

TORORO COMMUNITY HEALTH

TORCH

The Maternal and Child Health

Baseline Survey Report

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Executive summary

Background

This maternal and child baseline study was carried out in August-September 1996 in Tororo District

Objectives

Main objective

- to identify and measure indicators of maternal and child health status in Tororo District

Specific objectives

- to determine the age-specific prevalence of acute illness amongst children in Tororo District
- to determine the prevalence of disability in children in Tororo District
- to determine the proportion of children with completed immunisation for age
- to estimate infant mortality; i.e. deaths within one year of age per 1000 live births
- to determine the current access to health care and use by the households
- to determine various maternal health indicators; e.g. antenatal attendance, supervised delivery, and use of contraceptives
- to assess associations between morbidity, mortality and health care services utilisation with socio-economic, demographic, and access factors

Design

A cross-sectional household survey with an analytical component to assess associations between determinants and outcomes.

Setting

Tororo District

Subjects and Methods

Multistage cluster sampling was applied using the sub-county and village and household as cluster strata, i.e., sampling unit. Only households with children under five were included in the sample.

Six hundred and forty-one households from forty villages were visited in August and September 1996. In each household, one woman of childbearing age was interviewed and a reproductive health history obtained. Household characteristics were obtained from the head of the household or someone available and knowledgeable about the household. All children under five had their weight, height and immunisation status taken and recorded. Data was analysed for the whole district and for the different sub-counties.

Results

Key findings

There were 1096 children under five years of age in the households visited. About 27.3% of the children under five were reported ill in the two weeks prior to the survey. Febrile illness contributed 46.3% of the illness episodes among the children in the last two weeks. Acute respiratory infection (ARI) accounted for 34% of the cases while diarrhoeal disease occurred in only 4.6%. Febrile illness was commonly treated in private clinics, drug shops or by self-medication at home. Acute respiratory tract

infections were treated in the health units. There were geographical differences noted in the reporting of the common illnesses. Febrile illness was reported in 39.5% of the households in Buhehe and only 3.1% of the households in Mukuju. Relatively similar proportions of ARI were reported in the five subcounties. Significant socio-demographic factors that seem to play a role in 14 days period prevalence of illness include large household population and collection of water from a protected source. Maternal education and maternal age did not seem to have any significant effect on reported illness.

Although 90 % of the households reportedly had access to immunisation services, only 40.6% of the children were completely immunised for age. There was an immunisation dropout rate of 27.4% for Polio (1 to 3), 22.7% for DPT (1 to 3), and 30.6% for the BCG-Measles vaccination. Factors that were associated with incomplete immunisation were no or little maternal school education and rural residence. The nutritional status of the child and maternal age did not have a significant association with completion of immunisation.

Using the WHO/NHCS anthropometric standards for underweight, stunting and wasting, more than one in five (23.3%) of the children were underweight while 41.4% and 5.2% were stunted and wasted respectively. There were geographical differences in the rate of stunting, underweight and wasting. Wasting was most frequent in Budumba and least in Mukuju. Both stunting and underweight were most frequent in Buhehe and least in the Municipality. Wasting was more prevalent in the boys less than one year of age. Millet growers had the least proportion of underweight children while rural children were twice more at risk of being stunted than their urban counterparts. Maternal age and education did not seem to have a significant role to play in determining the nutritional status of the children.

The maternal health indicators used show that 92.4% of the women attended antenatal clinics in the previous pregnancy; only 7.0% attended in the first trimester, 45.0% had four or more visits and most women started late in the second trimester. Only 25.4% of

the mothers delivered under supervised care at health units while the rest delivered at home. About a third of the mothers (33.5%) had birth intervals that were less than 24 months. About 80% of the women could spontaneously mention a method of contraception, but only 44.5% could actually mention three or more contraceptive methods. The total contraceptive prevalence rate was 12.1 % but the contraceptive prevalence rate for the modern methods was 5.2% while that for the traditional methods was 7.1%.

A simple method of estimating infant mortality was tested giving estimates (83 per 1000 live births) that were close to the national estimates for the region (98.1 per 1000 live births).¹³

Only twelve cases of physical disability, blindness, deafness, and mental disability were identified in the households visited. These were too few for further analysis.

The geographical differences shown in this study suggest that health service delivery should consider geographical differences in planning health interventions. Priority health activities should address this geographical inequity present in Tororo.

The five key indicators that can be used for monitoring the health status and service utilisation for children are: full immunisation for age, nutritional status, age-specific morbidity rates for acute illnesses, use of curative services for childhood illnesses and infant mortality rate. Maternal health indicators are: maternal nutritional status, birth intervals, antenatal attendance, delivery practices and contraceptive use.

In-depth qualitative research in health communication, nutrition, and strategies for women's' empowerment should be considered.