	df=1	
9) Residence	Rural	109(31.6%)	232(67.3%)	341	5.172[a]	0.075
	Urban	2(0.6%)	0(0.0%)	2	df=2	
	Nomadic	0(0.0%)	2(0.6%)	2		
10) Type of house structure	Permanent structure	2(0.6%)	0(0.0%)	2	4.241[c]	**0.039***
	Temporary structure (Manyata)	109(31.6%)	234(67.8%)	343	df=1	

11) Distance from nearest health facility	Less than 5 Kms	39(11.3%)	32(9.3%)	71	21.213[a]	**0.000****
	More than 5 Kms	72(20.9%)	202(58.6%)	274	df=1	

a. 0 cells have expected count less than 5; b 1 cell has expected count less than 5; c 2 cells (50%) have expected count less than 5; ** Statistically significant (P<0.05), df=degree of freedom

The study found that age of respondents (p=0.000), period in a marriage (*p=0.047*), number of sexual partners (*p=0.041*), type of house structure one lived in (*p=0.039*) and economic activity (*p=0.009*) were positively associated with the access to family planning services or sexual reproductive health (SRH) services. Similarly, monthly income (p=0.000) and level of education (p=0.000), distance from nearest health facility (p=0.000) were also statistically significant.

3.5 Institutional Barriers to Accessing Sexual Reproductive Health Services Among the Ik

Theme 1c: Limited range of available reproductive health services and service delivery points

Gaps in access to SRH services were further explained by limited number of reproductive health services and limited access points for these reproductive health services. One participant informed us that there is only one private ambulance provided by the area member of Parliament, only one public health facility per sub county and no private service provider options.

> *"[…] there is only one government HCIII (Kamion), there's no single private clinic or drug shop[…]"* **(KII- Respondent III, 22/6/2019)**

> *"[…] going to health centre doesn't mean that you get all the services that you want. First of all, you will inquire that I would like to do my blood test which actually you will not get it unless they will refer you either to the clinic or the gov't health facility in Kaabong […]"* **(FGD woman aged 22 years, 19/6/2019)**

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> *"[…] going to health centre doesn't mean that you get all the services that you want. First of all, you will inquire that I would like to do my blood test which actually you will not get it unless they will refer you either to the clinic or the gov't health facility in Kaabong […]"* **(FGD woman aged 22 years, 19/6/2019)**

Theme 2c: Distance of from nearby health facility

Majority of participants reported that the health facilities were approximately 20 to 40 kilometers (KM) away from their residences. This makes it hard to first think of seeking health services from a far health facility when one falls sick due to the distance that one has to move in order to reach the service delivery points. As a result, sick people abandon seeking for services at the health facilities and resort to other available options such as using herbal medicine, delivering from home and even staying home till they die.

> *"[…] most people live far from the health centre and find it very hard to reach there when they fall sick here. As a result, if a person falls sick, they just stay home till they die […]"* **(KII-Respondent I, 18/6/2019)**

> *"[…] if health services are actually closer to people, which means everyone can actually access the medication. Then everyone (the side of women) can help them to deliver safely instead of risking their lives in giving birth in villages […]"* **(FGD – A Man aged 6 years, 20/6/2019)**

> *"[…] to reach at this health centre, you have to cross two big hills to reach my home in the village. So, when I fall sick and think of an idea that I may not get help when I come here, I seek any available means instead of coming here […]"* **(FGD – Woman aged 38 years, 19/6/2019)**

Theme 3c: Lack of accommodation facilities for health workers at the health centers

The study discovered that majority of health workers resided very far from their work stations due to lack of accommodation facilities at their respective duty stations. This meant that health facilities may not be open to the public at times when the health services may be needed by the community members due to absence of the health workers at these health facilities. This acts as a great barrier for the Ik people to make a choice of seeking health services from the available health facilities when they fall sick.

> *"[…] the nurses first go to dig in their gardens instead of being at the center. Sometimes when you are very sick, you find no body at the health center because there's accommodation for those nurses […]"* **(FGD – woman aged 17 years, 19/6/2019)**

> *"[…] then antenatal, those delivery tools should be available and also the staff rooms where the staffs stay of which actually those are the needed things that can actually attract many people to go to the hospital [….]"* **(FGD – Woman aged 28 years, 19/6/2019)**

> *"[…] health workers are absent, when you go there the health unit is either locked or you wait for long period and sometimes go back without any person attending to you […]"* **(FGD-woman aged 24 years, 19/6/2019)**

Theme 4c: Poor Road and Telecommunication Networks

The Ik county has a hilly terrain that's traversed by seasonal rivers and high rocky landscape. This has made construction of road network and installation of communication masts very difficult. This has made movement using automotive and communication across the Ik county very difficult due to a poor road network and a hilly terrain throughout the County. This ultimately acts as a great barrier to accessing reproductive health services in the Ik County.

> *"[…] the roads are completely spoiled. The road that connects us to the sub county is completely spoiled and If you moved with a motorbike it takes you one hour to move to a place very near – 10km from here to the sub county. Even when referred, women fear to sit on the motorbike because of the poor roads […]"* **(KII- Respondent I, 18/6/2019)**

> *"[…] if you want to make a call or receive a message on the phone you go to that spot otherwise you never get any communication when you are here. There's no network […]"* **(KII-Respondent II, 22/6/2019)**

Theme 5c: Attitude and Behaviors of Health Workers

The study discovered that the attitude and behaviors of health workers at the respective health facilities were a major barrier to accessing the reproductive services to many Ik community members. They reported incidents where they were treated with harsh words including being called unwelcome names by the health workers. They mistreat them for being dirty when they present to the health facility and in return the Ik people choose to avoid these health facilities.

> *"[…] health workers are absent, when you go there the health unit is either locked or you wait for long period and sometimes go back without any person attending to you […]"* **(FGD-woman aged 24 years, 19/6/2019)**

> *"[…] they use bad language including harassing and abusing them. They call them names, dirty and those kinds of things discourage them from going to hospital […]"* **(FGD- A Man aged 40 years, 20/6/2019)**

Theme 6c: Sexual and Reproductive Health Knowledge Gap Among Health Workers

Participants echoed concerns of glaring knowledge gaps among health workers lacking the capacity to

effectively respond to cases of sexual and gender-based violence. For instance, health workers were observed to find it difficult to fill the F3 form (standard form for reporting sexual abuse cases) yet it's critically considered for justice. Such knowledge gaps among health workers make it hard for them to identify, assess and manage any cases of gender-based violence. Once such knowledge gaps among health workers are recognized by the community, its trust for the anticipated reproductive health service will be affected and will act as a barrier to accessing quality services.

> *"[…] those health workers cannot even fill in a form F3 in case of rape. When someone gets raped, she cannot go there because she will not get any help […]"* **(KII- Respondent I, 18/6/2019)**

4. Discussion

This study discovered that the perceived SRH needs of the Ik are protection from gender-based violence, access to information on SRH, access to safe motherhood programs and treatment of STIs. These findings are consistent with the 2019 report by Hamimu (2019) which revealed that women and children in the Karamoja region are regarded as defenseless against sexual exploitation and are often exposed to sexual assault as they walk long distances in search of water. In addition, women from ethnic minority groups that are rural and indigenous continue to suffer all forms of sexual and gender-based violence (Hamimu, 2019). Failure to access information on SRH in an understandable language means that they do not know where to access SRH services and their questions are never answered (Thongmixay, et al., 2019). Many approaches are thus required for improvement to be realized (Nayebare & Omona, 2021).

The study discovered that Ik County did not have a single Health Centre IV in its existing health infrastructure hence could not implement the Uganda minimum healthcare package (UMHCP). The existing health structures is unable to deliver comprehensive maternity services including treatment of STIs. These are all catered for in the essential health benefits package provided at a health centre III (Ssengooba, 2004).

This study discovered that duration in a marriage (*p=0.047*), number of sex partners *(p=0.041*), type of house structure one lived in (*p=0.039*) and one's economic activity (*p=0.009*) were positively associated with the use of family planning services while age, sex, monthly income, level of education and distance from health facility were not statistically significant. In other rural parts of Uganda education (AOR = 3.03, 95 % CI 1.57–5.83), prior use of contraceptives (AOR = 7.15, 95 % CI 1.58–6.37), partner communication about contraceptives (AOR = 1.80, 95 % CI 1.36–2.37), and perceived need of contraceptives (AOR = 2.57, 95 % CI 1.09–6.08) were the predictors for contraceptive use among postpartum women (Sileo, Wanyenze, Lule, & Kiene, 2015). Poverty, culture, language and poor attitudes of health workers were the major barriers to accessing SRH services among the Ik. The cost of service is one of the most important determinants for access to any health care service. This is because women tend to prioritize basic needs like food and shelter above basic rights like access to reproductive health in any set up where there's socioeconomic stress (Schmidt, Fargnoli, Epiney & Irion, 2018). Due to a lack of balance of authority in an Ik home, decisions are highly influenced by the men who prefer big families. This way, the Ik culture denies the Ik an opportunity to decide the number of children they want to have, when they want to have them and with who (UNFPA & Guttmacher institute, 2014). (7). Poor attitudes have been recorded in Nepal where some health workers are judgmental and take on a policing role as they impose their own beliefs when providing reproductive health services to members of minority groups (Pandey, Seale & Razee, 2019). There's lack of respect, they are harassed and embarrassed in public by nurses who are rude and have no time to listen to their long stories (Chilinda, et al., 2014). The study findings are similar to a recent study (Mugumya & Omona, 2020), on involvement of parents in sexuality and reproductive health education of adolescents in Hoima Municipality, Uganda and another in Butambala (Omona & Namuli, 2020).

5. Conclusion

The Ik people continue to have poor performance of key health indicators. They continue to be short of the universal access to sexual and reproductive health. As this study has shown, the critical reproductive health needs of the Ik are similar to those of the general public though their perceptions are skewed to the uniqueness of their environment. Provision of reproductive health services to the Ik is faced by barriers at individual and community level that need critical attention of the leadership and planners for this community. The limits of existing health centers coupled with poor attitudes of the health workers have indented the trust for the Ik community which has further limited their utilization of available health services. This is supported by findings of published studies from other parts of the world and its not unique to the Ik community given its unique features.

6. Study Limitation

The study had two major limitations; (1) Being predominantly qualitative in nature, most of findings are not generalizable (2) Being cross-sectional, the trends of the findings cannot be traced.

7. Implication of the Study

Given the results of the study, there is need to revamp, sustain and consolidate efforts toward SRH services for the Ik community. Failure to do so might push this community to be marginalized.

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Conflict of Interest

We declare not conflict of interest, in what-so-ever way.

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Research Tools

Appendix I: Key Informant Interview Guide

1) Tell me about the history, location, lifestyle and economic activities of the Ik people

……

2) What are those special characteristics that make the Ik people a unique group of people?*[probe for those features the Ik share in common- language, longevity, lifestyle, religion, shared attitudes, beliefs, practices, risk factors, common practices and common taboos*]

……

3) What do you think are the determinants of sexual and reproductive health among the Ik community? [*Probe for factors at an individual, community, interpersonal, organizational and district level including environmental factors, and any modifying factors that affects the health seeking behaviour among the Ik]*

……

4) According to your observations, what are the common SRH needs for the Ik people? *[Probe for all possible SRH needs with narration on how prevalent one may be common compared to another. These can include but not limited to family planning, ANC, facility-based deliveries, post-partum care, post abortion and abortion services, sexual and gender based violence]*

……

5) What are the existing SRH services for the Ik people? *[probe for knowledge on all existing points where the Ik seek for services when sick or in need of SRH services including health facilities, VHTs, TBAs, look for all available SRH services and where they are accessed in the Ik community*]

……

6) Let's imagine I am one of the Ik people, where do I go for SRH service, what exactly happens at the clinic?*[Probe for details of access to information, privacy and confidentiality, informed consent, patient records, follow ups, side effects and adverse event management system, referral system, competence of the HWs]*

……

7) What motivates an individual in the Ik community to visit a clinic and access SRH services?*[probe for all existing motivators, facilitators factors that encourage people to seek SRH services. Probe for the potential motivating factors that would promote access to SRH services by the Ik which are not yet in place or which if implemented would promote SRH services for the Ik]*

……..…

8) What are the barriers of access to SRH services among the Ik? [*probe for factors that limit the Ik from accessing SRH services, they could be individual, health system related, community, policy, lifestyle, geographical or cultural]*

……

9) What social beliefs or cultural norms of the Ik community could be preventing uptake of family planning, ANC, hospital deliveries and post-abortion services?*[probe for practices that discourage uptake of services]*

……

10) What do you think can be done to help and enable promote access and utilize SRH services in the Ik community? *[Probe for no cost and low-cost strategies, remember explore how and why such strategies will work for the Ik to increase access and utilization]*

……

11) In your opinion, what elements are necessary to deliver the essential SRH services targeting the Ik? *[probe for staffing, medicines and supplies, infrastructure and equipment by facility and community level]*

……

Appendix II: Focus Group Discussion Guide

Interview Question

1) Tell me about the history, location, lifestyle and economic activities of the Ik people

……

2) What are those special characteristics that make the Ik people a unique group of people?*[probe for those features the Ik share in common- language, longevity, lifestyle, religion, shared attitudes, beliefs, practices, risk factors, common practices and common taboos]*

……

3) What do you think are the determinants of sexual and reproductive health among the Ik community? [*Probe for factors at individual, community, interpersonal, organizational and district level including environmental factors, and any modifying factors that affects the health seeking behaviour among the Ik]*

……

4) According to your observations, what are the common SRH needs for the Ik people? *[Probe for all possible SRH needs with narration on how prevalent one may be common compared to another. These can include but not limited to family planning, ANC, facility-based deliveries, post-partum care, post abortion and abortion services, sexual and gender based violence]*

……

5) What are the existing SRH services for the Ik people? *[probe for knowledge on all existing points where the Ik seek for services when sick or in need of SRH services including health facilities, VHTs, TBAs, look for all available SRH services and where they are accessed in the Ik community]*

……

6) Let's imagine I am one of the Ik people, where do I go for SRH service, what exactly happens at the clinic?*[Probe for details of access to information, privacy and confidentiality, informed consent, patient records, follow ups, side effects and adverse event management system, referral system, competence of the HWs]*

……

7) What motivates an individual in the Ik community to visit a clinic and access SRH services? *[probe for all existing motivators, facilitator factors that encourage people to seek SRH services. Probe for the potential motivating factors that would promote access to SRH services by the Ik which are not yet in place or which if implemented would promote SRH services for the Ik]*

……

8) What are the barriers of access to SRH services among the Ik? *[probe for factors that limit the Ik from accessing SRH services, they could be individual, health system related, community, policy, lifestyle, geographical or cultural]*

……

9) What social beliefs or cultural norms of the Ik community could be preventing uptake of family planning, ANC, hospital deliveries and post abortion services?*[probe for practices that discourage uptake of services]*

……

10) What do you think can be done to help and enable promote access and utilize SRH services in the Ik community? *[Probe for no cost and low-cost strategies, remember explore how and why such strategies will work for the Ik to increase access and utilization]*

……

11) In your opinion, what elements are necessary to deliver the essential SRH services targeting the Ik? *[probe for staffing, medicines and supplies, infrastructure and equipment by facility and community level]*

……

Appendix III : Questionnaire

Questionnaire No.: ……. Date. _____

Name initials for respondent: ……. Address: …….

Part One: Socio-Demographic Characteristics

Instructions

Now I want to ask you a few questions about your characteristics. Please mark with a tick or an X or N/A (not applicable) against the response in the space or box provided or give the most appropriate answer accordingly. Please be as honest as possible.

1.	Age:	1. 15-19 yrs □ 2. 20-30 yrs □ 3. 31-49 yrs □
2.	Sex:	1. Male □ 2. Female □
3.	Marital status	1. Married □ 2. Not Married □
4.	If married, for how long have you been in this marriage?	1. Less than 1 year □ 2. More than 1 year □
5.	How many sexual partners do you have?	1. None □ 2. 1 sexual partner □ 3. More than 1 sexual partner □
6.	Religion	1. Christian (Protestant/catholic) □ 2. Muslim □ 3. Others □
7.	Education Status (highest achieved)	1. Completed Primary School□ 2. Never completed Primary School □
8.	Economic activity	1. Formally employed□ 2. Not formally employed □
9.	Family Residence	1. Rural □ 2. Urban □ 3. Nomadic □
15.	Type of housing	1. Permanent structure □ 2. Temporary house □ 3. No structure □
16.	What is your Monthly income (UGX)?	1. Less than UGX 50,000/= □ 2. More Than UGX 50,000/= □
17.	How far is the nearest health facility?	1. Less than 5 Km distance □ 2. More than 5Km □

Part Two: Knowledge, Attitude and Practices Related To SRH Needs

For the following section tick or shade your best response as a Yes or No

18	Have you ever heard of Family Planning?		□Yes	□No
19	What Family Planning method do you know about? (Tick all that apply)	The Pill (Oral contraceptive)	□	□
		Injection	□	□
		Condom	□	□
		Implant	□	□
		Intra Uterine Copper Device (IUCD)	□	□
		Vasectomy or male sterilization	□	□
		Tubal Ligation	□	□
	Have you or your sex partner ever used any family planning method?			
20	Which FP method have you or your partner ever used or are using? (Tick all that apply)	The Pill (Oral contraceptive)	□	□
		Injection	□	□
		Condom	□	□
		Implant	□	□
		Intra Uterine Copper Device (IUCD)	□	□
		Vasectomy or male sterilization	□	□
		Tubal Ligation	□	□
21	What are the reasons for using FP? *(Mark as many as applicable)*	To Space children	□	□
		To have sex without children	□	□
		To prevent pregnancy	□	□
		To Prevent STIs	□	□
22	Reasons for not accessing Family Planning when u ever needed it?	It's against my faith or religion	□	□
		Fear of sexual promiscuity	□	□
		Opposition from sex partner e.g. husband	□	□
		Distance to the access point for an FP service	□	□
		Poor attitude by health workers or FP providers	□	□
		Availability of facilities/equipment	□	□
		Awareness	□	□
		Schedule of FP clinic	□	□
		Cultural non-acceptance	□	□
		Language barrier	□	□
		Side effects of methods	□	□
		Myths and misconceptions	□	□
23	What factors encourage the use of FP?	Acceptance by the husband	□	□
		Cultural acceptance	□	□
		Effectiveness of FP methods	□	□
		Accessibility of FP services	□	□
		Attitude of FP provider	□	□
		Religious acceptance	□	□
24	Where did you first learn about Family planning?	Hospital	□	□
		Mass media (Radio or TV)	□	□
		Friends and family	□	□

		Religious Institution	□	□
25	Which of the following modern family planning methods are available in the community?	Condoms	□	□
		Oral pills	□	□
		Hormonal Injections	□	□
		Hormonal Implant	□	□
		Permanent methods	□	□
26	Where do you obtain family planning methods in the community?	Public Health Centre	□	□
		Private health facility / Drug shop	□	□
		VHT	□	□
		TBA	□	□
		Other	□	□
27	Have you ever heard of HIV/AIDS?		□	□
28	What do you know about HIV/AIDS?	Is it possible to cure HIV/AIDS?	□	□
		Do all people with HIV look very sick?	□	□
		Do you need a test to know your HIV status?	□	□
		Do you think HIV test and treatment is needed in the Ik community?	□	□
29	What are the symptoms and signs of STIs in Men? (Tick as many as you know)	Discharge from Penis	□	□
		Pain when urinating	□	□
		Genital sores	□	□
30	What are the signs and symptoms of STIs in women? (Tick as many as applicable)	Vaginal discharge	□	□
		Pain when urinating	□	□
		Genital sores	□	□
		Genital itching	□	□
		Any other	□	□
31	What symptoms have you ever experienced in the past 6 months?	Discharge from vagina/penis	□	□
		Genital sores	□	□
		Genital itching	□	□
		Pain when urinating	□	□
32	Do you seek for treatment when you experience symptoms of STIs?		□	□
33	Where do you go for treatment when you experience symptoms of STIs?	Public Health Centre	□	□
		Private health facility / Drug shop	□	□
		VHT	□	□
		TBA	□	□
		Other	□	□
34	In this community, what happens when a girl an unwanted pregnancy?	Has no option but carry the pregnancy till term	□	□
		Visit health facility for termination	□	□
		Visit a TBA for termination	□	□
		Be forced into a marriage	□	□
35	When a woman gets pregnant, what does she do in the 9 months?	Go to a health centre for antenatal care	□	□
		Go to a TBA for herbs	□	□
		Do nothing	□	□
36	Where does a pregnantwomango for delivery in this community?	At the Health facility	□	□
		TBA	□	□

		Relative (in law, elder, brother or sister)	□	□
		At Home	□	□
		Other (Specify)	□	□
37	In this community, are the following acts accepted or not accepted?	Female genital mutilation	□	□
		Domestic violence against women	□	□
		Domestic violence against men	□	□
38	Which of the following services are available in your community?	HIV counselling and testing	□	□
		HIV treatment	□	□
		Family Planning	□	□
		Antenatal	□	□
		Delivery at the health centre	□	□
		Postnatal services	□	□
		Post abortion services	□	□
		Care for victims of SGBV	□	□
		Testing and treatment of STIs	□	□
39	Do you consider the following services necessary in this community?	HIV counselling and testing	□	□
		HIV treatment	□	□
		Family Planning	□	□
		Antenatal	□	□
		Delivery at the health centre	□	□
		Postnatal services	□	□
		Care for SGBV victims	□	□
		Post abortion services	□	□
		Testing and treatment of STIs	□	□
40	If you are to seek SRH services, where would you prefer to go? (Mark as many as applicable)	Health worker at a health centre	□	□
		Member of the VHT	□	□
		TBA/ traditional healer	□	□
		At an out reach	□	□
		Religious leader/ church	□	□
		Others (Specify)	□	□