



ASSESSMENT REPORT
PROJECT KNOWLEDGE, PRACTICE, AND
COVERAGE (KPC)

**“Strengthening Community Participation through
Engagement (SCOPE) Project
Implemented under the VOICE Grant**

HANDLE Project Management Unit

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ABBREVIATION AND ACRONYM

CAPI	Computer-Assisted Personal Interviews
Covid-19	Coronavirus Disease 2019
C-SSR	Columbia Suicide Severity Rating Scale
HANDLE	Hope Alert Network for Development and Local Empowerment
IPT-G	Interpersonal Psychotherapy for Groups
KPC	Knowledge, Practice, and Coverage (KPC)
MRS	Mood Rating Scale
NGO	Non-Governmental Organization
PHQ-9	Patient Health Questionnaire-9
PWDs	People Living with Disabilities
SCOPE	Strengthening Community Participation through Engagement
SGBV	Sexual and Gender-Based Violence
VHT	Village Health Team
VSLAs	Village Saving and Loan Associations
WASH	Water, Sanitation, and Hygiene
WRA	Women of Reproductive Age

EXECUTIVE SUMMARY

Background

HANDLE, a respected NGO, secured funding from the VOICE Project to empower marginalized women in Northern Uganda through the strengthening Community Participation through Engagement (SCOPE) project. This project aimed to address the prevalent issues of depression, trauma, and limited community engagement among women of reproductive age. In response to the region's challenges, including high rates of depression exacerbated by gender-based violence and limited mental health services, SCOPE proposed implementing Interpersonal Psychotherapy for Groups (IPT-G) as a psychosocial support strategy. With support from the VOICE Project, SCOPE was launched in Koch Goma and Alero Sub County, Nwoya District, targeting marginalized groups of rightsholders affected by the COVID-19 pandemic. The Knowledge, Practice, and Coverage (KPC) survey, implemented as part of the SCOPE project in Nwoya District, Northern Uganda, aimed to assess changes in knowledge, behaviors, and coverage related to home management, referrals, care-seeking for maternal depression treatment, exclusive breastfeeding, and WASH practices among women of reproductive age (15-49 years) in Alero and Koch Goma sub-counties. Through a multistage sampling approach and intensive training, data was collected from 287 respondents, including right holders and non-right holders. Quality control measures ensured data accuracy and integrity throughout the survey process. Analysis conducted using Microsoft Excel provided insights into key indicators and demographic data points, informing future interventions and program adjustments to better support marginalized communities in the region.

Results

- In terms of **demographic information**, the KPC study examined household characteristics of women aged 15-49 revealing the following. Most are married (72.2%), with more right holders married (74.8%) than non-right holders (69.3%). The majority have primary education (75.0%), with right holders slightly higher (74.8%) than non-right holders (75.2%). 42.4% have young children (0-23 months), more among right holders (46.4%) than non-right holders (38.0%). Most rely on agriculture for income (83.3%), with right holders slightly less (81.5%) than non-right holders (85.4%). Over 92% earn <300,000 UGX monthly. Right holders have larger households (mean: 6.50) than non-right holders (mean: 5.99).

Home management, referral, and care-seeking for depressed mothers: Right holders show higher awareness of depression symptoms and the effectiveness of interpersonal psychotherapy for group than non-rightsholders (2.83 vs. 2.48), emphasizing the impact of depressive treatment on home management. Both groups exhibit moderate knowledge of mental health services (19.9% right holders highly knowledgeable vs. 6.6% non-right holders), with right holders more likely to seek information and engage in open communication (24.5% always seek information vs. 8.0% non-right holders; 26.5% always engage in open communication vs. 13.1% non-right holders). Treatment-seeking behaviors differ, with right holders favoring counseling (72.7%) and non-right holders relying more on medication (39.6%). Support from friends, family, and health professionals is crucial (134 right holders received emotional encouragement vs. 127 non-right holders), with right holders demonstrating higher knowledge and engagement. Village Health Teams (VHTs) are perceived as effective in addressing mental health needs (29.1% right holders highly effective vs. 27.7% non-right holders), indicating their potential role in community-based mental health support. These findings emphasize the importance of targeted interventions to enhance mental health literacy and support systems, particularly among vulnerable populations like women of reproductive age.

Exclusive breastfeeding and child nutrition: The KPC study reveals breastfeeding practices among mothers of children aged 0-23 months, shedding light on initiation timing, pre-lacteal feeding rates, and continued breastfeeding. Within 1 hour of birth, 65.7% of right holders and 59.6% of non-right holders initiate breastfeeding, emphasizing the crucial role of **early breastfeeding** in newborn health. However, concerning **pre-lacteal feeding**, only 11.4% of right holders engage in this practice compared to 13% of non-right holders, highlighting room for improvement. Breast milk remains the primary source of nutrition, with 65.7% of right holders and 75% of non-right holders opting for it. However, a significant proportion also introduce semi-solid foods (34.3% right holders, 40.4% non-right holders) and fruits (27.1% right holders, 32.7% non-right holders) within 24 hours. **Continued breastfeeding** rates stand at 67.1% for right holders and 76.9% for non-participants, reflecting positive health outcomes. Moreover, the majority of mothers **seek medical care** from healthcare professionals for sick children (69.0% right holders, 64.3% non-right holders), indicating a proactive approach to child healthcare. These findings underscore the importance of promoting early breastfeeding, discouraging pre-lacteal feeding, and supporting continued breastfeeding for optimal child health outcomes.

Water, Sanitation, and Hygiene (WASH):

- **Safe drinking water** remains a priority, with 59.3% of households accessing improved sources, while 40.97% rely on non-improved sources. This underlines the ongoing need for universal access to safe drinking water, especially considering the significant disparities between beneficiary and non-beneficiary households (56.95% right holders vs. 62.04% non-right holders using improved sources). In terms of **water collection time**, the majority (90.10%) of individuals, regardless of right holders' status, can access clean water within a 30-minute timeframe, aligning with WHO guidelines. However, a small proportion (11.32% right holders, 8.33% non-right holders) require more than 30 minutes, indicating room for improvement in accessibility. **Gender dynamics** are evident in water fetching responsibilities, with adult women shouldering the primary burden (53.3% participants, 53.6% non-right holders), followed by female children under 15 years old (29.5% right holders, 28.5% non-right holders). Interestingly, adult men play a minimal role (3.8%, right holders 3.3% non-right holders), highlighting gendered patterns in household chores. Regarding **water treatment knowledge**, 77.5% of right holder's households and 73.3% of non-right holder's households adopt recommended water treatment techniques. Boiling water is the most common method (70.6% right holders, 64.4% non-right holders), followed by straining through cloth and the use of water filters. In terms of **water storage**, the majority of households (77.5%, right holders 75.6% non-right holders) safely store drinking water, with ceramic or clay pots being the preferred option, showcasing a blend of traditional and modern practices.
- Moving to **sanitation**, less than 1% of households lack sanitation facilities, highlighting low health risks associated with human waste disposal. However, disparities exist in the use of improved sanitation facilities (69.54% right holders vs. 37.96% non-right holders), with pit latrines being the most common choice. In hygiene practices, 50.99% of beneficiary households have a dedicated handwashing facility, indicating better access compared to right holders (37.96%). Additionally, a high percentage of households (92.9%, right holders 90.4% non-right holders) dispose of child feces safely, emphasizing adherence to hygienic waste disposal practices. Proper household waste disposal practices vary, with a small percentage using bins or buckets (0.66% right holders, 0.73% non-right holders) and the majority opting for dug pits (72.19% right holders, 67.88% non-right holders). Promoting proper waste management strategies is crucial for environmental sustainability and public health.

Recommendation: The implementation team should focus on sustainability measures, gain support from relevant authorities, document lessons learned, collaborate with health officials, replicate successful innovations, translate interventions into policies, and plan further assessments and interventions to address challenges related to depressive symptoms and behavioral changes among women of reproductive age.

BACKGROUND

1.1 Introduction

Hope Alert Network for Development and Local Empowerment (HANDLE) a highly esteemed non-governmental organization (NGO), was awarded a grant from the Voice Project to implement a program empowering and supporting the marginalized groups of women of reproductive ages (15-49 years), enabling them to overcome the effects of trauma, depression, and limited community engagement. As part of the program “Strengthening Community Participation through Engagement (SCOPE), the Knowledge, Practice, and Coverage (KPC) assessment report serves to establish, document, and publish the influence of treatment of maternal depression on the adoption of behaviors and practices related to home management, referrals, and care-seeking for sick children, exclusive breastfeeding and WASH among women of reproductive ages (15-49 years old). Specifically focused on key outcome indicators related to knowledge, practices, and coverage measures of well-being among Women of reproductive ages (WRA) 18-49 years. This report details the methodology and results of the cluster sample KPC survey implemented in the two sub-counties of Alero and Koch Goma, geographically located in Nwoya District, Northern Uganda

1.2 Brief Context

In Northern Uganda, vulnerable groups of rightsholders like women, children, youth, and persons with disabilities face heightened risks of exploitation, abuse, and depression. Approximately three in ten women in the region experience depression, compounded by limited community involvement that exacerbates their vulnerability. The baseline report of HANDLE published and Monitor asserts that the high prevalence of depression among women in Nwoya, Uganda, has been attributed to rampant gender-based violence and the lack of psychiatric services in public health facilities¹². Due to the scarcity of psychiatrists, locals are resorting to seeking mental health support from traditional herbalists and witch doctors. Depression not only impairs functionality but also isolates individuals from meaningful activities, with untreated cases leading to severe mental health issues and potential self-harm. Maternal depression, particularly impactful on women, carries economic and human costs, often resulting in disability. Further, rural communities lack awareness about depression, its causes, and its effects, hindering active participation in community activities and decision-making processes.

In response to this, the SCOPE project proposed by HANDLE sought to address the vulnerabilities experienced by women and people living with disabilities (PWDs) in Nwoya District as a result of the COVID-19 pandemic. The effects of the pandemic, such as trauma and mental illness, have had a significant impact on these communities, hindering their meaningful and active participation in decision-making and community engagement activities. To mitigate these challenges, SCOPE proposed to utilize Interpersonal Psychotherapy for Groups (IPT-G) as a psychosocial support strategy. By implementing the IPT-G approach and integrating economic activities, SCOPE strives to empower and support these marginalized groups of rightsholders, enabling them to overcome the effects of trauma, depression, and limited community

¹ HANDLE Baseline report (Sep 2023) for the SCOPE project published in the Ugandan Media and the organization website <https://handle-uganda.org/>

² <https://www.monitor.co.ug/uganda/news/national/why-depression-is-high-among-women-in-nwoya-4377404>

engagement. With funding from the VOICE Project, the 15-month SCOPE project was therefore launched and implemented by HANDLE in Koch Goma and Alero Sub County, Nwoya District.

The principal intervention strategy was the implementation of the Interpersonal Psychotherapy for Groups (IPT-G) methodology, as a low-cost, tested, and effective approach to uplifting mental health disorders and trauma. This involved screening vulnerable individuals targeting women between the age of 15 – 49 years in Alero and Koch Goma sub-counties for depression and trauma using standardized tools like PHQ-9, C-SSR, and MRS. Those with low to moderate depression were grouped into 8-12 member groups, led by trained facilitators like village health team (VHT) members, for weekly or bi-weekly meetings over 12-15 weeks. Participants were engaged and supported through open discussion of their depression causes and coping mechanisms, engaging collaboratively to find solutions. Confidentiality was emphasized and maintained throughout the sessions by the project team in each IPT group per location.

The project objective: By 2024 in Koch Goma and Alero Sub-County, the project specifically aims to; i) eliminate depressive symptoms in 400 Women of Reproductive Ages (WRA); ii) contribute to improved adoption of maternal behaviors related to water sanitation and hygiene practices; iii) contribute to improved adoption of maternal behaviors related to home management referrals care seeking for sick children; and iv) contribute to reduction of domestic sexual related gender-based violence in targeted households.

1.3 Objective of the KPC Assessment

The assessment mainly aimed to assess the influence of treatment of maternal depression on the adoption of behaviors related to home management, referral, and care-seeking for depressed mothers, Exclusive breastfeeding and child nutrition, and WASH practices among women of reproductive ages (15-49 years).

PROCESS AND PARTNERSHIP BUILDING

2.1 Survey Process and Partnership Building

During the implementation of the Knowledge, Practice, and Coverage (KPC) survey in the rural community of Alero and Koch Goma, Nwoya District, a strategic focus on process and partnership building was instrumental in ensuring the survey's effectiveness and relevance within the local context. Our approach prioritized establishing collaborative relationships with the SCOPE project key stakeholders, including community leaders, health workers including village health service teams (VHTs), to facilitate data collection and promote community engagement throughout the survey process.

Before commencing the survey, extensive consultations were conducted with community members and local entities to gain insights into community dynamics, needs, and cultural nuances. This collaborative groundwork not only informed the survey design but also cultivated trust and understanding within the community, setting a strong foundation for successful data collection and interpretation.

Partnerships with the local health center (HC IIIIs) and Village Health Teams (VHTs) community health workers played a pivotal role in mobilizing resources, identifying survey participants, and ensuring alignment with existing health initiatives and community priorities. Leveraging their expertise and networks enabled us to reach a wider audience, enhance data quality, and instill a sense of community ownership over the survey process and outcomes.

Through tailored training sessions, engaged six (6) local enumerators and two (2) supervisors equipped with the necessary skills and knowledge to conduct the survey ethically, accurately, and respectfully. This investment in local capacity not only elevated the quality of data collected but also empowered community members to actively engage in the survey, deepening their understanding of health practices and behaviors.

Sustaining open communication channels and feedback loops with the team and stakeholders facilitated ongoing dialogue, feedback exchange, and mutual learning throughout the survey implementation. Regular updates, debriefing sessions, and collaborative problem-solving ensured that challenges were addressed promptly, and insights were shared transparently, fostering a culture of shared responsibility and accountability.

METHODOLOGY

3.1 Survey Design and Strategy

Knowledge, Practice, and Coverage (KPC) Survey was designed and implemented to establish coverage of the project indicators to measure change over time in levels of knowledge, key behaviors, and coverage of project activities. This targeted women of reproductive age as the key rightsholder affected by depression in the project context. The pre-implementation phase of the KPC survey involved consultations with external evaluators and both the project staff in which the sampling strategy and the actual sample were developed and all data needs were assessed. The questionnaire was reviewed and finalized and the logistics, strategy, and training of supervisors and interviewers were planned. The field implementation phase involved the recruitment, selection, and training of the data collectors and the actual collection of data in all selected communities of two project implementation zones/sub-counties of Alero and Koch Goma taking into account the geographical and access difficulties to reach all communities and households. The post-implementation phase involved tabulating and analyzing the data and manual data aggregation and disaggregation using MS Excel.

3.2 Sampling Design

The survey employed a multistage sampling approach, utilizing a two-stage cluster sampling technique combined with simple random sampling. Clusters were defined based on membership status in Interpersonal Psychotherapy for Groups (IPT-G), distinguishing between IPT-G members and non-members. The member and non-membership were based on the targeted rightsholder's exposure and participation in the established IPT-Gs under the SCOPE intervention in Alero and Koch Goma. Participants within each cluster were then randomly selected for inclusion in the survey. A total of 287 respondents (rightsholders) were interviewed during the study, comprising 151 participants (rightsholders exposed to IPT-G) and 137 non-participants (rightsholder not engaged in the IPT-Gs). Specifically, a minimum of 15 members were interviewed from each of the randomly sampled 10 IPT-G groups, while 137 respondents were interviewed from non-group members within the project's geographical boundaries. The criteria for inclusion and exclusion were as follows: (i) a population particularly aged 18-45 years old; (ii) selection of sub-counties where partners were implementing SCOPE initiatives; and (iii) inclusion of sub-counties within communities affected by the Covid-19 pandemic. It's important to note a discrepancy in the number of non-participants, likely due to challenges in accessing certain areas. Poor road conditions and scattered households posed logistical hurdles, making it difficult to achieve a truly random sample.

3.3 Questionnaire

The study adopted and modified the standard KPC survey modules questionnaire and the baseline questionnaire to capture the required data for measuring the indicators of interest. Specifically, modifications were made to the WASH (module 1A) and Breastfeeding and Infant/Child Nutrition (module 2) sections outlined in the KPC2000+ Field Guide. The questionnaire comprised five sections covering demographic and general information, Home Management, Referral, and Care-Seeking for Depressed Mothers, Exclusive breastfeeding and child nutrition, and WASH. During training, the questionnaire was tested by the survey supervisors and enumerators, and minor adjustments were made to adjust the questionnaire to the local context and to check local comprehension.

3.4 Selection and Training of Supervisor, Interviews

The study employed the services of six (6) enumerators to collect the primary data. All six enumerators had experience in conducting surveys including the knowledge of the language used in the target population. One field supervisor with a strong background in monitoring and evaluation (M&E) was also engaged throughout the survey phases to identify and correct any errors and to reinforce ethical interview practices. One-off intensive training was conducted with participation from both the field enumerators and the project team, with emphasis on the contents of the survey questionnaire and techniques to be adopted for the survey. During the training, practice interviews were conducted first between enumerators, and subsequently with a sample of respondents in the neighboring project location under the close supervision of the lead M&E specialist.

3.5 Survey Process and Quality Control

The primary data was collected through a research-administered approach using Kobo Collect after being trained on the questioning approach ensuring the privacy and confidentiality of the respondents. Quality control measures were rigorously implemented throughout the survey to uphold data accuracy and reliability. Training sessions equipped interviewers with the necessary skills, while supervisors provided ongoing support and oversight. Standardized data collection procedures and quality-control checklists ensured consistency and completeness of data. Computer-Assisted Personal Interviews (CAPI) methods enable efficient data collection through the use of phones. The study used Structured Questionnaires where standardized scales and validated questions were administered through face-to-face interviews with the sampled women to assess the KPC aspects of home management, referral, and care-seeking for depressed mothers, Exclusive breastfeeding and child nutrition, and WASH among WRAs. The supervisor conducted regular team checks to assess data collection practices, with prompt resolution of any issues. During the field engagement, errors were carefully

3.6 Data Analysis

All interview data were coded, cleaned, and analyzed using the Microsoft Excel tool. Double-entry verification and data cleaning processes were employed as part of the analysis phase to minimize errors. Subsequent quality assurance checks at various stages helped maintain data integrity and upheld the survey's high standards of quality. Microsoft Excel was used to obtain lists, frequencies, and tables that included calculated percentages, means, and ranges for all KPC indicators and demographic data points for each result.

KEY RESULTS AND DISCUSSION

4.1 Demographic Characteristics

The Knowledge, Practice, and Coverage (KPC) study which included 151 right holders (participants) and 137 non-right holders (non-participants) provides a distinct and detailed insight into the household characteristics of targeted women of reproductive age during the assessment period (see table in **Appendix II**). It reveals that overall, the majority of the women are married (72.2%), with more participants being married (74.8%) compared to non-participants (69.3%). The **age distribution** of the women is relatively evenly spread across the different age categories, with the largest proportion of women falling in the 25-34 years old category (43.1%).

In terms of **education attainment**, the majority of the women have primary education (75.0%), with a slightly higher percentage of participants (74.8%) having primary education compared to non-participants (75.2%). The table also shows that 42.4% of the women have young **children aged 0-23 months** living in their households, with participants being more likely to have young children (46.4%) compared to non-participants (38.0%).

When it comes to the main **income source** of the women, the majority rely on agriculture (83.3%), with participants relying more on agriculture (81.5%) compared to non-participants (85.4%). The table also showed that the majority of the women have low monthly incomes, with over 92% of both participants and non-participants earning below 300,000 UGX per month.

The targeted participants have a mean **household size** of 6.50 (SD = 2.61, range: 2-15), while non-participants have a mean household size of 5.99 (SD = 2.50, range: 1-13). This finding is consistent with other studies that show depression is associated with household size, among other risk factors, in the adult population in Uganda³.

4.2 Home management, referral, and care-seeking for depressed mothers

Household Knowledge about depressive symptoms

To assess the household knowledge of depression, the participants were asked how they would rate their knowledge about the symptoms of depression on a 5-pointer scale of 1 (Very low knowledge) to 5 (Very High knowledge). The survey findings on the knowledge about the symptoms of depression among women of reproductive age showed that one average (mean), both participants and non-participants had moderate levels of awareness, with participants rating their knowledge at 2.83 and non-participants at 2.48, both with a standard deviation of 0.92. This indicates a need for targeted interventions to improve mental health literacy in this demographic group, particularly regarding depression symptoms. The survey results highlight the significant influence of the intervention that could be adopted by similar programs on incorporating community-based education and awareness sessions aimed at enhancing knowledge about mental health

³ Kiconco Allen, Waswa Bright Laban, Ssemakula Edward et al. *Prevalence, Risk Factors and Prevention of Depression in the Adult Population in Mbarara District, Uganda, 28 February 2022, PREPRINT (Version 2) available at Research Square [https://doi.org/10.21203/rs.3.rs-1107439/v2]*

issues in women of reproductive age, thereby addressing specific gaps and promoting overall mental health literacy.

Table 1: Household knowledge about the symptoms of depression

Question	Respondent Category	Mean	Std. Dev	Min	Max
On a scale of 1 to 5, how would you rate your knowledge about the symptoms of depression?	Beneficiary	2.83	0.92	1	5
	Non-Beneficiary	2.48	0.92	1	5

Household effectiveness in establishing daily home routines:

The findings in **Table 2 (question 1)** below indicate the effectiveness of establishing routines for daily tasks, meals, and self-care in managing symptoms of depression. The results show that on average (mean), participants, or individuals receiving treatment for depression, rate the effectiveness of routines at 4.2 out of 5, while non-participants rate it at 2.75 out of 5. This suggests that participants find routines more effective in managing depression symptoms compared to non-participants. This finding supports the benefits of establishing daily routines for managing depression. A similar finding on depression among patients with severe mental illnesses found that the mean score for the effectiveness of routines in managing depression was 3.7 out of 5⁴. This implies that the effective establishment of routines can be a helpful strategy in managing depression symptoms for women of reproductive age. Accordingly (**Table 2 second question**), a significant influence was revealed with a mean (average) rating of 8.14 out of 10, with a standard deviation of 1.32, for the extent to which depression treatment positively influences home management, referral, and care-seeking practices among individuals indicates a strong positive impact of treatment on these aspects. This suggests that individuals perceive their depression treatment as significantly beneficial in improving their ability to manage daily tasks, seek appropriate care, and maintain their home environment effectively.

Table 2: Effectiveness in establishing routines in managing depressive symptoms

Question 1	Respondent Category	Mean	Std. Dev	Min	Max
On a scale of 1 to 5, How effective do you find establishing routines for daily tasks, meals, and self-care in managing symptoms of depression?	Beneficiary	4.2	0.88	1	5
	Non-Beneficiary	2.75	0.87	1	5
Question 2	Mean (N=151)	Std. Dev	Min	Max	
On a scale of 1 to 10, please rate the extent to which your depression treatment has positively influenced your home management, referral, and care-seeking practices.	8.14	1.32	2	10	

Household information seeking and support (engagement) for depression management

Assessing household engagement in information-seeking and open communication on depressive symptoms and respective management strategies is crucial for improving mental health literacy and addressing specific gaps in knowledge⁵. According to this study, there were varying frequencies of

⁴ Kaggwa MM, Najjuka SM, Bongomin F, Mamun MA, Griffiths MD (2022) Prevalence of depression in Uganda: A systematic review and meta-analysis. *PLoS ONE* 17(10): e0276552. <https://doi.org/10.1371/journal.pone.0276552>

⁵ Lloyd A, Broadbent A, Brooks E, et al. The impact of family interventions on communication in the context of anxiety and depression in those aged 14–24 years: systematic review of randomized control trials. *BJPsych Open*. 2023;9(5):e161. doi:10.1192/bjo.2023.545

information seeking about depression and engagement in open communication within households regarding emotional well-being and mental health among participants and non-participants. Participants, individuals likely receiving treatment for depression, exhibit higher rates of actively seeking information about depression and engaging in open discussions within their households compared to non-participants.

During the assessment, respondents (participants and non-participants) were asked; *How often do you actively seek information about depression and available treatment options when experiencing symptoms? and how often do you engage in open communication within your household regarding emotional well-being and mental health?* Specifically (**See Table 3**), 24.5% of participants always seek information about depression, while only 8.0% of non-participants do so. Similarly, in terms of household open engagement, 26.5% of participants always engage in open communication compared to 13.1% of non-participants.

Table 3: Household information seeking and open engagement regarding depression management

Frequency	Information seeking			Household open engagement		
	Beneficiary (N=151)	Non-Beneficiary (N=137)	Overall	Beneficiary (N=151)	Non-Beneficiary (N=137)	Overall
Always	24.5%	8.0%	16.7%	26.5%	13.1%	20.1%
Never	13.2%	40.9%	26.4%	10.6%	32.1%	20.8%
Rarely	60.9%	50.4%	55.9%	61.6%	54.7%	58.3%
Sometimes	1.3%	0.7%	1.0%	1.3%	0.0%	0.7%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

These findings agree with the assertion of a similar study by [Huang, Xc., Zhang, Yn., & Wu, Xy. et al. \(2023\)](#) in China on the importance of information-seeking and open family communication on depression⁶. Nevertheless, over 60% reported rarely seeking information compared to non-participants implying a high level of access to information through the SCOPE intervention and respective referral centers within and around the program's geographical area. In terms of open engagement, the majority of the participants also revealed that they rarely engage in open discussions on emotional well-being and mental health. This signifies a reduced level of depression in the intervention zones where the SCOPE program was rolled out. In the instance where mental health resources are limited, these findings underscore the impact of the SCOPE program and the importance of proactive information-seeking and open communication within households to address the prevalence of depression and promote mental health awareness. This further highlights the critical need for accurate information sources and support systems for individuals experiencing depression and anxiety, emphasizing the role of education and communication in enhancing mental health literacy. By encouraging information-seeking behaviors and fostering open dialogues about mental health within households, we can empower individuals especially women to better understand and manage depression, ultimately improving mental health outcomes across diverse populations.

Ways in which support is provided to family members experiencing depression

Household engagement in providing support for individuals experiencing depressive symptoms and their respective management strategies is crucial for promoting mental health and well-being. Emotional encouragement, assistance with daily tasks, accompanying individuals to therapy sessions, and listening

⁶ Huang, Xc., Zhang, Yn., Wu, Xy. et al. A cross-sectional study: family communication, anxiety, and depression in adolescents: the mediating role of family violence and problematic internet use. *BMC Public Health* 23, 1747 (2023). <https://doi.org/10.1186/s12889-023-16637-0>

without judgment are key forms of support identified in the context of depression management⁷. The study results in **Figure 1** below revealed that participants offer various forms of support to family members experiencing depression. The most common way of support is emotional encouragement, with the majority of 134 (out of 151) participants compared to 127 (out of 131) non-participants reporting this form of assistance. Other forms of support include assistance with daily tasks (78 vs 76), listening without judgment, and accompaniment to therapy sessions (10 vs 4) respectively. These findings align with the recommendations from mental health organizations, which suggest that providing emotional support, encouraging treatment, and assisting with daily tasks can be beneficial for individuals experiencing depression⁸⁹. Noteworthy, support from friends and family to a greater extent plays a crucial role in the recovery process for individuals with depression¹⁰

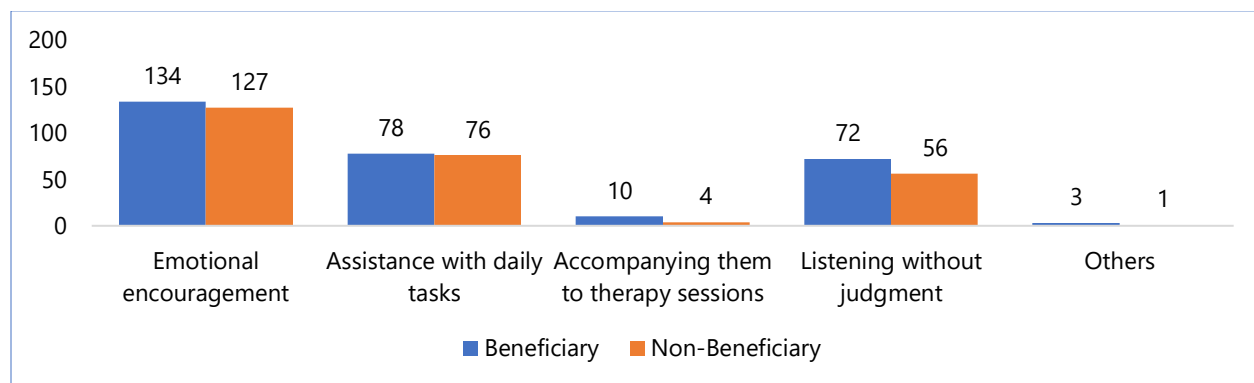


Figure 1: Ways in which support is provided to family members experiencing depression

Knowledge level of mental health support and referral services for depression

The study targeted assessing the knowledge level of participants and non-participants regarding mental health support and referral services for depression in the SCOPE intervention zones of Nwoya. The results in **Table 4** below indicate that more participants (19.9%) compared to non-participants (6.6%) are highly knowledgeable about these services, while the majority (67.5%) of participants and 51.8% of non-participants are moderately knowledgeable. With the majority reporting a moderate knowledge level, this indicates more room for improvement in enhancing the understanding of the available avenues and sources of these services among the target communities. Interestingly, 12.6% of participants and 41.6% of non-participants are not knowledgeable about mental health support and referral services for depression, further presenting the awareness gap and the need for the necessary initiatives to address this. Overall, the disparity highlights the potential impact of the SCOPE intervention in equipping participants with a comprehensive understanding and awareness of available mental health support resources.

Table 4: Knowledge level on mental health support and referral services for depression

Level of knowledge	Beneficiary (N=151)	Non-Beneficiary (N=137)	Grand Total
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⁷ Ko JY, Farr SL, Dietz PM, Robbins CL. Depression and treatment among U.S. pregnant and nonpregnant women of reproductive age, 2005-2009. *J Womens Health (Larchmt)*. 2012 Aug;21(8):830-6. doi: 10.1089/jwh.2011.3466. Epub 2012 Jun 12. PMID: 22691031; PMCID: PMC4416220.

⁸ <https://www.mind.org.uk/information-support/types-of-mental-health-problems/depression/for-friends-and-family/>

⁹ Mayo Clinic Health System: Friday, December 16, 2022; Supporting a loved one experiencing depression.

<https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/how-to-support-a-loved-one-with-depression>

¹⁰ Melinda Smith, M.A., Lawrence Robinson and Jeanne Segal (2024): Helping Someone with Depression

Highly knowledgeable	19.9%	6.6%	13.5%
Moderately knowledgeable	67.5%	51.8%	60.1%
Not knowledgeable	12.6%	41.6%	26.4%
Grand Total	100.0%	100.0%	100.0%

Treatment seeking behaviors

The treatment-seeking behaviors coverage was determined by the percentage of depressed mothers/women who have sought referrals from mental health organizations or support groups for depression-related help, along with the types of treatment received. Based on the study, about 65.5% of the women (participants) sought referrals compared to non-participants (35%). This indicates the knowledge gap among the non-participants of the SCOPE intervention. Further, **Table 5** offers insights into the treatment-seeking behaviors of participants and non-participants regarding depression-related help from mental health organizations or support groups. Among participants, 4.0% opted for combined therapy or treatment, indicating a preference for comprehensive approaches. The majority, 72.7%, chose counseling, highlighting the value placed on therapeutic interventions like individual counseling and group therapy (Interpersonal Psychotherapy for Groups). Additionally, 21.2% of participants received medication, such as antidepressants or mood stabilizers, suggesting a significant reliance on pharmacological treatments. A smaller percentage, 2.0%, underwent therapy like cognitive-behavioral therapy or interpersonal therapy, indicating a preference for specific therapeutic modalities like IPT-G.

In contrast, non-participants showed different patterns in treatment choices. While none opted for combined therapy or treatment, 60.4% sought counseling, indicating a similar inclination towards therapeutic interventions as participants. Interestingly, a higher percentage of non-participants, 39.6%, received medication compared to participants, suggesting a greater reliance on pharmacological interventions among this group. Notably, no non-participants reported undergoing therapy.

Table 5: Type of treatment received by depressed women in referrals

Treatment received	Beneficiary (N=99)	Non-Beneficiary (N=48)	Grand Total
Combined therapy or treatment (all the above mentioned)	4.0%	0.0%	2.7%
Counseling (e.g., individual counseling, group therapy)	72.7%	60.4%	68.7%
Medication (e.g., antidepressants, mood stabilizers)	21.2%	39.6%	27.2%
Therapy (e.g., cognitive-behavioral therapy, interpersonal therapy)	2.0%	0.0%	1.4%
Grand Total	100.0%	100.0%	100.0%

Source of support services for depression

The table illustrates where individuals seeking support for depression-related issues have accessed help with the majority of the women under the intervention highlighting high capabilities in terms of access to services. This underscores SCOPE's commitment and performance associated with enhancing knowledge, information, and treatment-seeking among women of reproductive ages as well as the target communities (**see respective Table above**). Among participants, 32 individuals sought assistance from trained mental health professionals at health facilities, 34 received support from VHTs, 58 received help from NGOs involved in psychosocial/mental health support services, and 62 received support from friends and relatives,

including members of social groups. In comparison, non-participants had 15 individuals seeking help from trained mental health professionals, 10 from VHTs, 25 from NGOs, and 36 from friends and relatives. The results indicate a higher score for participants than non-participants signifying the significant impact of the SCOPE initiative in Nwoya, specifically in Alero and Koch. Further, these findings highlight the diverse sources individuals turn to for support when dealing with depression. It showcases the importance of a multi-faceted approach to mental health support, involving both formal channels like health facilities and NGOs, as well as informal networks such as friends and family.

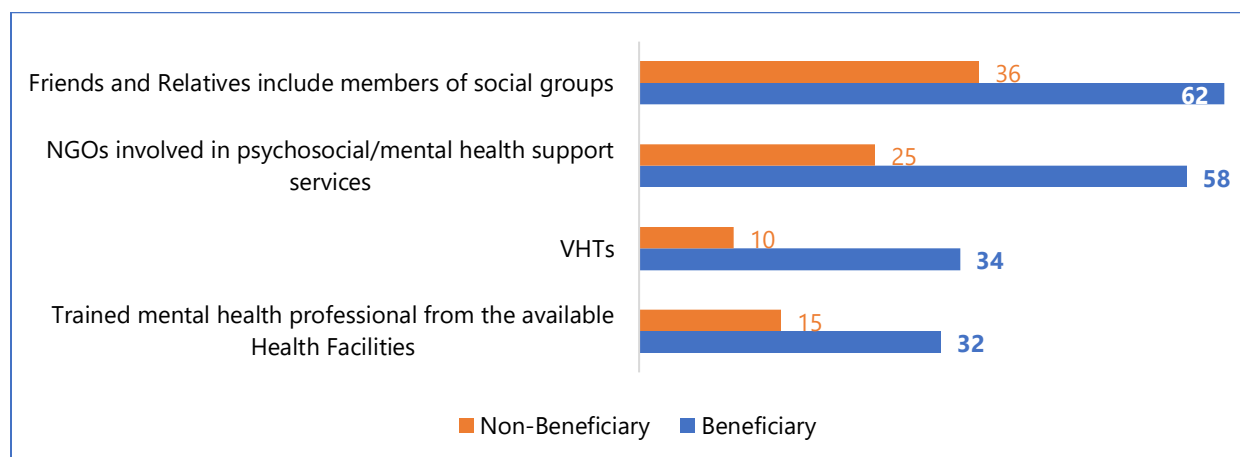


Figure 2: Source of support services for depression

Levels of comfort among women of reproductive ages regarding discussion of their mental health concerns with healthcare providers

The SCOPE realized the importance of creating supportive and accessible environments for the discussions of depressive concerns among vulnerable women of reproductive ages within healthcare settings. The study assessed this coverage based on the responses to the question "How comfortable are you discussing your mental health concerns with healthcare providers?" The results in **Table 6** below present the various levels of comfort among participants and non-participants. The majority of participants (47.0%) reported feeling somewhat comfortable discussing their mental health concerns with healthcare providers, while 29.8% reported feeling very comfortable.

Table 6: Comfort levels regarding discussion of mental health concerns with healthcare providers

Question	Responses	Non-Beneficiary		Grand Total
		Beneficiary (N=151)	Beneficiary (N=137)	
How comfortable are you discussing your mental health concerns with healthcare providers?	Neutral	9.3%	19.0%	13.9%
	Somewhat comfortable	47.0%	48.9%	47.9%
	Somewhat uncomfortable	9.9%	8.0%	9.0%
	Very comfortable	29.8%	16.8%	23.6%
	Very uncomfortable	4.0%	7.3%	5.6%
Grand Total		100.0%	100.0%	100.0%

On the other hand, 48.9% of non-participants reported feeling somewhat comfortable, and 16.8% reported feeling very comfortable. A small percentage of both participants (9.3%) and non-participants (19.0%) reported feeling neutral about discussing their mental health concerns with healthcare providers. Some individuals from both groups reported feeling somewhat uncomfortable (9.9% of participants and 8.0% of

non-participants), while a smaller percentage reported feeling very uncomfortable (4.0% of participants and 7.3% of non-participants). These findings signify the significant stride of the SCOPE as it prioritized enhancing both the knowledge and confidence of the participants in seeking and engaging the service providers in depression management. Further, this level of confidence and comfort revealed how the project ensured that individuals feel supported and comfortable when seeking help for their mental health concerns.

Perceptions regarding the effectiveness of specialized mental health services for WRA

The perception of the effectiveness of specialized mental health services for women of reproductive ages (15-49 years) varies among the different populations everywhere in the country including those in Nwoya. This is not limited to individuals as participants and non-participants of the SCOPE program influenced by the scarcity of mental health professionals¹¹ including sociocultural differences¹². According to the assessment results in **Table 7**, the majority (31.1%) of participants compared to 27.7% of non-participants perceive these services as highly effective, while 62.3% of participants and 67.2% of non-participants find them moderately effective. A small percentage, 6.6% of participants and 5.1% of non-participants do not consider these services effective. These insights underline the complex landscape of mental health care within the SCOPE intervention zone, especially Alero and Koch, and the importance of continuous efforts to enhance specialized services for vulnerable populations like women of reproductive age (WRA).

Table 7: Perceptions regarding the effectiveness of specialized mental health services for WRA

Question	Responses	Beneficiary (N=151)	Non-Beneficiary (N=137)	Grand Total
How effective do you perceive the specialized mental health services for women of reproductive ages (15-49 years) in addressing their mental health	Highly Effective	31.1%	27.7%	29.5%
	Moderately Effective	62.3%	67.2%	64.6%
	Not Effective	6.6%	5.1%	5.9%
	Grand Total	100.0%	100.0%	100.0%

Effectiveness of Village Health Teams (VHTs) in addressing the mental health needs and concerns of women of reproductive ages (15-49 years)

The SCOPE program prioritized the involvement of Village Health Teams (VHTs) as a strategy for improving access, promoting respect for human rights, affordability, and cost-effectiveness, and generating good health outcomes among women of reproductive ages in Koch and Alero. This resonated with the recommendation of the World Health Organization (WHO) toward the integration of mental health into primary healthcare services¹³. In this intervention, the VHTs were named IPT-G Promoters who played an active role in the identification, enrollment, and support including referrals of the depressed women to the respective service health centers or points.

Results in **Table 8** indicate how effective the Village Health Teams (VHTs) were in addressing the mental health needs and concerns of women of reproductive ages (15-49 years) within the SCOPE intervention zones. Respectively, the majority of the participants report a higher percentage for high effectiveness

¹¹ Kagawa, Mark & Harms, Sheila & Mamun, Mohammed. (2022). *Mental health care in Uganda*. *The Lancet Psychiatry*. 9. 766-767. [10.1016/S2215-0366\(22\)00305-4](https://doi.org/10.1016/S2215-0366(22)00305-4).

¹² Ronald Asiimwe, Racheal D. Nuwagaba-K, Lekie Dwanyen, Rosco Kasujja, *Sociocultural considerations of mental health care and help-seeking in Uganda*, *SSM - Mental Health*, Volume 4, 2023, 100232, ISSN 2666-5603, <https://doi.org/10.1016/j.ssmmh.2023.100232>.

¹³ Nakku, J.E.M., Rathod, S.D., Garman, E.C. et al. *Evaluation of the impacts of a district-level mental health care plan on contact coverage, detection and individual outcomes in rural Uganda: a mixed methods approach*. *Int J Ment Health Syst* 13, 63 (2019). <https://doi.org/10.1186/s13033-019-0319-2>

contrariety to moderate than the non-participants. Specifically, among participants, 29.1% perceive VHTs as highly effective, 64.9% find them moderately effective, and 6.0% consider them not effective. Among non-participants, 27.7% consider VHTs highly effective, 70.1% find them moderately effective, and 2.2% see them as not effective. These findings suggest that VHTs are generally seen as effective in supporting the mental health needs of women of reproductive ages in the target areas of Koch and Alero in Nwoya, with a majority of both participants and non-participants acknowledging their effectiveness. This positive perception highlights the potential role of VHTs in addressing mental health concerns within communities and their potential to contribute to the improvement of mental health services in the region.

Table 8: Effectiveness of VHTs in addressing the mental health needs and concerns of WRAs

Question	Responses	Beneficiary	Non-Beneficiary	Grand
		(N= 151)	(N= 137)	Total
How effective are VHTs in supporting the mental health needs and concerns of women of reproductive ages (15-49 years) in your community?	Highly Effective	29.1%	27.7%	28.5%
	Moderately Effective	64.9%	70.1%	67.4%
	Not Effective	6.0%	2.2%	4.2%
	Grand Total	100.0%	100.0%	100.0%

4.3 Exclusive breastfeeding and child nutrition

Percent of children aged 0-23 months put to the breast within 1 hour of birth:

The study assessed breastfeeding practices based on the percentage of mothers of children aged 0-23 months who were put to the breast within 1 hour, 24 hours, and 2-3 days of birth. The table suggests that most children were breastfed within 1 hour of birth, with a higher percentage among the participants (65.7%) compared to non-participants (59.6%). However, a significant number of children were not breastfed within 3 days, particularly among non-participants. Specifically, among participants, 65.7% were put to the breast within 1 hour of birth, 30.0% within 24 hours, and 4.3% were not breastfed within 3 days. For non-participants, 59.6% were put to the breast within 1 hour of birth, 30.8% within 24 hours, and 9.6% were not breastfed within 2-3 days. These findings highlight the importance of promoting and supporting breastfeeding in the early stages of a child's life, as it provides essential nutrients and immunities for the baby's growth and development. According to the World Health Organization (WHO), this finding is significant because early breastfeeding initiation is a key factor in reducing newborn mortality. WHO recommends that children should be breastfed within the first hour of life, as this can avert 22% of newborn deaths¹⁴.

Table 9: Breastfeed babies within 24 hours of birth

Breastfed babies within 24 hours of birth	Beneficiary (N=70)	Non-Beneficiary (N=52)	Grand Total
< 1 Hour	65.7%	59.6%	63.1%
< 24 Hours	30.0%	30.8%	30.4%
2-3 Days	4.3%	9.6%	6.6%
Grand Total	100.0%	100.0%	100.0%

¹⁴ World Health Organization; Dec 2023: Infant and young child feeding: <https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding#:~:text=WHO%20and%20UNICEF%20recommend%3A,years%20of%20age%20or%20beyond>.

Accordingly, awareness of the timing of antenatal care visits and the place of birth, such as district hospitals or health centers, could have influenced breastfeeding practices among the respondents in the study. Significantly, the program integrated their awareness with the VHTs factors like maternal education, socioeconomic status, and access to healthcare services can also impact the likelihood of early breastfeeding initiation. Based on these findings, improving the support and resources for breastfeeding mothers, as well as promoting awareness about the importance of early breastfeeding, can help increase the percentage of children being breastfed within the first hour of life.

Pre-lacteal feeding

Percent (11.4%) of mothers with children aged 0-23 months who received a pre-lacteal feeding: Pre-lacteal feeding involves giving foods or liquids other than breast milk to newborns before initiating breastfeeding. To assess these practices, the targeted mothers of children aged 0-23 months asked if, during the first three days after delivery, their children were given anything to drink other than breast milk. This was further compared among the 70 benefiting and 52 non-benefiting mothers who reported having children aged 0-23 months living in their households. Results in **Figure 4** below revealed that only a few or a limited percent (11.4%) of the mothers under the SCOPE program (participants) gave their newborn babies pre-lacteal feeding. This was contrary to non-participants with over 13% practicing pre-lacteal feeding in the first three days of birth. Further, in contrast, among participants, 88.6% did not give pro-lacteal feeds, and 11.4% did during the same period, resulting in an overall total of 87.7% who didn't pro-lacteal feeding compared to 12.3%. In line with such infant care practices, WHO and UNICEF recommend exclusive breastfeeding for the first six months, followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond. However, it is also important to note that some mothers may not be able to breastfeed due to various reasons, such as health issues or personal preferences. In such cases, alternative feeding methods, such as formula feeding, should be provided to ensure the child's nutritional needs are met¹⁵.

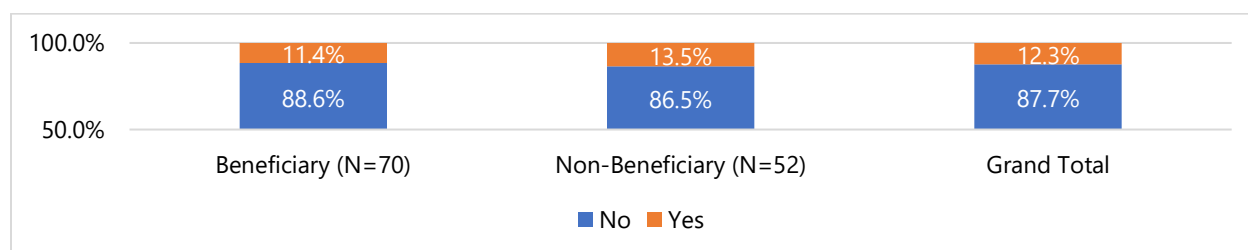


Figure 3: Prevalence of pre-lacteal feeding among mothers with children aged 0-23 months

Intake of various nutritious liquids, fruits, and foods among babies

The study further revealed significant practices regarding the intake of various liquids, fruits, and foods among babies in the 24 hours (a day and at night) before assessment. This was assessed to this practice, comparing participants and non-participants. The findings in **Table 10** below indicate that breast milk is the most common source of nutrition for babies, with 65.7% of mothers (participants) who gave breast milk and 75.0% of non-participants receiving breast milk. Additionally, a significant percentage of mothers with babies received semi-solid foods (34.3% participants, 40.4% non-participants), fruits (27.1% participants, 32.7% non-participants), and milk (25.7% participants, 23.1% non-participants). Moreover, a notable

¹⁵ World Health Organization; Aug 2023: Feeding of infants unable to breastfeed directly in care facilities: <https://www.who.int/tools/elena/interventions/breastfeeding-inability>

proportion of mothers whose babies were given sugar-salt-water solutions or ORS (24.3% participants, 26.9% non-participants) was revealed in the assessment.

Table 10: Intake of various nutritious liquids, fruits, and foods among babies

Liquids, fruit, or food	Beneficiary (N=70)	Non-Beneficiary (N=52)	Grand Total
Breast milk	65.7%	75.0%	55.9%
Milk (fresh cow milk, tin milk, baby formula, other)	25.7%	23.1%	19.7%
Sugar-salt-water solution or a solution made from ORS	24.3%	26.9%	20.4%
Fruits (vitamin-A rich)	27.1%	32.7%	23.7%
Semi-solid foods (porridge, rice water, soup, etc);	34.3%	40.4%	29.6%

Continued breastfeeding

Percent of mothers with children aged 0-23 months who are still breastfeeding: The results in **Table 11** below revealed that the majority of mothers (71.3%) continued breastfeeding their children aged 0-23 months, while 28.7% did not (overall). Among participants, 67.1% continued breastfeeding, while 32.9% did not. Among non-participants, 76.9% continue breastfeeding, while 23.1% do not. These findings suggest that the majority of mothers are breastfeeding their children, which is a positive outcome for the health and development of the children. However, a significant proportion of mothers are not continuing breastfeeding, which may have negative consequences for the children's health and development. Cultural beliefs and values on other overlooked hindrances of behavioral change could have also influenced breastfeeding practices among these mothers. For instance, in some societies, religious beliefs may encourage breastfeeding for a longer duration, while in others, cultural norms may discourage breastfeeding after a certain age. In line with this, further, intervention shall prioritize challenging these norms and beliefs to enhance continued breastfeeding among women of reproductive health.

Table 11: Mothers with children aged 0-23 months practiced continued breastfeeding

Continued breastfeeding mothers	Beneficiary (N=70)	Non-Beneficiary (N=52)	Grand Total
No	32.9%	23.1%	28.7%
Yes	67.1%	76.9%	71.3%
Grand Total	100.0%	100.0%	100.0%

Care-seeking for sick children

The practice of care-seeking behaviors for sick children among participants and non-participants was assessed by asking the respondents how they typically manage childhood illnesses for their children. According to the results in **Figure 4**, the majority of mothers (caregivers) seek medical care from healthcare professionals, with 69.0% of participants and 64.3% of non-participants doing so. Administering over-the-counter or prescribed medications was the second highest common approach, with 11.9% of participants and 10.0% of non-participants following this method. Using home remedies was also chosen by 8.1% of participants and 7.1% of non-participants. A combination of medical care and home remedies is preferred by 8.1% of participants and 6.7% of non-participants while observing and waiting for symptoms to improve was less common at 2.9% for both groups.

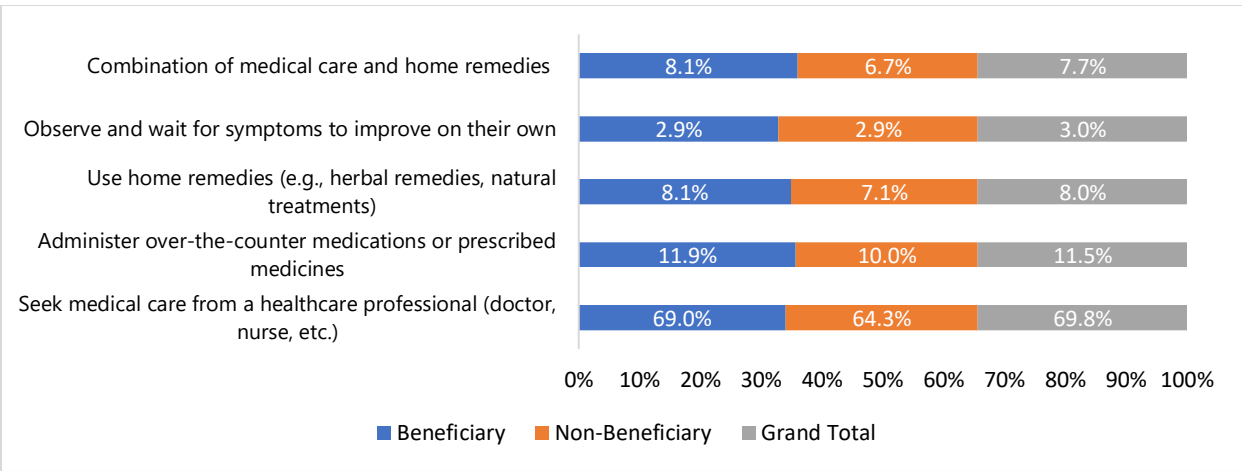


Figure 4: Care seeking for sick children

4.4 Water and Sanitation (WASH)

Safe drinking water

The study assessed the cleanliness of the household’s drinking water by probing to determine the source from which the household obtains the majority of its drinking water. The different sources of drinking water, are categorized as improved (safe) and unimproved sources. While a majority (59.3%) of households have access to improved sources, a significant portion (40.97%) still relies on non-improved sources (**Figure 5**). This stresses the importance of continued efforts to ensure universal access to safe drinking water, address disparities in access, and promote sustainable water management practices for the well-being of communities.

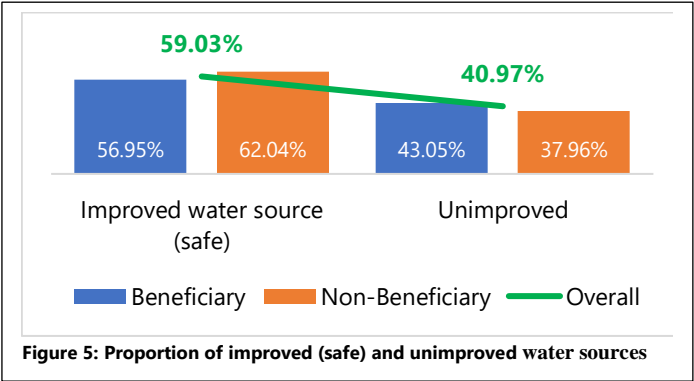


Figure 5: Proportion of improved (safe) and unimproved water sources

Percentage of households using an improved source of drinking water: Analysis (**Table 12**) of water source utilization reveals significant disparities between participants and non-participants of the SCOPE project. Improved sources assessed include piped water, protected spring, protected well, public tap/standpipe, rainwater collection (0.3%), and tube-well/borehole, while non-improved sources consist of Surface water (13.2%), unprotected spring (4.5%), and unprotected well (22.9%) (see **Table 12** below). Tube wells/boreholes are the most utilized source among both groups, with 31.8% and 44.5% of households respectively, highlighting a pronounced gap in accessing improved water sources. Additionally, protected spring sources show a notable difference in usage, with 7.3% among participants compared to 1.5% among non-participants. Overall, 56.95% of the participants compared to 62.04% of non-participants are using improved water sources.

Table 12: Main source of water in the target community

Main water sources	Beneficiary (N=151)	Non- Beneficiary (N=137)	Grand Total
Improved			
Piped into compound, yard, or plot...	0.7%	0.7%	0.7%
Piped into dwelling	2.6%	3.6%	3.1%
Piped to neighbor	1.3%	0.7%	1.0%
Protected spring	7.3%	1.5%	4.5%
Protected well	6.6%	7.3%	6.9%
Public tap/standpipe	6.0%	3.6%	4.9%
Tube-well/borehole	31.8%	44.5%	37.8%
Rainwater collection	0.7%	0.0%	0.3%
Unimproved			
Surface water (river, stream, dam, lake, pond, canal, irrigation channel)	13.2%	13.1%	13.2%
Unprotected spring	6.0%	2.9%	4.5%
Unprotected well	23.8%	21.9%	22.9%
Grand Total	100.0%	100.0%	100.0%

Water collection time

Percentage of households with improved sources of drinking water within acceptable reach and available daily: In line with the coverage of water collection time within the study group, the majority of individuals, whether classified as participants or non-participants, have access to clean water within a 30-minute timeframe. Specifically (**Table 13**), 88.68% of participants and 91.67% of non-participants fall within this category, with an overall average of 90.10% across the entire sample. In contrast, a smaller percentage of individuals, 11.32% of participants and 8.33% of non-participants require more than 30 minutes to access clean water. This implies that there is a relatively equitable distribution in the time taken to access clean water between participants and non-participants, with a slight variation in the proportion of individuals requiring more than 30 minutes for access. According to WHO, the maximum queuing time including collection of safe drinking water should not exceed 30 minutes for the household in a round trip¹⁶.

Table 13: Time taken to access clean water

Time taken to access clean water	Beneficiary (N=53*)	Non-Beneficiary (N=48*)	Grand Total (N=101)
Within 30 minutes* ¹⁷	88.68%	91.67%	90.10%
More than 30 minutes	11.32%	8.33%	9.90%
Grand Total	100.00%	100.00%	100.00%

* The respondents included in this analysis were those who reported using safe or protected water sources

Household responsibility in fetching water

Percent distribution of the person who usually fetches water for the household: The study targeted assessing practice in line with the distribution of individuals responsible for fetching water from a water

¹⁶ WHO; Improved sanitation facilities and drinking-water sources. <https://www.who.int/data/nutrition/nlis/info/improved-sanitation-facilities-and-drinking-water-sources>

¹⁷ An improved water source that is either on the premises or within 30 minutes of the household and that has not been unavailable for 24 hours within the previous two weeks is referred to as Acceptable reach and available.

source for households, categorized by beneficiary and non-beneficiary groups. The results presented in **Table 14** indicate that in both beneficiary and non-beneficiary households, adult women (age 15 or older) are the primary individuals responsible for fetching water, accounting for 53.3% in beneficiary households and 53.6% in non-beneficiary households. Female children under 15 years old follow as the next significant group involved in fetching water, with 29.5% in beneficiary households and 28.5% in non-beneficiary households. This revealed the gendered dynamics of water collection responsibilities, with adult women shouldering the primary burden, especially among the non-beneficiary rather than beneficiary households. Further, Male children under 15 years old are involved in 13.0% of beneficiary households and 14.6% of non-beneficiary households. Adult men (age 15 or older) have a minimal role, with only 3.8% in beneficiary households and 3.3% in non-beneficiary households responsible for water collection. This further highlight how the men of the benefiting household are to some extent supporting their spouses in domestic cores. Interestingly, a negligible percentage of households have water delivered by someone external to the household, accounting for only 0.4% in beneficiary households and 0.0% in non-beneficiary households.

Table 14: Percent distribution of the person who usually fetches water for the household.

Who usually goes to this source to fetch the water for this household	Beneficiary (N=151)	Non-Beneficiary (N=137)	Grand Total
Adult woman (age 15 or older)	53.3%	53.6%	53.4%
Adult man (age 15 or older)	3.8%	3.3%	3.6%
Female child (under 15 years old)	29.5%	28.5%	29.0%
Male child (under 15 years old)	13.0%	14.6%	13.8%
Water is delivered by someone, not from this household	0.4%	0.0%	0.2%
Grand Total	100.0%	100.0%	100.0%

Water treatment knowledge

The study examined household water treatment practices among participants and non-participants, revealing that out of 70 households, 30 participants, and 40 non-participants actively took steps to improve drinking water safety (**Figure 6**). This proactive approach suggests higher awareness levels among those with access to clean water sources. However, the presence of households not implementing safety measures indicates room for improvement in promoting safe water practices. Additionally, some households expressed uncertainty about safety measures, highlighting the need for enhanced education campaigns.

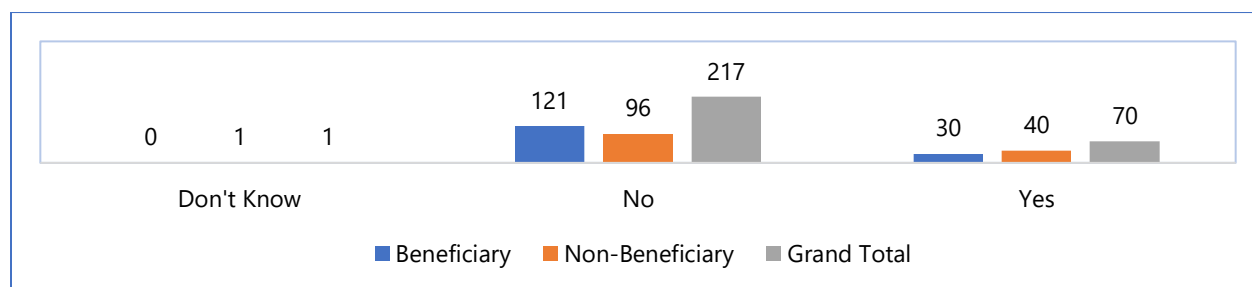


Figure 6: Households who have taken steps to make water safer to drink

Percentage of households using recommended household water treatment technologies: Resultantly, the findings in **Table 15** showed that the majority of the beneficiary households (77.5%) compared to non-beneficiary (73.3%) adopted the use of recommended water treatment techniques. Specifically, boiling water was the most widely practiced method, with 70.6% of beneficiary households and 64.4% of non-

beneficiary households utilizing this technique. Straining water through a cloth is another common practice, with 23.5% of beneficiary households and 26.7% of non-beneficiary households employing this method. In contrast, the use of water filters, such as ceramic or sand filters, is less prevalent, with only 2.9% of participants and 6.7% of non-participants opting for this technology. Adding bleach, chlorine, or water guard is a less commonly used method, with 2.9% of participants and 2.2% of non-participants implementing this approach. Interestingly, solar disinfection shows no reported usage in either beneficiary or non-beneficiary households. These findings underscore the varying adoption rates of water treatment technologies and highlight opportunities for promoting and expanding the use of effective water treatment methods to enhance water safety and quality in households.

Table 15: Water treatment techniques adopted

Water treatment	Beneficiary	Non-Beneficiary	Grand Total
Boil	70.6%	64.4%	67.1%
Add bleach/chlorine/water guard	2.9%	2.2%	2.5%
Strain it through a cloth	23.5%	26.7%	25.3%
Use water filter (ceramic, sand, composite, etc.)	2.9%	6.7%	5.1%
Solar disinfection	0.0%	0.0%	0.0%
Grand Total	100.0%	100.0%	100.0%

Household water storage

Percentage of households that safely store drinking water: The study results in **Table 16**, revealed that the majority of the households (77.5% participants and 75.6% non-participants) store water safely with recommended containers. Specifically, ceramic or clay pots emerge as the most popular choice, with 66.9% of beneficiary households and 72.3% of non-beneficiary households opting for this traditional storage method. Covered jugs or pitchers are also commonly used, with 22.5% of participants and 23.4% of non-participants selecting this option. In contrast, containers such as buckets, jerry cans, and bottles are less favored, with only 10.6% of participants and 4.4% of non-participants utilizing them for water storage. Overall, these findings highlight the utilization of ceramic or clay pots as the primary mode of water storage in both beneficiary and non-beneficiary households, showcasing a blend of traditional practices and modern alternatives in ensuring safe drinking water storage within communities.

Table 16: Household water storage materials

Household Water Storage	Beneficiary (N=151)	Non-Beneficiary (N=137)	Grand Total
Ceramic or clay pot	66.9%	72.3%	69.4%
Containers (bucket, jerry can, jerkin, bottle, drum, etc.)	10.6%	4.4%	7.6%
Covered jug or pitcher	22.5%	23.4%	22.9%
Grand Total	100.0%	100.0%	100.0%

Sanitation

Sanitation is a critical aspect of public health and well-being, encompassing the safe management of human waste to prevent the spread of diseases and protect the environment¹⁸. WHO reiterates that access to improved sanitation facilities is essential for maintaining hygiene and reducing health risks associated with poor sanitation practices. Improved sanitation facilities, such as flush or pour-flush toilets connected to sewer systems, septic tanks, or pit latrines with slabs, play a crucial role in separating human excreta from human contact, thereby preventing the transmission of diseases¹⁹. In this study, the target households categorized as participants and non-participants were asked about the kind of toilet facility members of this household usually use. The results of the study revealed that less than 1% of the households (0.66% participants and 0.73% non-participants) had no sanitation toilet facility (**See Table 17** below). This indicates a low level of health risk associated with human waste disposal including environmental contamination.

Table 17: Household sanitation toilet facility

Facility	Beneficiary	Non-Beneficiary	Grand Total
Flush or pour-flush toilet	0.66%	0.73%	0.69%
Ventilated improved pit latrine	13.91%	9.49%	11.81%
Pit latrine with slab	54.97%	27.74%	42.01%
Pit latrine without slab / open pit	29.80%	61.31%	44.79%
No facility/bush/field	0.66%	0.73%	0.69%
Grand Total	100.00%	100.00%	100.00%

Percentage (69.54%) of households use an improved toilet facility: The distribution of household toilet facilities between participants and non-participants shows significant variations in preference and availability. The results in **Table 17** above revealed that the majority of participants (69.54%) than non-participants (37.96%) use improved sanitation toilet facilities. Specifically, participants predominantly use pit latrines with slabs, accounting for 54.97%, while non-participants favor pit latrines without slabs or open pits at a higher rate of 61.31%. Ventilated improved pit latrines are more common among participants at 13.91%, compared to non-participants at 9.49%. Flush or pour-flush toilets are utilized by both groups, with a slightly higher percentage among non-participants at 0.73%. Overall, these statistics highlight the differing choices in toilet facilities between beneficiary and non-beneficiary households

Hygiene

Good hygiene practices include behaviors, community engagement, and proactive steps to reduce disease risks is essential. It is crucial to base these efforts on people's own understanding of risks and disease prevention to encourage positive health behaviors. As part of assessing knowledge levels, the study asked participants about the availability and proximity of handwashing²⁰

Percentage (50.99%) of households had a dedicated handwashing device located within or near the home or toilet facility: Results in **Table 18** below revealed that among participants, 50.99% reported having a handwashing facility, indicating relatively better access to this crucial hygiene resource closer to the toilet facility compared to the non-participants (37.96%). Additionally, a significant proportion of both

¹⁸ Dereje Oljira Donacho, Gudina Terefe Tucho, Abebe Beyene Hailu; Households' access to safely managed sanitation facility and its determinant factors in Jimma town, Ethiopia. Journal of Water, Sanitation and Hygiene for Development 1 February 2022; 12 (2): 217–226. doi: <https://doi.org/10.2166/washdev.2022.003>

¹⁹ WHO (October 2023): Sanitation factsheet; <https://www.who.int/news-room/fact-sheets/detail/sanitation>

²⁰ WaterAid (October 2020); Technical guide for handwashing facilities in public places and buildings

participants and non-participants either did not know about the presence of handwashing facilities or reported not having access to them, with 0.35% and 0.73% respectively in the "Don't Know" category, and 54.86% and 61.31% respectively in the "No" category.

Table 18: Availability of handwashing device closer to the sanitation toilet facility

Handwashing facility	Beneficiary (N=151)	Non-Beneficiary (N=137)	Grand Total
Don't Know	0.00%	0.73%	0.35%
No	49.01%	61.31%	54.86%
Yes	50.99%	37.96%	44.79%
Grand Total	100.00%	100.00%	100.00%

Percentage (92.9%) of households disposed of their child's feces safely the last time they passed stool: The results in **Table 19** present how the waste (feces) disposal practices among participants and non-participants are managed in their households. The majority of both beneficiary and non-beneficiary households opt for proper waste disposal methods, with 92.9% of participants and 90.4% of non-participants choosing to throw waste in a toilet or latrine. This indicates a high level of adherence to hygienic waste disposal practices in both groups. A smaller percentage, 7.1% of participants and 9.6% of non-participants reported burying waste in the yard. While the overall trend shows a preference for using toilets or latrines for waste disposal, the study highlights the need for continued education and promotion of proper waste management practices to ensure environmental and public health standards are maintained within communities.

Table 19: Household Waste (feces) disposal

Waste (feces) disposal	Beneficiary (N=70)	Non-Beneficiary (N=52)	Grand Total
Buried in yard	7.1%	9.6%	8.2%
Thrown in toilet/latrine	92.9%	90.4%	91.8%
Grand Total	100.0%	100.0%	100.0%

Proper household waste disposal: The study sought to assess this by asking participant how their household usually disposed of rubbish. Results in **Table 20** below revealed a minimal percentage of both participants and non-participants (0.66% and 0.73% respectively) reported using bins or buckets for rubbish disposal. Approximately 11.26% of participants and 13.14% of non-participants disposed of rubbish in the surrounding bush, while a small percentage of both groups (3.97% of participants and 1.46% of non-participants) disposed of rubbish in bushes far from their homes. The majority of both participants and non-participants (72.19% and 67.88% respectively) reported using a dug pit specifically for rubbish disposal. Additionally, a portion of households (10.60% of participants and 13.14% of non-participants) disposed of rubbish in pit latrines, while a small percentage of both groups (1.32% of participants and 3.65% of non-participants) disposed of rubbish by throwing it around the house. This implies the diverse waste disposal practices within communities and highlights the importance of promoting proper waste management strategies for environmental sustainability and public health. The result is in line with the assertion of [Stanisavljevic & Brunner \(2020\)](#). They revealed that effective waste disposal methods involve using bins or

buckets, disposing of waste in designated areas like pit latrines or specific pits for rubbish, and avoiding practices like throwing rubbish around the house or in bushes²¹.

Table 20: Household waste (rubbish) disposal

Waste (Rubbish) Disposal	Beneficiary (N=70)	Non-Beneficiary (N=52)	Grand Total
Bin/Bucket	0.66%	0.73%	0.69%
Bush (surrounding bush)	11.26%	13.14%	12.15%
Bush (very far from home)	3.97%	1.46%	2.78%
Dug Pit specifically for rubbish	72.19%	67.88%	70.14%
Pit latrine	10.60%	13.14%	11.81%
Throw around the house	1.32%	3.65%	2.43%
Grand Total	100.00%	100.00%	100.00%

RECOMMENDATION

Based on the findings and discussions outlined above, the implementation team should focus on establishing sustainability measures, including garnering support from district authorities and engaging with key stakeholders involved in ongoing initiatives within the area. It is recommended to develop a comprehensive document detailing lessons learned to disseminate successful interventions and innovations effectively. Collaborating with district and subcounty health authorities, leveraging insights from the SCOPE project's KPC assessment, is crucial in applying these lessons and replicating successful project innovations, such as community-based methodologies and IPT-G. Furthermore, efforts should be made to translate proven interventions into public policies. Planning additional assessment activities and corresponding interventions is essential to address specific challenges related to depressive symptoms and behavioral changes including other KPC indicators among women of reproductive age effectively.

²¹ Stanislavjevic N, Brunner PH. The user - beneficiary or victim of modern waste management systems? *Waste Manag Res.* 2020 Jun;38(6):597-598. doi: 10.1177/0734242X20924283. PMID: 32471339.

ANNEXES

Annex 1: KPC Survey tool

Strengthening Community Participation through Engagement (SCOPE) Project

KPC Survey 2024 HOUSEHOLD QUESTIONNAIRE

Instruction to enumerators (field monitor):

Thank you for supporting this exercise, kindly check to ensure the device has enough battery to enable you to start and complete this task. Please enable the LOCATION function and ensure that the device DATE and TIME are correct. Before you start the interview ensure you have sought consent from the interviewee.

Hello. My name is _____. I am working for the SCOPE Project and we are conducting a Knowledge, Practice, and Coverage (KPC) assessment on the impact of treatment of maternal depression on the adoption of behaviors related to 1. Home management, referral, and care-seeking for depressed mothers, 2. Exclusive breastfeeding and child nutrition, and 3. WASH practices among women of reproductive ages (15-49 years). Your household has been selected to participate in this important survey. Therefore, we would like to ask you some questions about your household. The interview will take about 5 to 10 minutes. All information from the survey will be kept confidential. May we proceed? Y/N If NO – terminate the interview and proceed to another household.

SECTION ONE - GENERAL INFORMATION	
S1.1 Subcounty	1: Alero 2: Koch Goma
S1.2 Parish	
S1.3 Village	
S1.4 Name of respondent	
S1.5 Date of Interview (dd/mm/yyyy)	

SECTION TWO – HOUSEHOLD DEMOGRAPHY	
S2.1 Is the respondent the Household head? IF Yes >>>S2.3	1=Yes 0=No
S2.2 How is the respondent related to the household head?	1=Spouse 2=Daughter 3=Other (Specify)
S2.3 What is the respondent's age (in completed years)	
S2.4.1 What is the sex of the household head?	1=Male 0=Female
S2.5.1 Respondent's number of completed years of formal education	_ _ (Record 88 if the respondent doesn't know)
S2.6 What is the marital status of the respondent/household head?	1=Married 2=Single 3=Widowed 4=Separated / divorced
S2.7 How many people are in your household (eating with you every day)?	_____people
S2.8 How many people in your household are aged 0-23 months old?	_ _ (Record 88 if the respondent doesn't know)
S2.9 What is the main income source in your household?	
S2.10 What is the estimated income level of your household?	

SECTION THREE – Home Management, Referral, and Care-Seeking for Depressed Mothers	
S3.1 How knowledgeable are you about mental health support resources and referral services for depression?	1=Not knowledgeable, 2=Moderately knowledgeable, 3=Highly knowledgeable
S3.2 On a scale of 1 to 5, how would you rate your knowledge about the symptoms of depression?	1=Very low knowledge 2= low knowledge 3= moderate low knowledge 4= High knowledge 5= Very high knowledge
S3.3 How often do you actively seek information about depression and available treatment options when experiencing symptoms?	a) Always b) Often c) Sometimes d) Rarely e) Never
S3.4 How often do you engage in open communication within your household regarding emotional well-being and mental health?	a) Always b) Often c) Sometimes d) Rarely e) Never
S3.5 In what ways do you provide support to family members experiencing depression?	1=Emotional encouragement 2=Assistance with daily tasks 3=Accompanying them to therapy sessions 4=Listening without judgment 5=Other (please specify) _____
S3.6 How effective do you find establishing routines for daily tasks, meals, and self-care in managing symptoms of depression?	1= Very effective 2= Somewhat effective 3= Neutral 4= Not very effective 5= Not at all effective
S3.7 Have you ever sought referrals from mental health organizations or support groups for depression-related help?	1=Yes 0= No
S3.7b If yes, please specify the type of treatment received	1= Medication (e.g., antidepressants, mood stabilizers) 2= Therapy (e.g., cognitive-behavioral therapy, interpersonal therapy)

SECTION THREE – Home Management, Referral, and Care-Seeking for Depressed Mothers	
	3= Counseling (e.g., individual counseling, group therapy) 4=Combined therapy
S3.7c If Yes; Where did you get this support from?	1= Trained mental health professional from the available Health Facilities 2= VHTs 3= NGOs involved in psychosocial/mental health support services 4= Friends and Relatives include members of social groups
S3.8 Are you aware of any other specialized mental health services available for women of reproductive ages (18-45 years) in your community?	1=Yes 0= No 99= Not sure
S3.8b If yes, please rate your overall satisfaction with the specialized mental health services you have accessed:	1= Very Satisfied 2= Satisfied 3= Neutral 4= Dissatisfied 5= Very Dissatisfied
S3.8c If no, please indicate the reasons why you have not accessed specialized mental health services.	1= Lack of awareness 2= Lack of accessibility 3= Stigma associated with seeking help 4= Cost-related reasons 5= Other (Please specify)
S3.9 How comfortable are you discussing your mental health concerns with healthcare providers?	a) Very comfortable b) Somewhat comfortable c) Neutral d) Somewhat uncomfortable e) Very uncomfortable
S3.10 In your opinion, how effective do you perceive the specialized mental health services for women of reproductive ages (18-45 years) in addressing their mental health concerns?	1= Highly Effective 2= Moderately Effective 3= Not Effective
S3.11 In your opinion, how effective are VHTs in supporting the mental health needs and concerns of women of reproductive ages (18-45 years) in your community?	1= Highly Effective 2= Moderately Effective 3= Not Effective
S3.12 On a scale of 1 to 10, please rate the extent to which your depression treatment has positively influenced your home management, referral, and care-seeking practices.	1 (No influence) to 10 (Significant influence)

SECTION FOUR – Maternal and Household Practices Related to Exclusive breastfeeding and child nutrition	
S4.1 Have you ever breastfed? (If No, go to S4.4)	1= Yes 2= No

SECTION FOUR – Maternal and Household Practices Related to Exclusive breastfeeding and child nutrition	
S4.2 How long after birth did you put your child to the breast?	1 = < 1 Hour 2 = <24 Hours 3 = 2-3 Days 4 = N/A
S4.3 During the first three days after delivery, did you give your child yellow liquid that came from your breasts?	1= Yes 2= No
S4.4 During the first three days after delivery, was given anything to drink other than breast milk?	1= Yes 2= No
S4.5 If yes , what was the child given to drink immediately or three days after delivery?	1= Animal Milk 2= Plain Water 3= ORS 4= Syrup (medicine) 5= Infant formula 6= Tea / Juice 7= Herbal infusions 8= N/A 9= Others
S4.6 Are you still breastfeeding	1= Yes 2= No
S4.7 How many times did you breastfeed the child yesterday during the day and at night?	[.....] Times
S4.8 Since this time yesterday, has the child received (insert each item here)? 1=Breast milk; 2=Plain water; 3= Teas, millet water, fruit juice, sweetened water & herbal teas; 4= Milk (fresh cow milk, tin milk, baby formula, other); 5= ORS; 6= Other fluids/liquids; 7= Fruits; 8= Semi-solid foods (porridge, rice water, soup, etc); 9= Solids or mushy foods (meat, fish, eggs, beans, rice, potatoes, stew, etc.); Others (Specify)	1= Yes 2= No 3= Not applicable
S4.9 At what age did you start giving the child other foods in addition to breast milk?	[.....] Month; 98= Not applicable
S4.10 At what age do you intend to stop breastfeeding the child?	[.....] Month; 98= Not applicable
S4.11. How do you typically manage childhood illnesses for your child (e.g., seeking medical care, home remedies)?	1= Seek medical care from a healthcare professional (doctor, nurse, etc.) 2= Administer over-the-counter medications or prescribed medicines 3= Use home remedies (e.g., herbal remedies, natural treatments) 4= Observe and wait for symptoms to improve on their own 5= Combination of medical care and home remedies

SECTION FOUR – Maternal and Household Practices Related to Exclusive breastfeeding and child nutrition

	6= Other (please specify): _____
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SECTION FIVE – Maternal and Household Practices Related to WASH

S5.1 What is the MAIN source of drinking water for members of your household? (ONE Answer Only)	<p>Piped water (1=Piped into dwelling; 2=Piped into compound, yard or plot; 3=Piped to neighbour; 4=Public tap / standpipe)</p> <p>Dug well (5=Protected well; 6=Unprotected well)</p> <p>Water from spring (7=Protected spring; 8=Unprotected spring)</p> <p>9=Rainwater collection 10=Surface water (river, stream, dam, lake, pond, canal, irrigation channel) 11=Bottled water 12=Other (specify)</p>
S5.2 How long does it take to go there, get water, and come back?	Number of minutes: If water is present on compound circle0 Don't Know 1
S5.3. Do you know how to treat water to make it safe for drinking? IF No >>>S5.6	1= Yes 2= No
S5.4. Who usually goes to this source to fetch the water for this household?	1=Adult woman (age 15 or older) 2=Adult man (age 15 or older) 3=Female child (under 15 years old) 4=Male child (under 15 years old) 5=Water delivered by someone, not from this household
S5.4. Do you do anything to the water you draw from unprotected sources to make it safer to drink?	1= Yes 2= No 3= Not applicable
S5.5 What do you usually do to make the water safer to drink? <i>Probe: Anything Else?</i>	<i>Record ALL items mentioned.</i>
Possible List {1=Boil; 2=Add bleach/chlorine/water guard; 3=Strain it through a cloth; 4=Use water filter (ceramic, sand, composite, etc.); 5=Solar disinfection; 6=Don't Know (DK)}	
S5.6 How do you store drinking water?	1= in containers (bucket, jerry can, jerkin, bottle, drum, etc.) 2=Roof tank or cistern 3=No water stored
Am going to ask you about environmental hygiene practice	
S5.7 Has this household ever had a toilet facility?	1= Yes 2= No

SECTION FIVE – Maternal and Household Practices Related to WASH	
S5.8 What kind of toilet facility do members of this household usually use?	1=Flush or pour-flush toilet Pit latrine 2=ventilated improved pit latrine 3=pit latrine with slab 4=pit latrine without slab / open pit 5=Composting toilet 6=Bucket toilet 7=Hanging toilet / hanging latrine 8=No facility/bush/field
S5.9 Do you share this facility with other households?	1= Yes 2= No
S5.10 Including your own household, how many households use the facility? IF Yes in S5.9 Put 0 if no. of households is less than 10; 95 for 10 or more households; 98 for DON'T KNOW	
S5.11 How do you dispose of faeces from young children?	1= In the toilet. 2= Pit latrine 3= In the rubbish pit. 4= In the nearby bushes 5= In the streams/river 6= Other, specify
S5.12 Is there any hand washing facility located close to the toilet for use by users of the toilet?	1= Yes 2= No 3 = N/A 4 = DK
S5.13 What times (or after what events) do you wash your hands? Probe: WHAT ELSE? List {1=After visiting the toilet; 2=Before preparing food; 3=Before eating food; 4=After eating food; 5=Before eating fruits; 6= After changing baby's nappies; 7=Before feeding the baby/child; 8=After washing napkins; 9=Others(specify)}	Record ALL items mentioned.
S5.14 When washing hands what do you use? List {1= Running water; 2=Soap; 3=Ash; 4=Basin}	(Multiple Response Possible)
S5.15 Where does your household usually dispose of rubbish?	1= Dug Pit specifically for rubbish 2= Pit latrine 3= Bin/Bucket 4= Bush (surrounding bush) 5= Bush (very far from home) 6= Throw around the house Other, specify

Record the GPS Coordinates of the household

Survey start time: \${start}

Survey end time: \${end}

Name of the interviewer

Name of the supervisor

Annex II: Analysis of Household Characteristics of the respondent

Household Characteristic	Beneficiary	Non-Beneficiary	Grand Total	
Marital status of the respondent				
Married	74.8%	69.3%	72.2%	
Separated/divorced	4.0%	7.3%	5.6%	
Single	7.9%	15.3%	11.5%	
Widowed	13.2%	8.0%	10.8%	
Grand Total	100.0%	100.0%	100.0%	
Respondent's age category				
15-19 years old	2.0%	8.8%	5.2%	
20-24 years old	16.6%	19.0%	17.7%	
25-34 years old	43.7%	42.3%	43.1%	
35-49 years old	28.5%	20.4%	24.7%	
Above 49	9.3%	9.5%	9.4%	
Grand Total	100.0%	100.0%	100.0%	
Respondent's education status				
No Formal Education	15.2%	8.0%	11.8%	
Primary Education	74.8%	75.2%	75.0%	
Secondary Education	8.6%	15.3%	11.8%	
Tertiary Education	0.7%	1.5%	1.0%	
Vocational/Technical Education	0.7%	0.0%	0.3%	
Grand Total	100.0%	100.0%	100.0%	
Children aged 0-23 months living in the household				
No	53.6%	62.0%	57.6%	
Yes	46.4%	38.0%	42.4%	
Grand Total	100.0%	100.0%	100.0%	
Main income source of the respondent				
Agriculture (eg. farming, livestock rearing, and fishing.)	81.5%	85.4%	83.3%	
Casual labor	1.3%	2.9%	2.1%	
Formal employment	0.7%	1.5%	1.0%	
Small businesses (eg. retail shops, food stalls, or artisanal activities)	16.6%	10.2%	13.5%	
Grand Total	100.0%	100.0%	100.0%	
Estimated monthly income level				
1,000,000 - 2,000,000 UGX	1.3%	1.5%	1.4%	
300,000 - 1,000,000 UGX	6.6%	5.8%	6.3%	
Below 300,000 UGX	92.1%	92.7%	92.4%	
Grand Total	100.0%	100.0%	100.0%	
Household size				
	Mean	Std. Dev	Min	Max
Beneficiary	6.50	2.61	2	15
Non-Beneficiary	5.99	2.50	1	13