



# BASELINE SURVEY REPORT

**INTEGRATED RESPONSE TO A CONDUCTIVE HEALTH ENVIRONMENT (RICHE) PROJECT**

**JANUARY –DECEMBER 2019**

*Funded by the Australian Government under the Nairobi Direct Aid Program (DAP) Round FY 2018-19*

Uganda Network for Empowerment of the Marginalised Child and Youth (NEMACY  
UGANDA)

P. O. Box 1028, Jinja-Uganda

Kaluba road, Plots; 7, 9, 11 & 13 C3 Project, Mpumudde Division,

Jinja Municipal Council,

Jinja-Uganda

**Mob.Tel.** (+256 754 131414 /+256 759 609339 /+256 774 726246)

**Email(s):** [nemacyuganda2001@gmail.com](mailto:nemacyuganda2001@gmail.com) OR [jinnet03@yahoo.co.uk](mailto:jinnet03@yahoo.co.uk)

**March 2019**

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## CHAPTER ONE: INTRODUCTION

### 1.1 Introduction

This chapter of the baseline report deals with the background, survey objectives, and methodology of the baseline survey conducted in 41 villages, 9 parishes of Buwenge rural and Buwenge Town Council in Jinja district. Baseline survey data was collected in from 25th February -8th March 2019. Thereafter, the collected data was entered using Excel and analyzed with SPSS version 16. Results were summarized, interpreted and presented in tabular and graphical form with narration notes in each next section.

### 1.2 Background

NEMACY-UGANDA formerly Jinja Network for the marginalized Child and Youth (JINNET) is a membership organization consisting of Non Governmental Organizations (NGOs), Community Based Organizations (CBOs), Child Rights Advocates (CRAs) and Government Departments. It was established to harmonize the different interventions for promoting Children/Youths welfare fronted by Civil Society Organizations in Jinja District and Jinja Municipal Authorities. The network was registered as a Community based Organization (CBO) by Jinja District Local Government and in 2005 as a NGO under registration number 5914/5378 under the NGO Registration Act CQAP113.

NEMACY-Uganda **envisions** a society that respects the rights of young people and supports them to achieve their full potential while its mission is to coordinate and jointly implement interventions of members to deliver services to marginalized children and youth through; research, advocacy and capacity enhancement.

NEMACY UGANDA received funding from the Australian Government under the Nairobi Direct Aid Program (DAP) Round FY 2018-19 to implement the Integrated Response to Conducive Health environment (RICHE) Project (January –December 2019). The project will benefit directly 120 girls aged between 12 -16), 120 child mothers, 10000 community members and indirectly policy makers and other development actors in the target areas of Buwenge rural and town council, Jinja district. The total project cost is USD54068 and the Total Amount Requested is USD39748.

Previous situational analyses conducted by NEMACY UGANDA indicated Conducive Health environment was being caused by among others:

- Poor health services due to limited health facilities such as a maternity ward and waiting shelter (triaging area) for child mothers and pregnant teenagers at Buwenge Health centre IV
- Limited knowledge on community and reproductive health among girls (12 – 16years) resulting into increased teenage pregnancies,
- Limited basic knowledge on community health, hygiene and sanitation, and low community involvement in health initiatives (75%) leading to poor sanitation in homes
- Low family income levels among families of child mothers and pregnant teenagers leading into increased teenage pregnancies in communities

- Low health budgetary allocation (capitation grants) by policy makers resulting into poor health care services

RICHE project is designed to address poor health services through; involving communities to construct maternity wards and triage area (shelter) at Buwenge Health Center IV, train 120 child mothers in making washable sanitary pads, sensitize 8 communities in community health and 120 vulnerable girls in reproductive health. These strategies once implemented; service (health) delivery within the target areas will improve in the areas of Buwenge rural and Town Council, Jinja District- Eastern Uganda

The expected project outcomes include: a) Improved health facilities or services accessible by patients.

b). Reduced incidences of sickness in communities, c) Increased community involvement in improving community health facilities or services.

d) Prioritization of health sector by policy makers during budget allocation to enable communities access better health services.

e) Increased knowledge in reproductive health to result into positive behavior change and reduction in incidences of teenage pregnancies among 85% of trained girls between the ages of 12- 16 years.

f). Reduced poverty levels among 90% families of child mothers trained in making and marketing of washable sanitary pads .

### 1.3 Study Objectives

The major objective of the survey was to establish baseline status information of the RICHE Project in the target villages of Buwenge rural and Buwenge Town Council in Jinja district. While, the specific objectives in the study were:

- To examine availability, quality, and maintenance of environmental health and sanitation facilities at the household level in the target villages.
- To investigate family health and sanitation levels in the target areas
- Assess factors affecting access to and adoption of reproductive health and family planning practices among pregnant and child bearing mothers
- To find out the livelihood and food security status of households in the target area
- To establish levels of budgetary allocation (capitation grants) by policy makers to health sector in the past five years

## CHAPTER TWO: RESEARCH DESIGN AND METHODOLOGY

### 2.1 Research design

The research study combined descriptive, correlational, case study and survey designs. Both quantitative and qualitative approaches were used. The study aimed at collecting Information on environmental health, sanitation, family health and sanitation levels, reproductive health and family planning practices among pregnant and child bearing mothers, livelihood and food security statuses from sampled households.

Data and information from the respondents on the above variables was collected by interviewing and administering of questionnaires to sampled respondents drawn from the households in 41 out of 65 villages in the 9 parishes of Buwenge rural and Buwenge Town Council. Both primary and secondary data were used. Primary data will be obtained using a questionnaire and interview guide while secondary data was found from records (archives) kept at the resource centre of NEMACY-Uganda, Buwenge sub-county, Buwenge Town Council and Jinja district.

Household knowledge of on community health, possession and use of sanitation facilities were correlated with the disease burden (incidences) of commonly preventable diseases. Furthermore, household knowledge on community and reproductive health among girls (12 – 16 years) was correlated with incidences of teenage pregnancies in communities. On the other hand, some case studies in from of verbal testimonies supporting the findings were extracted and used.

### 2.2 Research study area

The study was carried out in Buwenge rural and Buwenge Town Council in Jinja district, Uganda. This was purposively selected since it is where the RICHE project is being implemented by NEMACY-UGANDA. The area is characterized by poor access to health services, high incidences of commonly preventable diseases, increasing teenage pregnancies, food insecurity and poverty levels.

### 2.3 Study population

The study focused on the household members, pregnant and childbearing mothers (reproductive health and family planning), sub-county and district officials as the entire source of data. Buwenge rural and Buwenge town council were projected to have a population of 79,400 people in 2012 (UBoS, June 2009). Mean household size is 4.5 and 4.1 for Buwenge and Buwenge Town council respectively.

	2009			2010			2011			2012			2012 H/hold s
	M	F	T	M	F	T	M	F	T	M	F	T	
Sub county/ Town council													
Buwenge S/C	26,600	28,500	55,100	27,900	29,700	57,600	28,700	30,500	59,200	29,500	31,200	60,700	13,489
Buwenge T/C	7,900	9,100	17,000	8,300	9,500	17,800	8,500	9,700	18,200	8,700	10,000	18,700	4,561
Total	34,500	37,600	72,100	36,200	39,200	75,400	37,200	40,200	77,400	38,200	41,200	79,400	18,050

The estimated total number of household in both Buwenge rural and Buwenge TC was about 18,050.

## 2.4 Sample study population

The subjects of study were randomly drawn from all the 18,050 households in *both Buwenge rural and Buwenge TC*. Respondents included household members either the wife or husband, pregnant and childbearing mothers

## 2.5 Sample size

The baseline survey covered all the nine (9) parishes in the two(2) sub-counties of Buwenge rural and Buwenge Town Council in Jinja district. Respondents were randomly selected from 41 out of 65 villages. The survey adopted a sample size of 413 household respondents in the target area. The sample selection was based on statistical tables referred from Sarantakos<sup>1</sup>, where a sample size of 384 may be used to represent a population of over one million at a 95% confidence interval with a Margin of Error of about  $\pm 4.4\%$ . Variability in the population was captured to allow more reliability of the study results. The list of villages selected for the study based on the criteria stated above is shown in *Appendix 2*.

Household interviews were limited to a randomly selected sample size of 30 households in each village. A total of 413 households/individuals from 41 villages in 9 parishes of Buwenge rural and Buwenge Town Council in Jinja district were randomly sampled to take part in the study. However, this number varied according to the number of villages and population size of each parish and village. The following table gives the breakdown of the respondents per *Sub county, parish and village*.

**Table 1: Distribution of sample size and respondents per Sub County, parish & villages**

S/N	Parish	No. of sampled villages	Total No. of villages	Sub-county	Total. No. of villages	Sampled Villages	Respondents by parish
1.	Buwera	7	8	Buwenge Rural	47	31	48
2.	Kagoma	9	9				61
3.	Kaira	6	12				53
4.	Kitanaba	1	5				8
5.	Magamaga	8	13				78
6.	Kagaire	2	5	Buwenge T/C	18	10	26
7.	Kalitunsi	2	4				20
8.	Kamwani	4	4				81
9.	Kasalina	2	5				38
	<b>Total</b>	<b>41</b>	<b>65</b>		<b>65</b>	<b>41</b>	<b>413</b>

## 2.6 Sampling techniques

As a process, sampling involves selecting a number of individuals or objects from the population such that the selected group contains elements representative of the characteristics found in the entire group (Orodho & Kombo, 2002). The research team adapted probability sampling techniques such as simple random, stratified and cluster sampling techniques. This enabled the research team to draw inferential statistics on the collected data and also provided equal opportunity of selection for each household in each zone of the 41 out of 65 selected villages. Purposive (Non-probability) sampling techniques were also employed whenever it was appropriate though minimally especially for pregnant and child bearing mothers on the section of reproductive health and family planning.

<sup>1</sup> Sarantakos S (1993) – Social Research; pp 124-147.

List of households and villages in the Buwenge rural and town council were obtained and categorized according to their respective parishes. A total of 41 villages were randomly selected out of the sampling frame of 65 villages. Then, households were randomly selected from the final select list of villages and interviewed till the required sample size was reached. This will ensure that all the sub-groups in the target population are represented in the sample in proportion to their number in the villages.

## 2.7 Research instruments

The research instruments used baseline survey included the: household questionnaire and interview schedule(guide) for focus group discussions and community meetings.

**a) Household questionnaire:** Open ended, semi-structured ad structured questions related to each of the stated objectives were compiled used to construct the questionnaire that was administered to the target sample study population.

**b) Interview guide:** A list of open and close-ended questions or topics that need to be covered by the interview were written and used to conduct semi-structured interviews. Focused interviews were conducted with the key informants at the health centre, sub-county and district levels.

## 2.8 Data collection methods

Participatory research methods were elicited in order to elicit and generate a wide spectrum of responses and ideas. Both primary and secondary data was gathered. Primary data was obtained through focus group discussions, field visits, observation, interviewing using interview schedules and administration of the questionnaires to a selected adequate sample of respondents at 0.5 % level of significance while secondary data was found from the review of documents. Community meetings were sometimes held to explain the purpose of the visit with the assistance of the local council leaders.

- **Household field visits** were arranged and a set of designed questions was administered to the respondents. Face to face conversations were conducted between the research team and the respondents for the purpose of obtaining the required information. The questionnaire was pre-tested and the study team was re-oriented for one day.
- **Focus Group Discussions (FGD)** were arranged with the key informants to gather information regarding causes of poor health and sanitation and appropriate measures.
- **Observation:** The researchers also directly observed and verified the availability and quality of environmental health and sanitation facilities.
- **Documents review:** Secondary data on health and sanitation in the target areas was reviewed.

## 2.9 Data collection procedure

The research team collected introductory letters from NEMACY UGANDA and delivered them to the local areas leaders including LC I-II Chairpersons, councilors, sub-county and district officials. Upon acceptance, the survey instruments were administered to the respondents through interviews and questionnaires. Finally, the gathered data were entered; coded, edited, cleaned, and analyzed using Spread Sheet and SPSS data packages and findings were generated, and presented in the survey report.



## 2.10 Methods of data analysis

Both qualitative and quantitative methods of data analysis were employed. Statistical packages such as excel and SPSS were used to analyze the collected data.

## 2.11 Survey coordination

The baseline survey was managed and undertaken by a team of 7 technical staff; 3 from ANPPCAN - Jinja Chapter and 4 from NEMACY-UGANDA. The members were from different technical expertise including Participatory Action Research, Public Health, Community Development, Livelihoods and Food security.

## 2.12 Limitations of the study

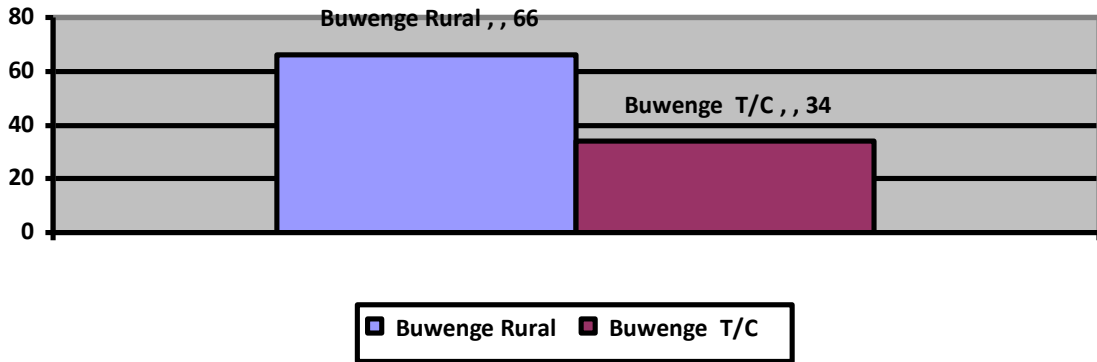
- Due to time and financial constraints, the study was restricted to only 41 out of 65 villages of Buwenge and Buwenge Town Council.
- The survey data on sanitation facilities was limited to only the presence of the facility without indicating the type of the building materials used say wattle, banana leaves, mud, cement and bricks, thatching grass and iron sheets. Hence, this particular information does not show changes in the investments into household health aspects which is usually indicative of household poverty levels.
- In addition, information on the disease burden at the health centre level was not captured for comparison with similar information collected at the community level.
- Other challenges faced included: data inaccessibility and lack of cooperation from some of respondents. The latter issue affected the response rate for some of the research components; for example: income, savings and expenditure patterns.

## CHAPTER THREE: PRESENTATION AND ANALYSIS OF SURVEY FINDINGS

### 3.1 Household Respondent Characteristics

#### 3.1.1 Respondents by sub-county

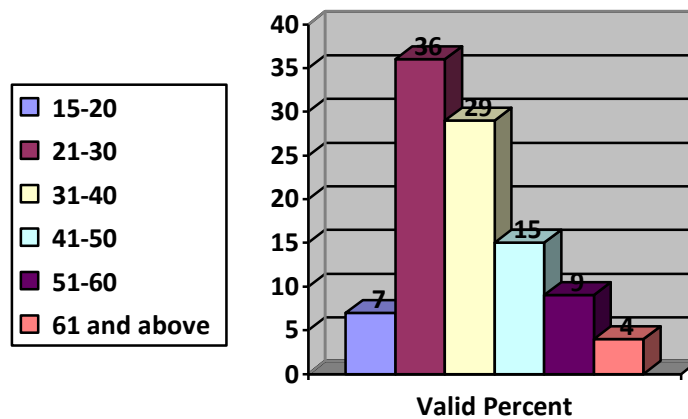
*Figure 1: Proportion of respondents by sub-county and gender*



As evidenced in Figure1:66 percent of the respondents who participated in the survey were from Buwenge rural sub-county while 34 percent came from Buwenge Town Council.

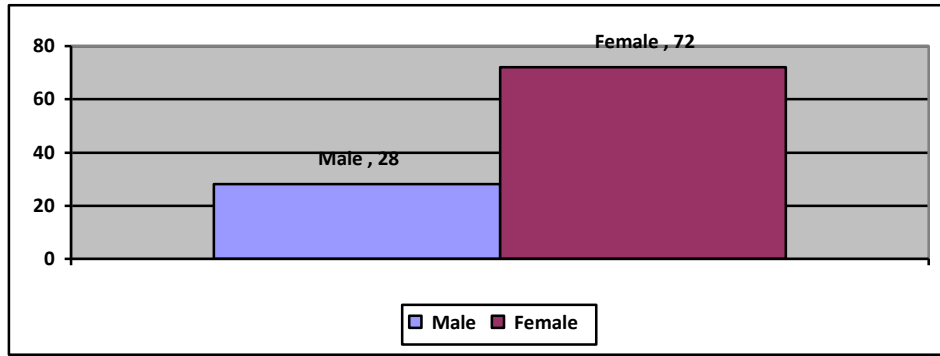
### 3.1.2 Respondents by Age in years

Percentage of respondents by Age in years (N=409)



Only 7 percent of the respondents were from the age cohort of 15-20. More than one third (36 percent) were in the age range of 21- 30 and just about three in ten were between the age 31 and 40. In addition, 15 percent were in the age range of 41-50 while 13 percent were beyond 51 years of age.

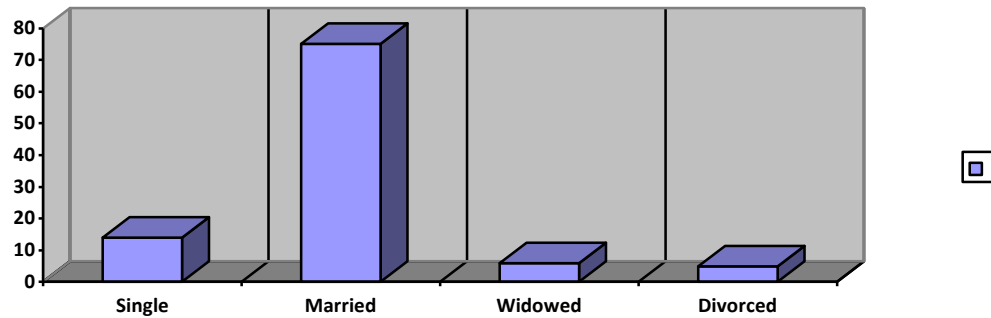
### 3.1.3 Respondents by gender



### 3.1.4 Respondents by gender

#### Marital Status

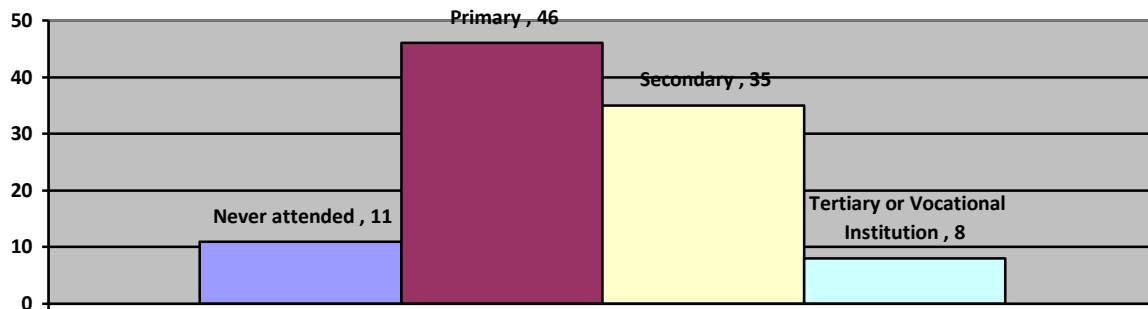
N=412



Majority of the respondents (75%) percent were married , 14 percent were single. A small proportion of the respondents 6 and 5 percent were widowed and divorced respectively.

### 3.1.5 Respondents by gender highest education level attended

#### Highest education level attended by respondents (N=390)



### 3.2 Environmental Health and Sanitation

Household data on environmental health and sanitation was collected and analyzed basing on the availability, quality and maintenance of the facilities in place:

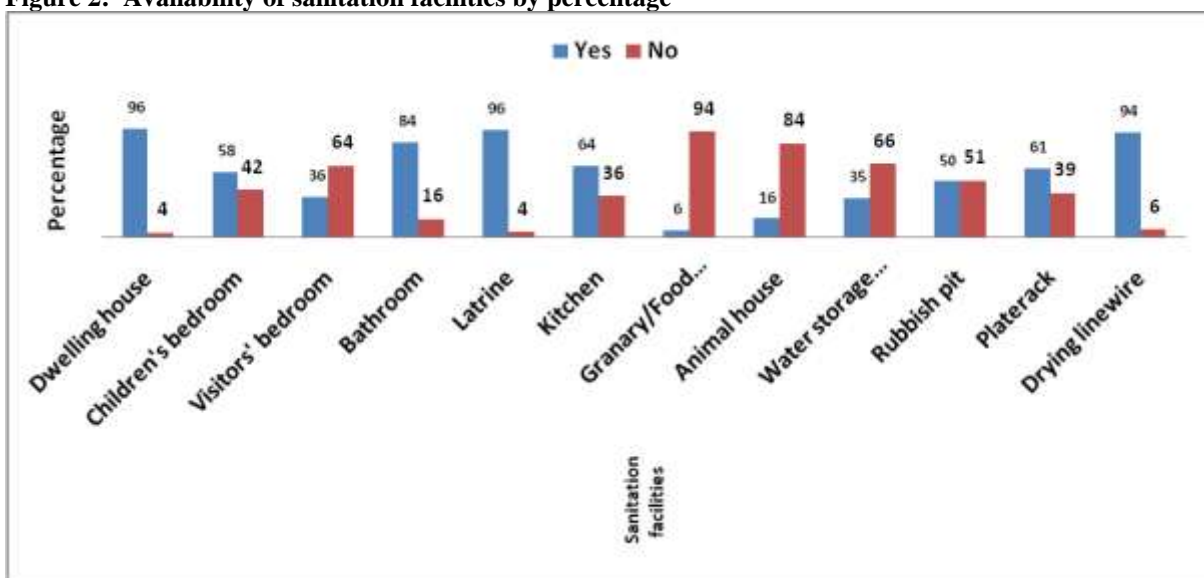
#### 3.2.1 Availability of health and sanitation facilities

From Table 1 and Figure 1 below, the overall situation is that the majority of the households had the dwelling houses, bathrooms, latrines, kitchens, plate racks and drying wires. Survey findings show that 397(96%) households had dwelling houses; 347(84%) had bathrooms, 395(96%) had pit latrines, 262(64%) had kitchens, 251(61%) had plate racks and 386(94%) had drying line wires. A moderate proportion of (58%) had children's bedrooms.

**Table 1: Availability of sanitation facilities by percentage**

	Dwelling house	Children's bedroom	Visitors' bedroom	Bath room	Latrine	Kitchen	Granary/Food Storage facility	Animal house	Water storage facility	Rubbish pit	Plate rack	Drying line-wire
Yes	96	58	36	84	96	64	6	16	35	50	61	94
No	4	42	64	16	4	36	94	84	66	51	39	6
Total	100	100	100	100	100	100	100	100	100	100	100	100

**Figure 2: Availability of sanitation facilities by percentage**



On the contrary, quite a minute number of households owned animal houses 67 (16%), visitors' bedrooms 148 (36%) and food storage facilities 25(6%). One-half of the respondents (50%) and 35% were disposing off their rubbish in one central place and had water storage facilities respectively.

**Table 2 :: Details on the number of sanitation and health facilities in place per Sub County:**

**Table 2A:**

Sub county	No. of respondents	Bathroom		Latrine		Plate stand		Rubbish pit		Tip tap	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Buwenge rural											
Buwenge T/C											
<b>Total</b>											

Average%											
----------	--	--	--	--	--	--	--	--	--	--	--

**Table 2B:**

Sub county	No. of respondents	Kitchen		Fss		Drying wire		Visitors shed	
		Freq.	%	Freq.	%	Freq.	%	Freq.	%
Buwenge rural									
Buwenge T/C									
<b>Total</b>									
<b>Average%</b>									

**Key**

<b>BR:</b> Bathroom	<b>PS:</b> Plate stand	<b>RP:</b> Rubbish pit	<b>Kit:</b> Kitchen	<b>TT:</b> Tip tap	<b>Cpd:</b> Compound
<b>PL:</b> Pit latrine	<b>V.G:</b> Vegetable garden	<b>Fss:</b> Fuel saving stove	<b>VS:</b> Visitors shed	<b>DW:</b> Drying wire	<b>MH:</b> Main house

**3.2.2 Quality of sanitation facilities**

After ascertaining the quantitative aspect of the environmental health and sanitation facilities, the survey assessed also their quality and maintenance by households. The low quality of sanitation facilities is attributed to the challenges of limited building materials for the sanitation facilities, poverty and sickness/old age, laziness and heavy work especially for women in households with gender disparities.

**3.3 Family Health and Sanitation**

**3.3.1 Have you attended any training about Community Health & Sanitation?**

From table 3, about 60 percent of the respondents had ever received a training in community health and sanitation.

**Table 3: Training in Community Health & Sanitation**

	<i>Frequency</i>	<i>Valid Percent</i>
Yes	245	60
No	165	40
<b>Total</b>	<b>410</b>	<b>100</b>

**3.3.2 Major household source of water**

One-half of the respondents (50%) reported the borehole as the major source of water in their homes while nearly one-third 126 (31%) fetched water from the tap. Only a small proportion of the respondents reported the spring (8%) and protected well (6%) as their major sources of water.

**Table 4: Major household source of water**

	<b>Frequency</b>	<b>Valid Percent</b>
Tap	126	31
Swamp	5	1
Borehole	205	50
River	1	0

Rain water	1	0
Spring	32	8
Protected well	23	6
Borehole & spring	12	3
Tap & Borehole	4	1
Tap & protected well	1	0
Tap & Swamp	1	0
<b>Total</b>	<b>411</b>	<b>100</b>

### 3.3.3 Distance of nearest water source from household home

Survey findings in table 5 show that the majority of the respondents 273(67%) fetched water within less than 1Km while 25% fetched domestic water in 1Km.

*Table 5: Distance of nearest water source from household home*

	Frequency	Valid Percent
Less than 1Km	273	67
1Km	104	25
2Km	17	4
3Km	9	2
No response	7	2
<b>Total</b>	<b>410</b>	<b>100</b>

### 3.3.4 Water storage

The survey also assessed how the target population store water within the homes. Interestingly, majority of the respondents 264(65%) stored water within jerricans while 11 percent stored water in the pots. About 11 percent stored water in both pots and jerricans. Only a small proportion of the respondents stored water in the drums (8%) and water tanks(4%).

*Table 6: How do you store your water in the home?*

	Frequency	Valid Percent
Water tank	16	4
Drum	33	8
Pot	47	11
Jerricans	264	65
Drum & Pot	3	1
Pot & Jerricans	43	11
Drum & Jerricans	3	1
<b>Total</b>	<b>409</b>	<b>100</b>

### 3.3.5 Washing of hands by household members

Results from table 7 indicated that an overwhelming majority of the respondents 402(98%) wash the hands with clean water and soap while preparing/serving/eating meals, feeding children, after disposal of faeces including children's and after using the latrine/toilet.

**Table 7: Do you always wash your hands with clean water & soap before meals & after use of latrine?**

	<i>Frequency</i>	<i>Valid Percent</i>
Yes	402	98
No	9	2
<b>Total</b>	<b>411</b>	<b>100</b>

### **3.3.6 Knowledge about diseases caused by poor sanitation and use of dirty water**

Majority of the respondents 383 (93%) reported to be aware of diseases caused by poor sanitation, drinking/ using dirty water (Table 8).

**Table 8: Are you aware of any diseases caused by poor sanitation, drinking/ using dirty water?**

	<i>Frequency</i>	<i>Valid Percent</i>
Yes	383	93
No	24	6
N/a	3	1
<b>Total</b>	<b>410</b>	<b>100</b>

Furthermore, about 37 and 32 percent reported only diarrhea and cholera as some of the diseases caused by poor sanitation. A small number of respondents mentioned typhoid 47(12%) and dysentery, 7(2%). In addition, a few respondents 19(5%) attributed Candida, cancer, tetanus, Ebola and UTI to poor sanitation practices.

**Table 9: If yes, which diseases**

	<b>Frequency</b>	<b>Valid Percent</b>
Diarrhea	144	37
Cholera	124	32
Typhoid	47	12
Dysentery	7	2
Bilharzia	10	3
Others(Candida, Cancer, Tetanus, Ebola, UTI & Vomiting)	19	5
Diarrhea & Cholera	11	3
Cholera & Typhoid	9	2
Diarrhea & Typhoid	11	3
Diarrhea & Dysentery	2	1
Typhoid & Bilharzia	2	1
<b>Total</b>	<b>386</b>	<b>100</b>

### **3.3.7 Incidences of falling sick in last month**

Data on the disease burden in the previous month was collected from 410 respondents in 41 villages and 9 parishes of Buwenge rural sub-county and Buwenge Town Council. Results of the findings are presented in table 10 below; indicated that majority of the households respondents 314(77%) reported to have a family member who fell sick in the previous month

prior to the survey. Only 23 percent did not record any case of a family member falling sick in the last month.

**Table 10: Did any family member fall sick last month?**

	Frequency	Valid Percent
Yes	314	77
No	95	23
N/a	1	0
<b>Total</b>	<b>410</b>	<b>100</b>

The survey attempted also to find out the specific members who fell sick in the previous month. Results in table 11 show that 30 percent of those who fell sick were adults while one third (33%) were children. In some households, 34 percent of those who fell sick in the previous month were both adults and children.

**Table 11: Who fell sick?**

	Frequency	Valid Percent
Adult	94	30
Youth	11	3
Child	104	33
Adult & Child	109	34
<b>Total</b>	<b>318</b>	<b>100</b>

### 3.3.8 Disease prevalence

The prevalence of various diseases was tracked at the community level from a sample of 404 respondents. Details of the survey findings are summarized in table 12 and reported as follows:

**Table 12: What diseases did they suffer from**

	Frequency	Valid Percent	Frequency	Valid Percent
Malaria	182	45	182	54
Diarrhea	14	3	14	4
Flue & Cough	88	22	88	26
Others	42	10	42	13
Malaria & Diarrhoea	4	1	4	1
Malaria & Flue & Cough	3	1	3	1
Diarrhea & Flue & Cough	1	0	1	0
N/a	70	17	0	0
<b>Total</b>	<b>404</b>	<b>100</b>	<b>334</b>	<b>100</b>

*Without N/a*

**Note:** Diseases categorized under others include others (UTI, sight problems, hands sprain, Ulcers, Typhoid, HB pressure, heart, skin, asthma, measles and Back pain)

From table 12 and figure XI, malaria is one of the major diseases affecting the target population with the highest record of cases: 182 (54%) and followed by flue and cough 88(26%) and Others 42(13%). Incidences of diarrhea recorded were only 4 percent.



### 3.3.9 Medical treatment/services

The survey found out also the places where the respondents sought medical services from when they fell sick. Details of the findings are presented in table 13 below.

Nearly two in five household respondents (38%) seek medical services from only health centers while 15 percent received medical treatment from only drug shops. One in ten household respondents (20%) seeks medical services from both drug-shops & Health centers. A small number of 33(8%) get medical treatment from both the health centre and hospitals. About 28(7 %) did not respond to the question while 7(2%) were visiting traditional healers for health check-ups when they fell sick.

Further analysis of the survey finding indicated that generally, a greater part of the household respondents (67 percent) seek medical treatment from health centers while 17 percent from hospitals and 36 percent from drug shops. Therefore, Health centers II-IV play a critical role and are the preferred facilities in terms of effective delivery of health services. There is need to monitor and regulate<sup>2</sup> effectively drug shops since they are an emerging alternative source of medical services in rural communities. For about 36 percent of the household respondents were administering medical treatments to themselves using bought drugs.

*Table 13: Where households seek for services when sick*

	<i>Frequency</i>	<i>Valid Percent</i>
Drug shop	61	15
Health centre	157	38
Hospital	37	9
Traditional healers	7	2
Health centre & hospital	33	8
Health centre & Drug shop	86	21
Drug shop & Hospital	1	0
N/a	28	7
<b>Total</b>	<b>410</b>	<b>100</b>

## 3.4 Reproductive Health and Family Planning

### 3.4.1 Problems faced by pregnant and childbearing mothers during pregnancy

About 25 (14%) of the respondents reported body weaknesses and morning sickness while 16 percent said that they were falling sick frequently during the pregnancy. About 8 percent reported back and abdominal pain, dizziness, spitting, loss of appetite and malaria fever. Survey results in table 14 show that 23(13%) were experienced back/abdominal pain /headache and severe vomiting accompanied by loss of appetite and body weakness.

*Table 14: Problems faced during pregnancy*

<i>Problems faced during pregnancy</i>	<i>Frequency</i>	<i>Valid Percent</i>
Back, abdominal pain and headache	23	13

<sup>2</sup> Do drug shops have qualified medical personnel?

Abortion	1	1
Appetite for food	1	1
Body weakness at the second trimester & <i>morning sickness</i>	25	14
Loss of appetite and dizziness & spitting	14	8
Flue	5	3
Malaria Fever	14	8
Barrenness	1	1
Frequent sickness throughout the pregnancy	29	16
High blood pressure & loss of appetite	1	1
Limited support from husband, lack of blood & no funds to purchase nutritious food	4	2
Long distance & high transport fares	9	5
Long queues	3	2
No drugs sometimes at the Health centers	4	2
Unprofessional conduct of health staff	3	2
Stomach pain	2	1
Painful joints & swelling of legs(lower part)	7	4
Painful tubes	1	1
Premature death of child/No child	4	2
Removing teeth for each child	1	1
Severe heart pain	1	1
Candida, Syphillis, UTI, discharge & bleeding	7	4
Vomiting accompanied by loss of appetite, body weakness & swelling of legs	23	13
	<b>183</b>	<b>100</b>

About 4 percent experienced swelling of legs (lower part) and painful joints; and infections such as candida, syphilis, UTI, discharge and bleeding. Furthermore, 4 (2%) reported receiving limited support from their husbands, lack of blood and food inaccessibility.

Other issues highlighted affecting access to quality medical services were long distance(5%) and high transport fares(5%), long queues(2%), stock outs of drugs (2%)and unprofessional conduct of health staff (2%) at the health facilities

### 3.4.2 Attending trainings in Sexual and reproductive health

From the findings in table 15, only 44 percent of pregnant and childbearing mothers had attended trainings in sexual and reproductive health.

**Table 15: Have you ever attended any training in Sexual and reproductive health?**

	<i>Frequency</i>	<i>Valid Percent</i>
Yes	123	44
No	155	56
<b>Total</b>	<b>278</b>	<b>100</b>

### 3.4.3 Age of first pregnancy or delivery of first child

Adolescent fertility and teenage pregnancies are very important and critical social and health issues in Buwenge rural sub-county and Buwenge TC. Children born to very young mothers are at increased risk of sickness and death.

From table 16, two in five women first got pregnant or delivered their first child between the age categories of 13-17 while 14 percent were first pregnant at the age of 18.

**Table 16: Age of first pregnancy or delivery of first child**

Age category	Frequency	Valid Percent
13-17	104	40
18	36	14
19-24	111	43
25-30	10	4
<b>Total</b>	<b>261</b>	<b>100</b>

According to the UNDHS 2016: 26, the percentage of adolescents age 15-19 who had began child bearing were 21 percent in Busoga region and 25 percent in Uganda. NEMACY UGANDA Survey findings show that 169(65%) of the girls and young women within the age range of 13-19 in the survey sample gathered from Buwenge rural and Buwenge TC had began child bearing.

Teenage mothers are more likely to experience adverse pregnancy outcomes and maternal deaths. Maternal deaths represent 18% of all deaths among women aged 15-49 during the 7-year period preceding the Uganda Demographic and Health Survey (UDHS) 2016. Teenage mothers are not able to pursue educational opportunities leading to numerous challenges of childbearing at a young age.

### 3.4.4 Access to antenatal care services when Pregnant

Mothers were asked if they had obtained antenatal care (ANC) services during the most recent pregnancy during the survey. Antenatal care (ANC) from a skilled provider is important to monitor pregnancy and reduce morbidity and mortality risks for the mother and the child during pregnancy, delivery, and the postnatal period (within 42 days after delivery). According to the survey findings in table 17, an overwhelming majority of the respondents accessed or attended antenatal care services when Pregnant.

**Table 17: Did you attend Antenatal care services when Pregnant**

	Frequency	Valid Percent
Yes	272	99
No	4	1
<b>Total</b>	<b>276</b>	<b>100</b>

### 3.4.5 Distance from antenatal care services from home

Over one third of the respondents (36 percent) said antenatal care services were within 1km from their homes, followed by 28 percent within less than 1km and 22 percent within km. only 15 percent accessed antenatal care services beyond 3km from their homes.

**Table 18: How far are antenatal care services from your home?**

	<b>Frequency</b>	<b>Valid Percent</b>
Less than 1Km	77	28
1Km	99	36
2Km	61	22
3Km	22	8
4Km+	18	7
<b>Total</b>	<b>277</b>	<b>100</b>

### **3.4.6 Number of Antenatal Care (ANC) visits**

Respondents were also asked the number of antenatal care visits during pregnancy. The survey results in table 19 show that 67 percent of the respondent mothers received ANC from a skilled provider at least four times for their last birth. About one in ten mothers (29percent) had 3 ANC visits for the most recent live birth while only 4 percent recorded 1-2 ANC visits.

**Table 19: Number of times mother attended antenatal care services**

	<b>Frequency</b>	<b>Valid Percent</b>
1 -2	8	4
3	51	29
4 or more	119	67
<b>Total</b>	<b>178</b>	<b>100</b>

The number of ANC visits is affected by area of residence, availability of health facilities, the level of education and household wealth

In the survey, respondent mothers were asked whether they had antenatal cards for verification of the ANC visits. As shown in table 20, only 30 percent had the cards present. About one third of the mothers said they did not have antenatal cards while 32 percent reported that they had lost them during the survey.

**Table 20: Do you have your antenatal card?**

	<b>Frequency</b>	<b>Valid Percent</b>
Card present	82	30
Lost card	87	32
Don't have card	92	34
Card left in the hospital	10	4
<b>Total</b>	<b>271</b>	<b>100</b>

### **3.4.7 Place of delivery**

Access to proper medical attention and hygienic conditions during delivery can reduce the risk complications and infections that may lead to death or serious illness for the mother, baby, or both (*Van Lerberghe and De Brouwere 2001; WHO 2006*). As shown in table 20, two thirds (67%) of the recent live births preceding the survey were delivered by a skilled provider at the health centre. In addition, one in five (20%) live births were delivered in a hospital. About 8percent of the respondent mothers delivered at maternity clinic and dispensary while only 6 percent delivered at home.

**Table 21: Where did you give birth from?**

	<i>Frequency</i>	<i>Valid Percent</i>
Home	16	6
Maternity clinic	15	6
Dispensary	5	2
Health centre	179	67
Hospital	53	20
Traditional Birth Attendant(TBA)	1	0
<b>Total</b>	<b>269</b>	<b>100</b>

### 3.4.8 Type of person who attended to mother during delivery

In the survey, respondents were also asked who attended to them when giving birth. As shown in table 21, just above one half of the mothers (51%) were assisted by skilled health service providers<sup>3</sup> including doctors(12%), nurse(26%) and midwives(13%) at the time of delivery. Meanwhile, about 14 percent of the mothers were assisted by husbands and 32 percent by others. Others included: Mothers (9%), sisters (6%), mother in law (9%), sister in law (3%), neighbors (3%), Co-wives, grandmothers and friends (2%).

**Table 22: Who attended to you when giving birth?**

	<b>Frequency</b>	<b>Valid Percent</b>
Doctor	30	12
Nurse	66	26
Midwife	34	13
Husband	37	14
Self	6	2
Others	83	32
<b>Total</b>	<b>256</b>	<b>100</b>

### 3.4.9 Post-natal care

Mothers were asked if they received a postnatal check during immediately after delivery. A large proportion of maternal and neonatal deaths occur during the first 48 hours after delivery. Thus, prompt postnatal care (PNC) for both the mother and the child is important to treat any complications that arise from the delivery, as well as to provide the mother with important information on caring for herself and her child. Safe motherhood programmes recommend that all women receive a check of their health within 2 days after delivery (UDHS 2016, 36).

To assess the extent of postnatal care utilisation, respondents were asked whether they had received a recent postnatal check after delivery. As shown in Table 22, 93 percent of women reported receiving a postnatal check during the first 2 days after birth. A small proportion of mothers (7%) did not receive the postnatal check at either a hospital or a health centre.

**Table 23: Do you always go the hospital/health centre after giving birth?**

<sup>3</sup> Skilled provider includes doctor, nurse/midwife, and medical assistant/clinical officer

	Frequency	Valid Percent
Yes	245	93
No	18	7
<b>Total</b>	<b>263</b>	<b>100</b>

Of those who did not receive the postnatal check, 87 percent reported absence of health complications on both the child and mother as the major reason for not going to the health facility after delivery. Other reasons included long distance of health facility from home (7%) and lack of money for medical checkup.

#### 3.4.10 Comparing maternal health care indicators for Buwenge, Busoga and Uganda

Region	Percentage Receiving antenatal care from a skilled provider	Percentage with 4+ ANC visits	Percentage delivered by a skilled provider	Percentage delivered in a health facility	Percentage of women with a postnatal check after birth
Buwenge	99	67	51	95	93
Busoga	97.8	66.0	74.7	76.5	43.3
National	97.3	59.9	74.2	73.4	54.3
<b>Data source: NEMACY-UGANDA 2019 &amp; UDHS 2016:34</b>					

#### 3.4.11 Child spacing

Respondents were also asked how long they take to space their children between births. As shown in table 24, just more than one half (53%) take 2 years while one in five (20%) take one year or less. About 23 percent take 3 years and above to space their children between births.

Table 24: How long do you take to space your children between births

	Frequency	Valid Percent
1 year or less	53	20
2 years	138	53
3 years	36	14
4 years plus	22	9
N/a	11	4
<b>Total</b>	<b>260</b>	<b>100</b>

#### 3.4.12 Infant and Young Child Feeding Practices

Breastfeeding is sufficient and beneficial for infant nutrition in the first 6 months of life. Breastfeeding immediately after birth also helps the uterus contract, which reduces the mother's postpartum blood loss.

Survey findings in table 25 show that 57 percent of the mothers take 2 years to breast-feed their children. In addition, 27 percent take one and half years while 16 breastfeed their children for less than one year. Supplementing breast milk before the child is age 6 months is discouraged because it may inhibit breastfeeding and expose the infant to illness. At a later stage of the baby's development, breast milk should be supplemented by other liquids and eventually by solid or mushy food to provide adequate nourishment (Pan American Health Organization 2002)

Table 25: How long do you breast-feed your babies?

Frequency Valid Percent



Less than 1 year	31	16
1 & half years	53	27
2 years	113	57
<b>Total</b>	<b>197</b>	<b>100</b>

### 3.4.13 Knowledge and adoption of Family Planning practices

Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods. Contraceptive methods are classified as modern or traditional methods. Modern methods include *female sterilisation, male sterilisation, the pill, the intrauterine contraceptive device (IUD), implants, injectables, male condoms, female condoms, emergency contraception, standard days method (SDM), and lactational amenorrhoea method (LAM)*. Methods such as rhythm, withdrawal, and folk methods are grouped as traditional.

The survey collected information on the knowledge, type and use of family planning methods in the target areas. As shown in table 26, majority of the respondents 199 (73%) said that they had ever been taught about family planning practices. However, only a few of these practiced family planning practices.

**Table 26: Knowledge and adoption of Family Planning practices**

	Have you ever been taught about Family Planning practices		Do you practice any family planning practices	
	Frequency	Valid Percent	Frequency	Valid Percent
Yes	199	73	152	56
No	74	27	113	42
No response	1	0	5	2
<b>Total</b>	<b>274</b>	<b>100</b>	<b>270</b>	<b>100</b>

Survey findings in table 27 show that majority of the respondent mothers were using injectables (66%). Followed by Tubuligation (10%) and intrauterine contraceptive device (IUD) (10%). A relatively small proportion was practicing pill plan (7%), condoms(5%) and natural method(2%).

**Table 27: If yes, which type of family planning method is practiced ?**

Type of family planning method	Frequency	Valid Percent
Tubuligation	15	10
Pill plan	11	7
Condoms	7	5
Injectaplan	100	66
Natural method	3	2
IUD	15	10
<b>Total</b>	<b>151</b>	<b>100</b>

### 3.4.14 Attending trainings on making sanitary pads

**Table 28: Have you ever been taught about how to make sanitary pads? (N=405)**

	<i>Frequency</i>	<i>Valid Percent</i>
Yes	63	16
No	342	84
Total	405	100

Majority of the pregnant and childbearing mothers had not received any training on making washable sanitary pads. ONLY a small proportion of 16 percent had received training in making sanitary pads made from tampoon (rolled small cotton), soft cloth, bark cloth, dry banana leaves and fibres, black polythene bags, toilet paper, and soft paper. However, it is more likely that this cohort acquired this reproductive health knowledge from parents or guardians/caretakers. The latter five types of materials used in place of sanitary pads are unsafe, unclean; and hence not recommended for use. During the training on making sanitary pads conducted by NEMACY-Uganda (April 10-13<sup>th</sup> 2019) in Jinja , it was found out that 7 out 120 (6%) child mothers did not have sanitary pads when they first experienced menstruation periods while only 21 out 120 (18%) ever attended a training from parents or caretakers on sexual and reproductive issues.

### 3.4.15 Household expenditure on sanitary pads in 3 months

*Table 29: Household expenditure on sanitary pads in 3 months*

<i>Expenditure category (Ugsh)</i>	<i>Frequency</i>	<i>Valid Percent</i>
2000-6000	44	18
6001-12000	140	58
12001-18000	17	7
18001-24000	15	6
24001-30000	13	5
30001-36000	2	1
Above 36000	9	4
Total	<b>240</b>	<b>100</b>

Majority of the respondents 140(58%) were spending between Ughs.6001-12000 while 18 percent spent Ugsh. 2000-6000 in 3 months on sanitary pads. The minimum amount being spent on sanitary pads was Ugsh.2000 while the highest amount recorded in the survey was Ughs.120,000 in three months. About 23 percent were spending Ugh.120,000 and above on sanitary pads in 3 months.

## 3.5 Livelihoods and Food Security

### 3.5.1 Household income savings

Households were asked whether they save money and the survey findings in table 30 show that a reasonable majority 264 (67 percent) said that they save part of their income.

*Table 30: Do you save any money*

<i>Do you save any money? (N=396)</i>
---------------------------------------



	Frequency	Valid Percent
Yes	264	67
No	132	33
Total	396	100

Of these who save, about 65 percent save with a community group/Association while 34 percent save individually. An insignificant proportion of one percent save at the Bank. The fact that majority of the respondents

### 3.5.2 How households save money

<i>How do you save money (N=250)</i>		
	Frequency	Valid Percent
Individually	85	34
Community group/Association	163	65
Others(Bank)	2	1
<b>Total</b>	<b>250</b>	<b>100</b>

### 3.5.3 Monthly/Seasonal Income

Household respondents were asked how much they earn monthly or seasonally from the various income sources. Three in ten household respondents (31 percent) were earning less than Ush.60,000 per month while 19 percent were earning Ugsh.60001-120,000.

<b>Monthly/Seasonal Income N=256)</b>		
Ugsh.	Frequency	Valid Percent
Less than 60,000	79	31
60001-120,000	48	19
120,001-180,000	25	10
180001-240,000	18	7
240,001-300,000	40	16
300,001-360,000	8	3
360,001-420,000	8	3
Above 420,000	30	12
	<b>256</b>	<b>100</b>

About 10 percent were earning Ugsh.120,001-180,000 and 16 percent were earning Ugsh.240,001-300,000. A small proportion of household respondents (6%) were earning income between 300,001-420,000. Furthermore, 12 percent were earning Ugsh.420,000 and above.

### 3.5.4 Type of education institution where children go to school

From the results in table 31, just more than one half of the respondents (53 percent) send their children to primary private schools while one in three (28 percent) send their children to primary government schools. In addition, over one in ten (11 percent) households send children to secondary day and only 3 percent send children to secondary boarding for education. Overall, only five percent of the household respondents were sending children to tertiary/vocational institutions.

*Table 31: Type of education institution where children go to school*

	<b>Frequency</b>	<b>Valid Percent</b>
Primary government	82	28
Primary private	152	53
Secondary Day	32	11
Secondary Boarding	8	3
Tertiary/Vocational	15	5
<b>Total</b>	<b>289</b>	<b>100</b>

### *3.5.4 Livelihoods and Food security*

The survey also assessed the food security status of the household respondent. As shown in table 32, about 244(61%) of the respondents were having more than three meals per day. This corresponds with the 68 percent of the respondents who said that they never experienced food shortages in the last six months. Furthermore, one in ten households (30 percent) were having two (2) meals per day and just about one in ten households (9%) were usually having one meal per day.

*Table 32: Number of nutritious meals usually eaten per day*

	<b>Frequency</b>	<b>Valid Percent</b>
1	38	9
2	121	30
3	233	58
4	11	3
<b>Total</b>	<b>403</b>	<b>100</b>

### *3.5.5 Household food shortages in last 6 months*

Results in table 33 reveal that nearly one third of the respondents (32 percent) experienced food shortages in last 6 months.

*Table 33: In the last six months did you have any food shortages?*

	<b>Frequency</b>	<b>Valid Percent</b>
Yes	131	32
No	276	68
<b>Total</b>	<b>407</b>	<b>100</b>

### *3.5.6 Causes of food shortage in last 6 months*

As shown in table 34, majority of the household respondents (54 percent) attributed food shortages to prolonged dry spell (hailstorms) that caused poor harvests. This was followed by poverty (low incomes) for purchase of enough food (23%) and lack of own land to grow adequate food (16%). Other causes of food shortages in the last six (6) months were Ill-health, planting sugarcanes instead of food crops, pests and diseases, theft of food in the garden and high food prices.

*Table 34: Causes of food shortage in last 6 months*

	<b>Frequency</b>	<b>Valid Percent</b>
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Lack of enough & own land to grow adequate food	20	16
High food prices	1	1
Ill-health prevented family from food production	3	2
Poverty/Low incomes for enough food purchase & stocks	29	<b>23</b>
Planting sugarcanes instead of food crops	3	2
Poor harvest due prolonged dry spell /hail storms	67	<b>54</b>
Poor harvests due to pests and diseases	1	1
Theft of food in the garden	1	1
<b>Total</b>	<b>125</b>	<b>100</b>

### 3.5.7 Household coping strategies of food shortages

The survey also assessed the mechanisms employed by households during food shortages. About 20 percent were waiting for rain to replant early next season. About 14 percent planning to purchase or hire more land for food production next season, planting more crops, halting sugarcane growing, improving Good Agricultural Practices(GAPs) and increasing the increase area under cultivation. 13 percent were surviving on **food** purchases or borrowed money for food purchase while 11 percent secured jobs or casual work such as agricultural labour.

Other coping mechanisms included: diversification of food crops and starting IGAs to spread the risk (7%), storing more food/not selling food(5%), growing own food to reduce on the food expenditure(5%), planting drought resistant crops such as cassava(4%), Savings and doing any other work available(3%) and reducing the quantity of food and number of meals per day to sustain the family

**Table 35: Household coping strategies of food shortages**

	<i>Frequency</i>	<i>Valid Percent</i>
Diversifying food crops and starting IGAs to spread the risk	5	7
Grow own food to reduce on the food expenditure	4	5
Waiting for rain and replanting early next season	15	20
Purchase /Hire more land for food production next season	11	14
Planting more crops/improve GAPs & increase area under cultivation/Stop planting sugarcanes	11	14
Planting drought resistant crops such as cassava	3	4
Secure a job/casual work such as agricultural labour	8	11
Reduce quantity of food & number of meals per day to sustain the family	3	4
Food purchases to survive/borrowed money for food purchase	10	13
Savings and doing any other work available	2	3
Storing more food/not selling food	4	5
<b>Total</b>	<b>76</b>	<b>100</b>

## CHAPTER 4: RECOMMENDATIONS AND CONCLUSIONS

### 4.1 Conclusions

#### Environmental Health and Sanitation

- A significant proportion of household respondents had environmental and sanitation facilities mainly the dwelling house, latrines, bathrooms, drying line wire. An average number of households had children's bedrooms, kitchens, plate racks and rubbish pits, Majority of household respondents did not have in place visitors bedrooms, granary (food storage), animal shelters and water storage facilities.
- Although three in five households had attended training sessions about community health and sanitation, the quality and maintenance of environmental health and sanitation facilities by households was very low. This is attributed to the challenges of limited building materials for the sanitation facilities, poverty and sickness/old age, laziness and heavy work especially for women in households with gender disparities.

#### Family Health and Sanitation

- The tap and borehole are the major sources of water within the target areas which were accessed in a distance of less than 1km. For some reasons, a few households were fetching water for domestic from unsafe water sources such as swamps.
- A significant number of households store water for domestic use in jerricans and pots while a negligible number has drums and water tanks to harvest rain water.
- An overwhelming majority of the respondents wash the hands with clean water and soap and were aware of the diseases caused by poor sanitation, drinking/ using dirty water.
- Incidences of falling sick (disease burden) from malaria, flue and cough remain high across the target areas and it is mainly children and adults who fell sick
- A greater part of target population (seven out ten) seek medical treatment from health centers II-IV. There is need to monitor and regulate<sup>4</sup> effectively drug shops since they are an emerging alternative source of medical services in rural communities.

#### Reproductive Health and Family Planning

- Child mothers face several challenges during pregnancy. The most common include body weaknesses, back and abdominal pain, dizziness, spitting, malaria and severe vomiting accompanied by loss of appetite. There were also issues of access to quality medical services specifically long distance, high transport fares, long queues, stock outs of drugs and unprofessional conduct of health staff at the health facilities.
- Less than one-half of pregnant and child bearing mothers have knowledge on Sexual and reproductive health
- Adolescent fertility and teenage pregnancies are very important and critical social and health issues in Buwenge rural sub-county and Buwenge TC since a high proportion (65 percent) of girls and young women began conceived and began child bearing at the age of 13-19. This is far higher than the figure recorded in Busoga (21Percent) and Uganda (25 percent) by the

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<sup>4</sup> Do drug shops have qualified medical personnel?

UNDHS 2016. Children born to very young mothers are at increased risk of sickness and death.

- Teenage mothers are more likely to experience adverse pregnancy outcomes and maternal deaths. Maternal deaths represent 18% of all deaths among women aged 15-49 during the 7-year period preceding the Uganda Demographic and Health Survey (UDHS) 2016. It is therefore recommended that awareness on sexual and reproductive health including menstrual health be urgently scaled up in both school and communities to prevent the likely adverse outcomes such as gender inequality in education<sup>5</sup>, and increased poverty levels.
- An overwhelming majority mothers accessed antenatal care (ANC) and postnatal check during immediately after delivery from a skilled provider including doctors, midwives and nurse. Area of residence, availability of health facilities, the level of education and household wealth influence the number of ANC visits. However, some mothers delivered at home which may increase the risk complications and infections that may lead to death or serious illness for the mother, baby, or both.
- About one in five mothers take 1 year or less to space their children between births while 16 breastfeed their children for less than one year. It is important to sensitize mothers on child spacing through the use of contraceptive methods and Infant and Young Child Feeding Practices especially breast feeding.
- Although more than three quarters reported to have attended Family Planning practices, just more than one half practiced family planning practices. The most preferred Family planning method was injectables, as husbands could not detect this.
- Majority of the pregnant and childbearing mothers had not received any training on making re-usable sanitary pads. Just about three in five respondents were spending between Ughs.6001-12000 while 18 percent spent Ughs. 2000-6000 in 3 months on sanitary pads.

### **Livelihoods and Food Security**

- Majority of the households do save but with a community group/Association. Deliberate efforts should be identify capacity gaps and also strengthen existing community based saving and credit associations.
- Incidences of poverty appear to be very high in the target areas of Buwenge rural and Buwenge Town Council. It is necessary to develop and implement a livelihood strategy.
- Nearly two in five households were having two less meals per day while three in ten experiencing food shortages in the last six months. Food insecurity is attributed to prolonged dry spell (hailstorms), poverty (low incomes) for purchase of enough food and lack of own land for food production, Ill-health, planting sugarcanes instead of food crops, pests and diseases, theft of food in the garden and high food prices.

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<sup>5</sup> low levels of educational attainment among women

## 4.2 Recommendations

- a) There is need to organize health and sanitation campaigns at the community and school levels to ensure that beneficiaries establish new as well as improve existing environmental and sanitation facilities. Men would need to be encouraged to actively participate in the exercise so as to reduce the women workload. However, more focus should be placed on: visitors' bedrooms, granary (food storage facilities), animal shelters, water storage containers and tiptaps. Households could be organized in self-interest basic work groups so that they help each other.
- b) Improve the water storage capacity at the community level through provision of community trainings on rain water harvesting techniques and distribution of large scale water harvesting facilities to specific zones and schools.
- c) The *Ministry of Health* should distribute Insecticide Treated Nets to vulnerable households to as to curb the high incidences of malaria while health centres needs to have regular and adequate supply of drugs for malaria, flue and cough.
- d) Government needs to strengthen the capacity of health centers II-IV to deliver quality of services since they play a critical role and are the preferred facilities to rural communities. In addition, there is need to monitor and regulate<sup>6</sup> effectively drug shops since they are an emerging alternative source of medical services in rural communities.
- e) Build capacity of health centre staff so that they adhere and exercise high level of professionalism while handling pregnant and child bearing mothers at the health facilities
- f) Awareness sessions on sexual and reproductive health including menstrual health and skills in making re-usable sanitary pads be urgently scaled up targeting adolescents at the school and out of school causing gender inequality in education<sup>7</sup> and increased poverty levels.
- g) Pregnant mothers should be encouraged to deliver from health centers or hospitals to prevent maternal and neonatal deaths, ensure treatment of any complications that could arise and access to important information on caring for themselves and the child.
- h) Train child mothers, young women and girls on family planning methods so that they make informed choices, child spacing through the use of contraceptive methods and Infant and Young Child Feeding Practices especially breast feeding.
- i) Deliberate efforts are needed to identify capacity gaps and also strengthen existing community based saving and credit associations to raise the household savings and investment into livelihood activities.
- j) Develop and implement a livelihood strategy. Such a strategy would incorporate coping strategies already identified such as diversification of income generating sources, promotion of drought resistant crops and appropriate irrigation systems. Programmes for households to purchase or hire land for food production and food storage facilities, control of pests and diseases and timely dissemination of weather forecast information is highly needed.

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<sup>6</sup> Do drug shops have qualified medical personnel?

<sup>7</sup> Low levels of educational attainment among women

## 5 APPENDICES

### 5.1 Questionnaire

**NEMACY-UGANDA  
BASELINE SURVEY QUESTIONNAIRE FOR RICHE PROJECT 2019**

IDENTIFICATION	CODE
<b>JSDQ NUMBER OUT OF</b> _____	
Interviewer _____	<input style="width: 50px; height: 20px;" type="text"/>
Interviewer's Organization _____	<input style="width: 50px; height: 20px;" type="text"/>
District _____	<input style="width: 50px; height: 20px;" type="text"/>
Sub county _____	<input style="width: 50px; height: 20px;" type="text"/>
Parish _____	<input style="width: 50px; height: 20px;" type="text"/>
LC I (Village, Zone) _____	<input style="width: 50px; height: 20px;" type="text"/>
Household Number _____	<input style="width: 50px; height: 20px;" type="text"/>
Name of Respondent _____	<input style="width: 50px; height: 20px;" type="text"/>

Date interview carried out: ----- / ----- / ----- Day    Month    Year	<input style="width: 50px; height: 20px;" type="text"/>
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#### INTRODUCTION AND CONSENT

Greeting. My name is \_\_\_\_\_; I have been sent by NEMACY-UGANDA and I work with \_\_\_\_\_ (where you work).

We are conducting a baseline survey about Integrated Response against Poor Health Services(RICHE) project in Buwenge rural and Buwenge TC. We are speaking to people within the households both male and female to get information that will help us know how we are living and the kind of health services received. We would very much appreciate your participation in this survey.

The survey will take only \_\_\_\_minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to any other persons.

At this time, do you want to ask me anything about the survey?

Are you ready to participate in the survey? YES  NO  (If no go to next respondent and mark this visit as a refusal)

Signature of Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

#### I. RESPONDENT BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	Record sex of respondent	Male	1
		Female	2
102	When were you born?	Date /Month /Year 1...../...../.....	
103	How old are you?	Age in completed years..... <input style="width: 40px;" type="text"/>	
104	What is your marital status?	Single	1
		Married	2

		Widowed	3
		Divorced	4
105	What is the highest level of school you attended?	Never attended	1
		Primary	2
		Secondary	3
		Tertiary or Vocational Institution	4

## II. ENVIRONMENTAL SANITATION FACILITIES

NO	FACILITY (Do you have the following?)	AVAILABILITY		QUALITY OF FACILITIES AND MAINTENANCE					
		Yes	No	Bricks, cement and plastered	Bricks cement not plastered	Bricks and mud	Mud and wattle	Iron sheets	Grass thatched
201	Dwelling house								
202	Children's bedroom								
203	Visitors' bedroom								
204	Bath room								
205	Latrine								
206	Kitchen								
207	Granary (food storage)								
208	Animal house								
209	Water storage facility								
210	Rubbish pit								
211	Plate rack								
212	Drying line/wire								

## III. FAMILY HEALTH AND SANITATION

301	Have you ever attended any training about community health and sanitation?	Yes	1
		No	2
		No response	3
302	What is the major source of water used in your home?	Tap	1
		Swamp	2
		Bore hole	3
		River	4
		Lake	5
		Rain water	6
		Spring	7
		Protected well	8
		Unprotected well	9
		B/hole & spring	10
303	How far is the nearest water source from your home?	Less than a km	1
		1 km	2
		2 km	3
		3 km	4
		4 km	5



		No response	6	
304	How do you store your water in the home?	Water tank	1	
		Drum	2	
		Pot	3	
		Jerricans	4	
305	Do you always wash your hands with clean water and soap before preparing/serving/eating meals, feeding children, after disposal of feces including children's and after using the latrine/toilet?	Yes	1	
		No	2	
306	Are you aware of any diseases caused by poor sanitation, drinking/ using dirty water?	Yes	1	
		No	2	
		Non Response	3	
307	If yes, which disease/ diseases?	Diarrhoea	1	
		Cholera	2	
		Typhoid	3	
		Dysentery	4	
		Bilharzia	5	
		Others please mention .....	6	
308	Did any family member fall sick last month?	Yes	1	
		No	2	
		Non Response	3	
309	Who fell sick?	Adult	1	
		Youth	2	
		Child	3	
		Adult & Child	4	
		N/A	5	
310	What disease(s) did they suffer from?	Malaria	1	
		Diarrhoea	2	
		Flue & cough	3	
		Others please mention .....	4	
		N/A	5	
311	Where do you get your medical services?	Drug shop	1	
		Health centre	2	
		Hospital	3	
		Traditional healers	4	
		Health centre & hospital	5	
		Drug shop & Health centre	6	
		N/a	7	

**IV. REPRODUCTIVE HEALTH AND FAMILY PLANNING  
(For Pregnant and Child Bearing Mothers)**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	What problems do you face during pregnancy?	..... ..... ..... .....	
402	Have you ever attended any training in sexual and reproductive health?	Yes	1

		No	2	
403	At what age did you first get pregnant or give birth to your first child?	..... .....		
404	Did you attend antenatal care when pregnant?	Yes No	1 → 2	405
405	How far are the antenatal care services from your home?	Less than 1Km 1 km 2 km 3 km 4 km+	1 2 3 4 5	
406	Do you have your antenatal card?	Card present Lost card Don't have card Card left in the hospital	1 → 2 → 3 → 4 →	407 408 408 408
407	Fill in how many times a mother attended antenatal. Date /Month /Year 1...../...../..... 2...../...../..... 3...../...../.....	How many times attended? ..... .....		
408	Where did you give birth from?	Home Maternity clinic Dispensary Health centre Hospital Traditional Birth Attendant	1 2 3 4 5 6	
409	Who attends to you when giving birth?	..... ..... ..... .....		
410	Do you always go to the hospital/health centre after giving birth?	Yes .....1 No.....2	→	412
411	If No, why?	..... ..... ..... .....		
412	How long do you take to space your children between births?	1 year 2 years 3 years 4 years+ N/a	1 2 3 4 5	
413	How long do you breastfeed your babies?	Less than a year 1 year 1 & Half years 2 years No Response	1 2 3 4 5	
414	Have you ever been taught about	Yes	1	

	family planning?	No	2	
		No response	3	
415	Do you practice any family planning method?	Yes	1	
		No	2	
		No response	3	
416	If yes, which type?	Tubuligation	1	
		Pill plan	2	
		Condoms	3	
		Injectaplan	4	
		Natural methods	5	
		IUD		

**V. LIVELIHOODS AND FOOD SECURITY (HOUSEHOLD INCOMES)**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP
<b>SANITARY PADS</b>						
501	Do girls and women in your home use (washable) sanitary pads?	Yes		1	<del>502</del>	
		No		2	<del>503</del>	
502	If yes, how much does your household spend on purchase of sanitary pads in 3 months?	.....				
503	If No, why?	.....				
504	Have you ever been taught about how to make washable sanitary pads	Yes		1		
		No		2		
<b>INCOME SOURCES AND SAVINGS</b>						
505	What are the major sources of income (IGAs) in your household?	.....				
506	How much do you earn per month from your income sources?	.....				
507	What products (services) and quantity do you produce for sell <i>monthly or seasonally</i> ? How much revenue do you earn from the products per month?	<b>Product</b>	<b>Quantity</b>	<b>Price (UgX)</b>	<b>Revenue (UgX)</b>	
508	Where do you sell your products or services and how far is it from your home?	.....				
509	How do you market your products or services?	.....				

510	What two major challenges have you faced in your business(IGA)?	..... .....	
511	How have you solved the challenges faced in your IGAs?	..... .....	
512	How much do you spend and on what major three items monthly?	<b>Item(s)</b> <b>Amount (Ushs)</b> .....                              ..... .....                              ..... .....                              .....	
	Do you save any money?	Yes.....1	515
		No.....2      →	
513	How do you save money?	Individually	1
		Community group/Association	2
		Others specify.....	3
514	If yes, how much do you save per month/ season?	..... .....	
515	Where do your children go to school?	Primary government	1
		Primary private	2
		Secondary Day	3
		Secondary Boarding	4
		Tertiary or Vocational Institution	5
	<b>FOOD SECURITY</b>		
516	How many nutritious meals do you usually have a day? (meals per household)	..... .....	
517	In the last 6 months, did you have any food shortage?	Yes	1
		No	2
518	If yes, what were the causes of this food shortage in last 6 months?	..... .....	
519	How do you overcome the problem of food shortage?	..... .....	

**THANK YOU**

## 5.2 Interview guides at health centre and local government levels

### 5.2.a Interview guides at health centre and local government levels

#### Access to health services at health centre level

1. Name of health facility:.....  
.....

2. Do you carry out community health outreaches? Yes  No

3. How many patients visited the health facility for health services in the last three years?

Category	2018	2017	2016	Total
Children 0-5 years				
Children (6-12) years				
Teenagers (13-19 years)				
Adult female				
Adult male				
Women attended Antenatal care				
Women delivered at a health facility				
Others				
<b>Total</b>				

4. What is the number of patients and their sex in all ages diagnosed by causes of Morbidity in the past 2 years at the health facility?

	Diagnosis	2018			2017		
		Male	Female	Total	Male	Female	Total
1	Malaria						
2	No Pneumonia - cold or cough						
3	Skin Diseases						
4	Diarrhoea - Acute						
5	Intestinal Worms						
6	Sexually Transmitted Infections (STI)						
7	Pneumonia						
8	Anaemia						
9	Eye Conditions						
10	Gastro-Intestinal Disorders						
11	Others please mention.....						
	<b>Total</b>						

5. What is the number of the key established medical staff at the health facility ?

Number	Medical personnel			
	Doctors	Midwives & Nurses	Clinical Officers	Nursing Assistants

6. What are the major two challenges faced by the health facility?

.....

*5.2b. Budgetary allocation to health and sanitation*

**How much of the annual funds were allocated by government to the health and sanitation sector in the last five years?**

<b>Local Government</b>	<b>2018</b>	<b>2017</b>	<b>2016</b>	<b>2015</b>	<b>2014</b>
Buwenge rural Sub-county					
Annual budget					
Buwenge Town Council					
Annual budget					
Jinja District					
Annual budget					

**THANK YOU**

### 5.3 Distribution of sample size and respondents per Sub County, parish & villages

S/ N	Parish	Village	No. of sampled villages	Total No. of villages	Respo ndents	Sub-county	Total No. of villages	Sampled Villages	Respondents by parish
1	Buwera	Buwera East	7	8	7	Buwenge Rural	47	31	48
		Buwera West			18				
		Buwolero			2				
		Buwolero central			5				
		Buwolero Nankulyaku			5				
		Buwolero-Mawolero			1				
		Yuuka			10				
2	Kagoma	Buwolomela-Kagoma	9	9	18				61
		Kagoma Central			17				
		Kanale			4				
		Mutai Central			1				
		Mutai central			5				
		Mutai-Busibe			7				
		Mutai-Kanale			3				
		Kabaganda			1				
		Namalere Central			5				
3	Kaira	Bubiro	6	12	6				53
		Bulagala			5				
		Butegana West			15				
		Kaira			10				
		Kigaya			5				
		Muwangi Bulagala			12				
4	Kitanaba	Mpungwe	1	5	8				8
5	Magamaga	Butangala A	8	13	4				78
		Butangala C			6				
		Igombe-Bulagala			5				
		Kalebera East			1				
		Igombe Bulagala			1				
		Kyerinda South			21				
		Magamaga East			23				
		Magamaga West			17				
6	Kagaire	Muhofa	2	5	10	Buwenge T/C	18	10	26
		Wamukolo			16				
7	Kalitunsi	Budumbuli	2	4	8				20
		Busiyya zone 1			12				
8	Kamwani	Bwase	4	4	42				81
		Church			18				
		Kabi			13				
		Musigiti			8				
9	Kasalina	Kadiba	2	5	18				38
		Market zone			20				
<b>Total</b>			<b>41</b>	<b>65</b>	<b>413</b>		<b>65</b>	<b>41</b>	<b>413</b>