# UGANDA PROGRAM FOR HUMAN AND HOLISTIC DEVELOPMENT (UPHOLD)

# TRIALS OF IMPROVED PRACTICES (TIPS)

# FINAL REPORT

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| TIPS | Trials of improved practices |
| UPHOLD | Uganda Program for Human and Holistic Development |
| IMCI | Integrated Management of Childhood Illnesses |
| CIMCI | Community Management of Child Hood Illnesses |
| ORS | Oral Re-hydration Solution |
| CORPS | Community Own Resource Person |
| HIV | Human Immune Virus |
| AIDS | Acquired Immune Deficiency Syndrome |
| ITNs | Insecticide Treated Nets |
| AMREF | African Medical Research Foundation |
| PTA | Parents Teachers Association |
| UPE | Universal Primary Education |

**Executive Summary**

Trials of Improved Practices (TIPs) was commissioned by the Uganda Program for Human and Holistic Development (UPHOLD). It is a formative research method that helps program planners to select and pretest actual practices that the program will promote. This was a response to the need to prioritize the key C-IMCI behaviors to be promoted at the household and community level. The trials were conducted in the three districts of Arua, Luwero and Mbarara.

The purpose of the TIPs was to identify practices that most people are both willing and able to do, barriers and motivations for the feasible practices and potential strategies to promote the feasible practices. The information obtained through TIPs will be useful in developing behavioral change strategies and activities. The trials tested nine practices in homes and schools: treatment of diarrhea, malaria (fever) treatment, pneumonia recognition and care seeking, proper feces disposal, hand washing, ITN use, school lunch and school hand washing and toilet use.

The trials were structured in two visits. In the first visits, researchers observed current practices and negotiated with each participant to reach an agreement on what specific practice he or she was willing to try. In households, researchers talked with individuals or family units. In schools, researchers met with School Management Committee (SMC) members, Parent Teacher Association (PTA) members, Head Teachers, teachers and pupil representatives.

The researchers returned two weeks later to find out the outcome of the trials: whether participants tried the practice or not, if they had modified it, if they liked it, if they shared the experience with others, if they benefited and if they were willing to continue with the practice.

*Diarrhea Treatment:* The TIPs on diarrhea treatment showed that diarrhea was indeed one of the common childhood illnesses in the districts. Researchers found fewer cases in Mbarara compared to the other districts, probably due to the dry season that prevailed during the trials. Among the recommended improved practices for diarrhea, the trials indicate that giving extra breast milk, other fluids and foods, checking for danger signs and recuperative feeding were feasible. However, there was no change in the number of parents who were willing to obtain or give ORS. Although they knew that they could obtain free packets of ORS from the health

centers, very few endeavored to do so. Some opted to give a mixture of salt and sugar locally made at home. Long distance and perceived poor quality of care at health centers were the major constraints cited.

*Acute Respiratory Infection (ARI):* Researchers focused on home care and outside care seeking for children with any respiratory problem since they did not find cases of pneumonia. Parents said that pneumonia is only common during the rainy season. Caregivers of children with respiratory problems were willing and able to give extra breast milk and other fluids, use paracetamol and check for difficult or fast breathing. They were willing to take children to the health center when they developed fast or difficult breathing.

*Malaria:* Malaria was reported to be the most common childhood illness in all the three districts. Most parents knew that mosquitoes cause malaria and that malaria can be prevented. Caregivers were willing and able to obtain and give children with fever the recommended treatment and to give more breast milk and fluids.

*ITNs:* The TIPS on insecticide treated nets (ITNs) revealed a very low use of the nets in all three districts. Lack of money to buy the nets was the major reason given for lack of nets. During negotiations with researchers, parents agreed to try to purchase nets, but only one **family** was able to get one within the two weeks. Most of the participants felt that two weeks was too short to raise the money.

*Feces Disposal:* Although all the households visited had latrines, the latrines were in poor condition. Latrines lacked proper walls, roofs and floors. However, participants were willing to renovate latrines, avail wiping materials to keep them clean and encourage all family members to use latrines consistently.

*Hand washing:* Participants were willing and able to wash hands with soap or ash and to set up a fixed place for washing hands. However, it was apparent from the discussions that the use of soap for washing hands all the time is not sustainable for most families due to the costs involved. Participants were not willing to set up tippy taps or have clean clothes for drying hands.

*Parent-Child Communication:* The trials showed that parent to child communication was the most widely accepted practice in all the districts. Although in the first trials it was found that parents were already talking to their children about how they want them to behave, many of them did not talk about sex and HIV/AIDS. They felt the children were too young to be involved in such issues. In the second TIPS however, almost all the parents interviewed had talked to their children about values and HIV/AIDS, a change that could be attributed to the encouragement given to them by the researchers.

*School Lunches:* The discussions in the schools revealed that the majority of the pupils in all the schools were doing without lunch. While school management, teachers and School Management Committee/Parent Teacher Association members acknowledged that this is a problem, they were unable to develop good solutions. Among the possible recommendations that they tried included asking parents to contribute money for lunch to be prepared at school and encouraging pupils to bring food/snacks from home. Results of the TIPs show that negotiations had been initiated with parents to contribute money for lunch for their children. In addition, it was reported that the number of children who were bringing food/snacks from home had increased. The other options were starting a school garden and asking pupils to bring some money to buy snacks at school.

*School Hygiene:* Researchers found that schools were able to institute more regular cleaning rotations of toilets, set up hand washing facilities with water and ash and put wiping materials in the toilets to keep them clean. Although teachers preferred to try to get soap for hand washing, it was not feasible in most schools. They were able to get and keep ash without difficulty. Schools were not willing to construct Tippy taps.

UPHOLD should promote several child health practices with little modification, including:

- Extra feeding and fluids and recuperative feeding for children with diarrhea;
- Extra feeding and fluids and checking for fast breathing and immediate care seeking for children with respiratory problems.
- Setting up hand washing facilities at toilets and hand washing with ash;
- Renovation of toilets, encouraging family members to use toilets and setting up wiping materials;

- Parent-child communication on delaying sex and avoiding risky situations;
- ITN purchase through alternative financing mechanisms. ITN use must be targeted towards men who make household decisions and **use nets if families own only one net.**

In schools, UPHOLD should promote the following practices:

- Revised toilet cleaning schedules;
- Putting wiping materials in toilets;
- Setting up hand washing facilities with ash;
- Compromises between schools and parents on prices of lunches or encourage pupils to carry snacks to school if they can't bring lunches

## 1.0 Introduction

This report is an outcome of a set of Trials of Improved Practices (TIPs) on a number of child health and school health and nutrition (SHN) topics commissioned by the Uganda Program for Human and Holistic Development (UPHOLD). UPHOLD is a USAID funded program that works to assist Ugandans to achieve improved health, and longer and more productive lives, through interventions in three integrated social sectors: Education, Health and HIV/AIDS. UPHOLD's main areas of focus in health include child and adolescent health; communicable disease control; integrated reproductive health; and school health and nutrition as an integrated strategy with education and HIV/AIDS.

Integrated Management of Childhood Illnesses (IMCI) remains an important approach in the promotion of child and adolescent health. The program encourages participation of households and the community in the sixteen key behaviors. However, while the C-IMCI Behavior Change Communication strategy contains many good ideas, its implementation still remains complex in terms of the targeted behaviors, target groups, and required messages. It is therefore important to prioritize the behaviors to be improved at the household and community level by identifying which are feasible for people to do and how best to promote the practices. Similarly, there are ideal recommendations within SHN that need to be prioritized based on which are feasible for schools and pupils to achieve.

Based on identified gaps in understanding feasible practices, UPHOLD selected nine recommendations to test: care for children with diarrhea, malaria (fever) treatment, respiratory illness recognition and care seeking, proper feces disposal, hand washing, ITN use, providing school lunches and hand washing and toilet use in schools.

### 1.1 Purpose of the TIPS

The purpose of the TIPs was to identify practices that are both technically efficacious in improving health, education and HIV/AIDS and realistic for UPHOLD to promote. Specifically, TIPs aimed to determine which recommendations most people are willing and able to do, modifications that people make to the recommendations, barriers to practicing the feasible

recommendations and perceived benefits. The results will inform behavior change strategies and activities.

## 2.0 Methodology

The TIPs consisted of the following activities and the field trials were structured in two visits:

i) Translation of the TIPS instruments into three local languages.
ii) Identification and training of field staff and pre-testing of the instruments.
iii) The initial field visit to negotiate with schools and caregivers to try one or two of the recommendations.
iv) A second visit to the same households and schools to examine the outcome of the trials, what worked and what did not work well and how to promote feasible practices

### 2.1 Translation of the TIPS instruments

The TIPS instruments were translated from English into three languages: Lugbara, Luganda and Lunyankole. The translation was done by the field staff (Research Assistants) in Kampala and continued during the training workshop in Luwero. This was done to ensure that the questions were clearly understood by the community members.

### 2.2 Identification and training of field staff

A total of nine field staff, three from each of the three study districts, were recruited on merit and experience in health and socio-economic research. In addition, researchers demonstrated fluency in the local languages and familiarity with local cultural practices.

The field staff attended a four-day training workshop in Luwero to learn the TIPs methodology, review interview techniques, and pretest instruments. Researchers pretested instruments in a primary school and households in Butuntumula Sub-county, Luwero District. It was useful to ensure that the questions and messages were clearly understood by both the field staff and participants. Researchers revised the instruments following the pre-test.

### 2.3 First field visits

Researchers visited a total of 42 households in each of the districts of Mbarara and luwero and 36 in Arua. At least six households tried each of the 7 child health recommendations in each district. The exception was in Arua where researchers did not explore malaria treatment. While Home-Based Management of Fever (HBMF) has not been implemented at scale in any of the districts to date, this was only expected in Arua before the study began. Researchers visited participants in their homes to observe and discuss background information, current practices, and recommended practices. The researchers then negotiated with each participant to reach an agreement on one to two recommendations that he or she would be willing to try.

Researchers also visited two schools in each of the three districts to discuss recommendations on lunches and hygiene with a group of people. They met with head teachers, teachers, SMC/PTA members and pupil representatives.. In Arua however, malaria treatment was not tried. In addition, two practices were tried in two schools in each of the districts. In-depth interviews were also conducted with parents and pupils in the age range 8 to 15 years.

### 2.4 Second field visits

Second field visits were arranged two weeks later in all the three districts to find out the response to and outcome of the trials: whether they tried the practice or not; what worked well and what did not work well; their feelings about it; modifications to the practices if any; the easy or difficulties experienced; and other people's reactions. Researchers returned to the same households and schools as they visited the first time.

### 2.5 Limitation of the study

TIPs involved negotiations with participants to try out specific recommendations in one visit and follow-up in another visit after two weeks. Some participants felt that two weeks was not long enough to try out some of the recommendations. This was particularly true for providing school lunches, buying mosquito nets and building latrines. The schools asked researchers to return next term to show that they are willing to try the recommendations but need more time.

## 2.6 The study communities

TIPs was conducted in three purposively selected districts: Arua District in the Northern Region, Luwero District in the Central Region and Mbarara District in the Southwest. In each of the districts, two parishes and two primary schools were selected. The primary schools were selected in consultation with the District Education Officers based on several criteria including participation in earlier meetings to discuss school quality and PTA/SMC activities.

In Arua, TIPs was conducted in Jako village in Dadam sub-county and Bongova village in Ajia sub-county. Jako is a peri-urban community while Bongova is a typical rural community. The population of Bongova is predominantly peasant farmers while Jako is a mixture of peasant farmers, wage earner workers and business people working in Arua town. Both communities are Lugbara speaking people. The TIPs on school practices were conducted in Jako and Bongova primary schools.

In Luwero, researchers visited Kamira and Kyagabakama villages in Kamira sub-county. The majority of the population is Baganda who are mainly peasant farmers. There is also a mixture of other tribes including the Baruli, Banyankole and the Banyarwanda who are mainly pastoralists. The TIPs on school practices were conducted in Kamira and Kyangabakama primary schools.

In Mbarara, researchers went to Biharwe village about seven kilometers on Masaka - Mbarara Highway and Kaiho village in Ndeija sub-county. While Biharwe is a peri-urban community with a mixture of Banyankole and Baganda who are mostly Moslem, Ndeija is a rural Banyankole community. Most of the people in Biharwe are subsistence farmers but engage in trading in produce, mainly tomatoes and onions. Ndeija community is made of peasant farmers. They also rear cattle. The school TIPs was conducted in Biharwe and Kaiho primary schools.

The most common health problems affecting children in the communities were reported to be malaria, diarrhea, flu and cough. Others were worms, wounds, epilepsy, skin diseases, enlarged spleen, and measles. Diarrhea was more commonly reported in Arua and Luwero compared to

Mbarara as Mbarara was experiencing a dry season while it was raining in Arua.

In Luwero and Mbarara six interviews were conducted with the caretakers on each of the seven household behaviors totaling 42 interviews in each of the districts. In Arua, where malaria treatment was not conducted, the total number of interviews was 36. Overall, a total of 18 trials were conducted on each of the household practices in the three districts with exception of malaria that had 12 trials in two districts.

**3.0 Treatment of diarrhea**

The first visits aimed at establishing caretaker behavior in regard to prevention and management of diarrhea. The specific concerns were to establish whether mothers give more breast milk, fluids and food to children with diarrhea, give oral re-hydration solutions and if they knew and could act on the danger signs of diarrhea. The first interviews showed that diarrhea was indeed one of the common childhood illnesses in all the three districts.

**3.1 Current situation, context and practices**

Mothers were concerned about diarrhea in children. They associate diarrhea with: body weakness, loss of appetite, loss of weight, stomachache, fever, cough, vomiting, watery stool and dehydration. They noted that in many cases children have died when the symptoms became severe.

"*He passes stool frequently, gets fever and becomes very weak*" (Mother, Luwero)

"*I get concerned and worried because the child may die. This is why I have to go to the clinic for treatment. I want the child to be healed* " (Mother, Mbarara)

Mothers have good knowledge of diarrhea and categorized diarrhea by how it presented. They mentioned the following types of diarrhea: watery diarrhea, yellowish diarrhea, diarrhea that looks like foam, greenish diarrhea, slippery diarrhea, and bloody diarrhea. There was a belief that diarrhea sometimes spreads and affects other children in the household. Mothers practiced a variety of home care and recuperative recommendations and most sought treatment outside the home when they recognized danger or when children did not improve through home

remedies.

*Home care:* Regardless of the type of diarrhea, some mothers gave children with diarrhea extra breast milk, fluids and food. They explained that these would replace what is lost through diarrhea. The mothers who gave extra fluids and food complained that the children did not take as much fluids or food as they were willing to give due to loss of appetite.

"*I give him a lot of breast milk, porridge and soup. I give him these drinks so that he can have strength because normally when a child has diarrhea it weakens him so much. These drinks replace the strength and weight lost*" (Mother, Arua).

"*She takes very little breast milk compared to when she was normal. She breastfeeds about five times a day, yet before she used to breastfeed about ten times*". (Mother, Luwero)

The type of fluids given varied from district to district because of contextual differences in which mothers live. For instance, in Luwero mothers gave passion fruit juice while mothers in Arua and Mbarara gave millet porridge. In addition, a few mothers gave re-hydration solutions to the children, either homemade or made from ORS packets obtained from a health unit. In the first visits 9 mothers reported giving their children ORS. The home made re-hydration solution was mainly salt and sugar obtained from ordinary shops and mixed in water.

However, results show that the mothers did not either mix or give the solutions in the recommended amounts. In order to help children gain weight and strength, some 2 mothers gave food such as mashed Irish potatoes, beans and cassava.

"*I boil two cups of water, leave it to cool and then I power the ORS powder into the water and mix. I then give the child two tea spoonfuls 3 times a day* (Mother, Arua).

"*I first boil water, then mix 4 spoonfuls of sugar and 1 spoonful of salt, then I give it to her. She feels a bit better after that*" (Mother, Luwero).

*Treatment Outside the Home:* Treatment depended upon the type of diarrhea. Bloody diarrhea was feared most and prompted faster health care seeking. The other types were perceived as mild and sometimes ignored to cure on their own. For instance, they didn't treat diarrhea associated with a child developing 'milk teeth' or when the mother has conceived and is still breast-feeding.

When mothers sought treatment for diarrhea outside the home, they opted for herbal or biomedial care after consulting family members – spouses and mothers-in-law – and trying home remedies. Six of the mothers reported seeking care from health workers in health centers or hospitals. While the rest went to private clinics, drug shops and traditional healers, or had only consulted a family member. The mothers who did not go to government health facilities believed that the quality of care at the facilities is poor. They complained of long waiting times, lack of drugs and equipment, and access related constraints like distance. In some cases, mothers explored both options beginning with traditional medicine and followed by a visit to a health facility if the child had not improved.

"*I consulted my mother in law who advised me to give local herbs before going to the hospital saying it is "engundu". I consulted her because the baby did not sleep well at night when the diarrhea started*" (Mother, Mbarara).

Although most of the mothers knew that they could obtain ORS sachets from government health facilities for free or from pharmacies, private clinics, and drug shops, only one had the sachets at home. While CORPS are supposed to provide ORS sachets, among other services, mothers reported that even where CORPS are known, they only conduct community health education.

*Prevention:* Mothers also had good knowledge of prevention of diarrhea and practiced some of the recommendations. To prevent diarrhea in their children, mothers reported that they consistently wash hands after and before eating and before feeding a baby, properly dispose of children's feces in a latrine or bury in a hole, boil drinking water, keep homes clean, ensure that children do not eat dirty things, eat properly prepared food, wash and dry plates well, and dress children in clean clothes. Mothers did not wash hands after visiting toilets, build and maintain latrines for feces disposal or sink rubbish pits.

*"We have to drink boiled water, use clean materials to hold the baby and prevent flies from reaching our food"* (Mother, Mbarara).

*"Yes I boil water for drinking, I cover food, and wash cooking utensils. We have a latrine where the feces are disposed properly"* (Mother, Mbarara)

### 3.2 Outcome of agreements

**Table 1A: Diarrhea treatment - Overall**

| Recommended **practice** | **Number asked** | **Number who agreed to try** | **Number who tried** | **Number who planned to continue** |
|---|---|---|---|---|
| 1. Increase the amount of breast milk, other fluids and foods offered to the child. | 17 | 16 | 15 | 15 |
| 2. Obtain mix, and give ORS | 12 | 12 | 6 | 6 |
| 3. Look for danger signs of diarrhea | 9 | 6 | 4 | 2 |
| 4. Give extra breast milk fluids and other foods for the next week after diarrhea stops | 8 | 7 | 5 | 5 |
| **Totals** | **47** | **39** | **31** | **29** |

**Table 1B Diarrhea treatment by district**

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Increase the amount of breast milk, other fluids and food | Arua | 6 | 5 | 5 | 5 |
| | Luwero | 5 | 5 | 5 | 5 |
| | Mbarara | 6 | 6 | 5 | 5 |
| 2. Obtain, mix and give ORS | Arua | 5 | 3 | 3 | 3 |
| | Luwero | 3 | 3 | 3 | 3 |
| | Mbarara | 5 | 4 | 1 | 1 |
| 3. Look for danger signs of diarrhea | Arua | 4 | 1 | 0 | 0 |
| | Luwero | 3 | 3 | 2 | 2 |
| | Mbarara | 2 | 2 | 2 | 0 |
| 4. Give extra breastmilk, fluids and other foods for one week after diarrhea stops | Arua | 3 | 2 | 1 | 1 |
| | Luwero | 4 | 4 | 4 | 4 |
| | Mbarara | 1 | 1 | 0 | 0 |
| **Totals** | | **47** | **39** | **31** | **29** |

*1. Increase the amount of breastmilk, other fluids and food.*

The results of the trials as shown in tables 1 A&B indicate that giving extra breast milk, other fluids and food to a child with diarrhea was a well accepted practice by the mothers in all the districts. 16 of the mothers agreed to try, 15 actually tried and were willing to continue with the practice. Researchers negotiated with mothers of children with diarrhea who had not given extra fluids and food agreed to try and all were able to do so. Mothers found it easy to offer extra fluids and food because they were easy to obtain. The fluids and food were obtained at minimal or no

additional costs as these, especially the food, came from their own gardens. In Luwero, for example, mothers were able to access passion fruits as these were readily available within the communities. In Mbarara, mothers were able to add milk to the porridge and also mix beans soup, greens and matooke and gave the sick children.

> *"I gave passion juice to the child six times, after every two hours. I also gave the child food three times a day in the morning, at lunch and super time. The child took the juice and food willingly." (*Mother, Luwero*)*

> *"I gave the child millet and maize porridge three times a day. I also mixed milk, beans, and greens (dodo) in matoke". (*Mother, Mbarara*)*

> *"I mixed porridge with milk and I kept giving him through out the morning hours. In the evenings drinking is poor because by that time he is satisfied" (*Mother Luwero*).*

Mothers agreed that the children benefited from taking the extra breast milk, fluids and food they gave. They felt that children recovered faster compared to the previous episodes. They also gained strength and weight.

*"I breastfed him about 10 times a day. Since he is still very young (2months) I have not started giving him other fluids – it is only breast milk. This has helped him and he is now better o*ff" *(*Mother, Mbarara).

The TIPS revealed that there were some variations in the types of food and fluids given to the children. For instance, while in Luwero mothers gave passion fruit juice, maize porridge and black tea, in Mbarara, they gave millet porridge and milk. A variety of locally available foods such as cassava, posho, irish and sweet potatoes, and beans were given in all the three districts. The exception was matoke that was given only in Luwero and Mbarara. The main barrier to giving juice was the lack of sugar as some of the families could not afford sugar to put in the fluids.

"*It was hard for me because at times there was no sugar for mixing the juice and also buying milk all the time was hard*" (Mother, Arua).

*2. Obtain, mix and give ORS.* There was low response from the mothers regarding efforts to obtain free ORS sachets from health facilities. Very few of the mothers were able to visit health facilities to obtain ORS because of the distance to health facilities and the cost associated with obtaining ORS from private facilities. In one of the communities in Mbarara, the nearest health center where free ORS could be obtained is about 10 kilometers away. In addition, mothers did not want to get ORS because they said children have to be forced to drink it because of its bad taste.

*3. Look for Danger Signs:* Researchers asked 9 mothers to check for danger signs in a child with diarrhea. The danger signs include: frequent watery diarrhea, diarrhea that continues for many days and blood in the diarrhea. Four out of the 6 mothers who agreed to try were able to check for the danger signs and reported that it was easy because they already knew the danger signs and the signs could be physically recognized. The mothers agreed to take a child immediately to a health facility should any of the danger signs occur. One mother whose child developed more frequent watery diarrhea took her child to a nearby clinic without delay.

> *"I checked every time the child passed stool through out the day but most especially when the child passed stool." (*Mother, Mbarara*)*

> *"I went immediately to the nurse when the child kept crying and passing watery stool."* (Mother, Luwero)

*4. Give extra fluids and food for one week.* Overall, 8 mothers were asked to try giving extra breast milk, other fluids and food for one week after the diarrhea stopped. Seven were willing to do this and 5 were able to give extra fluids and food for one week after the diarrhea stopped. They said this was easy because it was a continuation of giving extra fluids and food to a child suffering from diarrhea. They also reported that it was easy because children who have just recovered from diarrhea feel like drinking and eating most of the time as they regain their normal appetite.

*"I kept giving extra fluids – that is millet and maize porridge. The porridge is given when it is warm and not thick. Now after recovery she takes about three times a day." (Mother, Mbarara)*

*"I breastfeed her every time she cries. On average I breastfeed her about 12 times a day. I also give her Irish potatoes with beans soup. The child has now gained weight."* (Mother, Mbarara)

In summary, most mothers were willing and able to give extra breast milk, other fluids and food during a diarrhea episode. This is this a change since more mothers were able to do this than before. Mothers in Luwero were willing and able to do this during recovery as well. Mothers were not willing to get ORS to give to their children. Regarding care seeking outside of the home, mothers in 2 districts were willing to check for danger signs and take the child to a facility if any appear. UPHOLD could therefore promote giving extra breast milk, other fluids and food and checking for danger signs of diarrhea.

**4.0 Parent-child communication**

The TIPS on parent - child communication sought to establish whether parents are willing and able to talk to their children about values, expectations and appropriate behavior in regard to HIV prevention with emphasis on delaying sex and avoiding risky situations

**4.1 Current situation, context and practices**

All the parents interviewed (5 fathers, 13 mothers) reported that they typically talk to their children about how they want them to behave now and what they want them to do in future. The advice parents give includes respect for other people, hard work, heeding teachers' advice, concentration on studies, avoiding premarital sex, avoiding moving at night, keeping clean and warning girls to stay away from boys at the wrong hours.

"*I always tell her to read hard in order to be able to stand on her own in future. I also advise her to be hard working at home, learn most types of work so that in future she can proper*" (Mother, Arua).

"*I talk to my children to respect elders. For example, they respect me and believe in what I tell them"* (Grand mother, Mbarara).

"*I tell her to respect both at home and outside home. I also advise her to follow whatever we tell her to do in terms of behavior. She should actively participate in domestic work like fetching water, cleaning the compound and cooking*" (Mother, Arua)

Twelve out of 18 parents interviewed (9 mothers, 3 fathers) reported that they talk to their children about preventing HIV/AIDS[1]. The parents preferred to talk about HIV/AIDS to children 15 years old and above. The key message they give is that AIDS kills and that abstinence is the safest way one can avoid it. They did not report talking about condoms. Parents said that they felt free to talk to their children about the dangers of HIV and how it can be avoided.

> *"I like it and I don't even fear to talk to my children about HIV/AIDS. I am always free and tell them a lot about it." (Mother*, Mbarara*)*

> "*I tell them the only way to prevent HIV/AIDS is to abstain from sex. They should only have sex in future during marriage and should check for HIV with the partner before getting married. On average I talk to them especially when there are dances around, games or other activities that can bring them together with other people"* (Mother, Arua).

> "*When I tell her about it she keeps quiet but she understands, she does not react badly towards it"* (Mother, Mbarara)

They were willing to talk to their children more often about HIV/AIDS, and at younger ages, and wanted to learn some new ideas on how these talks could go even better. A few parents, however, were hesitant to share sensitive issues with their children because they felt that children under ten years were still too young. Fear of sad memories was also reported to hinder free discussion on HIV/AIDS with children who have lost a parent.

[1] LQAS results showed that parents talked to 26% of girls and 22% of boys in the past 3 months about HIV/AIDS.

"*I do not talk about it because their mother died of HIV/AIDS. It is difficult to talk about it with them"* (Caretaker, Luwero).

The researchers shared a guide for parents to talk to young children about values, expectations and HIV/AIDS prevention. The parents were willing to use the information in the guide. They said that they would prefer to talk to children when they are free from domestic chores especially in the evenings after supper and on Sundays after church. They felt that they would talk inside the house or somewhere within the compound where it is private.

"*We have agreed about that – I am going to use the contents of this guide to issues to do with HIV/AIDS with my daughter"* (Father, Arua).

Some of the parents felt that it should be the mother to talk to the children because she spends more time with them and that the children tend to be more free with their mothers. Mothers said that fathers don't care much about these things, have little time for children and usually return home late in the night when drunk. Some parents still said that the father is the right person to talk to the children because children take what the father says more seriously. They also said that fathers are more likely to be able to understand and follow the guide. Others preferred both parents because raising children should be a shared responsibility.

"*I feel we will sit together with their mother, when it comes to sensitive issues about sex, it is the mother who will talk about them*" (Father, Arua).

### 4.2 Outcome of the agreement

**Table 2A: Parent child communication - Overall**

| Recommended Practice | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|
| Discuss values and appropriate behavior with child | 18 | 18 | 16 | 16 |

**Table 2B: Parent child communication by district**

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| Discuss values and appropriate behavior with child | Arua | 6 | 6 | 6 | 6 |
| | Luwero | 6 | 6 | 6 | 6 |
| | Mbarara | 6 | 6 | 4 | 4 |
| **Totals** | | **18** | **18** | **16** | **16** |

Talking to children about values and appropriate behavior in relation to HIV/AIDS was the most widely accepted practice in all the three districts. In the second visits, almost all the parents interviewed had talked to their primary school-age children aged between 8 to 15 years about HIV/AIDS with emphasis on delaying sex and avoiding risky situations. The discussions focused on strategies to delay sex in order to prevent HIV/AIDS.

> *"I talked about prevention of HIV/AIDS and told him not to indulge in premarital sex. I also emphasized good behavior." (Father, Mbarara)*

> "*I talked about many things which included what HIV/AIDS is, how dangerous it is – as it has no cure. I talked about what causes it and how it can be prevented. Lastly, I talked about how one can know that he of she has the disease"* (Mother, Arua).

Most parents held discussions with their children at least once a week and usually the discussions lasted 30 minutes or more. Most of the discussions were held at night after supper.

> "*We had just finished supper then he talked to me about HIV prevention and good behavior."* (Male child, Mbarara)

In practice, the mothers and fathers held separate discussions with the children. Mothers had 8 discussions while fathers held 6. It was only in one case when both parents talked to the children together. In one case where the parents had died, the grandmother, talked to the children.

Although there were no major difficulties reported, parents felt it was difficult to come out boldly to tackle sexuality issues. Faced with this situation, parents approached the topic by beginning with non-sensitive issues. They also try to assure the children of their love for them and concern about their safety.

> "*I tell them how much I love and care for them for they are the only children I have so I don't want to see anything wrong happening to them. I ask them about HIV/AIDS and explain to them what it is and how someone can get it. I feel relieved because their mother died of HIV/AIDS."* (Grandmother, Luwero)

> "*It went on well only that I felt uneasy to openly talk about certain things related to sex to the young boy.*" (Father, Arua) [how old was the child? what happened? Did this father change? Stop?]

The subsequent discussions that followed the first one were said to be easier as children became more relaxed, talked and asked questions. Discussions became participatory as parents and children grew more comfortable.

> "*It was difficult for the first time because I failed to start on the HIV/AIDS thing and also the children did not ask me anything. But in the second and third discussions they were free, talked and asked questions"* (Mother, Mbarara)

Parents reported that these discussions were different from ones that they had with the children before. Using the guide, they were able to dialogue back and forth, spend quality time with each child, and go in-depth into the topics about HIV/AIDS.

*“It was different from the previous ones because now I concentrate and make sure he understands everything and the timing is good since we usually talk after supper since you came.* “(Father, Mbarara).

“*This one was about life and death and others have been on things like their education and other responsibilities.*” (Grandmother, Luwero)

Parents used the guide, but picked out what they felt they would comfortably pass on to the children. The parents appreciated the fact that it is easier to convince young children to delay sex than to have them stop after they have started. However, they felt more comfortable emphasizing abstinence than encouraging the use of condoms. They feared that talking about sex and introducing issues like condom use at that age may arouse their curiosity to venture into sex. In spite of this difference, they promised to continue using the same guide because they feel it is educative to them and the children.

“*I liked all the information apart from that on condoms to be discussed with this young man. I feel at this age the emphasis should be on abstinence. Talking to such a young boy about condoms would look like I am teaching him bad manners of trying sex with condoms.”* (Father, Arua)

Children of parents who did talk about condoms were uncomfortable; they were not happy about their parents talking to them about the use of condoms.

“*I never liked when she told me about condoms. This is because myself I don’t recommend condom use so if you are advising someone you should not tell him to use condoms.* ” (Male child, Mbarara). [was this common?]

Some parents were not sure if the talks were useful.

“*It is difficult to judge this from these young children. Because they are still young, it is not easy to tell whether they have appreciated or not.*” (Mother, Luwero)

Most of the parents interviewed recommended that it is important to approach other families to ask them to try similar discussions with younger children.

> "*Yes other parents should know how to approach their children and talk to them about HIV/AIDS which has killed many people. It is good to keep talking to other families about this and giving them advice."* (Father, Mbarara)

Most of the children interviewed accepted that their parents had talked to them about HIV/AIDS prevention. Some of them were said to have already started putting in practice what their parents had told them. For example, they were avoiding unnecessary playing at night and mixing with the opposite sex at wrong hours. They said the discussions went on well because they realized that what their parents were telling them was right.

> **"***He talked to me about HIV/AIDS, what causes it and how it can be prevented and how one can know that he has AIDS or not." (Male child, Arua)*

> ***"****I liked it because what he told me was good. As he was talking I listened to him****."*** *(Child, Mbarara)*

In summary, talking to children about appropriate behavior and values with regard to HIV/AIDS prevention was well accepted by the parents in the TIPs. This is demonstrated by the increase in the number of parents who were able to talk to their children about HIV/ADS during the second visits up from the first visits. However, the TIPS showed that parents are still reluctant to discuss sensitive issues such as condom use with the young adolescents. UPHOLD should promote this practice with emphasis on parents coming out more boldly to tackle more sensitive sexuality issues with young adolescents.

**5.0 Hand washing**

The TIPS on hand washing focussed on the following specific practices: washing hands at some key times; use of soap or other cleansing agent to wash hands; rubbing hands well when washing hands; availability of water for washing hands; a fixed place for washing hands; and drying hands on a clean cloth or air drying them.

**5.1 Current situation, context and practices.**

Researchers observed that most people routinely wash their hands before and after eating when at home, without soap or another cleansing agent. Washing hands before preparing food, before eating or feeding a child, after visiting toilets, after digging, and after disposing children's feces were not common practices despite good knowledge on the benefits of hand washing.

> "*I don't wash my hands when in the field especially when the water source is far, because I don't carry water to the garden. Even when going to eat mangoes or cassava we don't carry water"* (Mother, Mbarara).

> "*He washes two times, when we are going to eat lunch and super but when he is going to eat fruits, I don't want to tell you a lie he does not wash hands. For the toilets it is me who cleans him"* (Mother, Mbarara).

In the first visits 12 families had either a jerry can or a basin located somewhere within the compound or inside the house where they would draw water for washing hands. No family had a properly set up hand washing facility at a specific location, something for drying hands or drainage at the location where they wash hands. They usually wash hands anywhere within the compound.

Families noted that a major barrier to hand washing was an inconsistent supply of water. Families obtained water from bore holes, dams and wells during rainy seasons. During dry seasons some water sources dry up and people have to move long distances to fetch water such as what was happening in Mbarara district during the TIPs.

> "*Sometimes the bore hole breaks down and takes close to a year when we have a serious water problem, and when the dry season comes the dams also dry up."* (Mother, Luwero).

> *"We often get backache and headache due to carrying water. We also send children for water and they also complain of the distance and the heavy load that*

*results in chest pain. The place is very hilly so it is difficult to carry something heavy."* (Mother, Mbarara)

Among those who washed hands, 9 families out of 18 families used soap occasionally, while others never used soap.

**"***I don't use soap for washing hands all the time even when I am from the latrine because sometimes soap is not there.***" (**Mother, Mbarara**).**

Without soap, no family in the first visits improvised local materials such as leaves and ash to wash hands.

## 5.2 Outcome of agreements

**Table 3A: Hand washing - Overall**

| **Recommended Practice** | **Number Asked** | **Number who agreed to try** | **Number who tried** | **Number who planned to continue** |
|---|---|---|---|---|
| 1. Hand washing with soap or another cleansing agent | 14 | 12 | 12 | 12 |
| 2. Willingness to make and use a tippy tap | 13 | 7 | 0 | 0 |
| 3. Setting up a hand washing place with hand washing facilities and drainage | 15 | 15 | 9 | 11 |
| 4. Hand drying with a clean piece of cloth after washing hands | 10 | 9 | 3 | 3 |
| **Totals** | **52** | **44** | **25** | **25** |

## Table 3B: Hand washing by district

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Put water and soap or other cleansing agent near the latrine | Arua | 4 | 3 | 3 | 3 |
| | Luwero | 5 | 5 | 5 | 5 |
| | Mbarara | 5 | 4 | 4 | 4 |
| 2. Secure one fixed place for hand washing with trench or drainage | Arua | 6 | 4 | 4 | 4 |
| | Luwero | 4 | 4 | 0 | 0 |
| | Mbarara | 5 | 5 | 5 | 5 |
| 3. Secure a clean cloth for drying hands | Arua | 1 | 1 | 0 | 0 |
| | Luwero | 4 | 3 | 2 | 2 |
| | Mbarara | 5 | 5 | 1 | 1 |
| 4. Washing hands at all key times. | Arua | 2 | 2 | 2 | 2 |
| | Mbarara | 2 | 1 | 1 | 1 |
| 5. Rub hands well when washing | Arua | 2 | 1 | 0 | 0 |
| 6. Setting up a tippy tap | Arua | 6 | 0 | 0 | 0 |
| | Luwero | 6 | 6 | 0 | 0 |
| | Mbarara | 1 | 1 | 0 | 0 |
| **Totals** | | **58** | **48** | **29** | **29** |

Families were willing and able to improve hand washing using soap or other cleansing agent such as ash. However, parents found that ensuring that children wash their hands at key times is difficult since the parents are not always with them.

Twelve families were able to get and use soap for washing hands, a slight increase from the first visits. However, people complained that soap is expensive and may not be able to continue buying it. In addition, families found they risked losing the soap to rains, animals, children or thieves if they kept it near the hand washing facility. As a result, one mother explained that she found it easier to use as which is to obtain without any cost. Others decided to keep the soap in the house to avoid loosing it.

> "*I got the ash from my kitchen and put it in a plastic container. Because for ash it is easy to get and yet for soap children waste it and yet it is expensive.*" (Mother, Mbarara)

> "*Children waste the soap and play with it so I put the soap and the water in the house.*" (Mother, Mbarara)

It featured from the discussions with parents that since they have not been using soap to wash hands at some key times like after visiting the toilet they tend to forget. This tendency could be minimized by setting up the hand washing facility just next to the latrine. The presence of this facility would serve as a reminder for them to wash hands except for the fear of losing the soap to children, petty thieves and rain. They usually wash hands anywhere within the compound.

> "It is not *hard but we forget as we are not used to washing hands with soap always.*" (Mother, Arua)

Nine of the families visited in Mbarara and Arua during the follow up visits had set up and were using a fixed place for washing hands compared to none during the first visits. Most of the washing places were located near the latrine. They appreciated it and like it because it served as a reminder for them to always wash hands especially after visiting the toilet. However, in

some families it was mentioned that children don't wash from the central washing places. In contrast, results show that this practice was not well embraced in Luwero.

> "*I now wash my hands always because this place reminds me all the time that I should wash my hands after visiting the latrine.*" (Mother, Mbarara)

In summary, hand washing with soap and securing one fixed place for hand washing were well accepted though the latter were not well embraced in Luwero. Securing a clean cloth for wiping hands after washing, setting up a tippy tap and rubbing hands well when washing seem not to have been well accepted in the households. A major constraint to hand washing with soap is the cost involved in purchasing the soap rendering the practice unsustainable for most families. UPHOLD should therefore to promote hand washing with other cleaning agents such as ash and leaves. Even families that opt to use soap should be encouraged to keep ash at the latrine for easy access and reminder.

## 6.0 Use of insecticide treated nets (ITNs)

The TIPs on ITNs aimed at finding out how families that do not have ITNs can obtain an ITN and how families that have ITNs can ensure that the most vulnerable use the ITNs correctly.

### 6.1 Current situation, context and practices

Researchers interviewed the homes they came to first and found that there was no single net in either community in Mbarara and two nets in Arua. In Luwero, researchers found four families with nets. The availability of nets in Luwero is probably due to AMREF, which is promoting ITN use in the district. One family in Luwero had a net but it was not being used due to lack of a proper place to hang it.

"*I don't hang the net these days because my ceiling is to high. Instead I suggest keep it in the suit case. I don't know how to do this. I can put all the children in the net once I get a proper place to hang the net*" (Mother, Luwero).

The major reason given for lack of ITNs was lack of money at one time to purchase them. Fears of the nets catching fire from candles and burning houses and perceived side effects of the

insecticide used for treating the nets were also cited. One mother blamed her husband for negligence and laziness when it comes to buying mosquito nets. She asked researchers to talk to her husband about buying nets.

> "*My husband is lazy and doesn't take it as something very important.*" (Mother, Luwero)

> "*You try to write some small letter for him saying you have been here and you want us to have a net.*" (Mother, Luwero).

> "*We had that that thing has some bad chemicals in it and that it can cause other diseases* (Mother, Arua)

Asked whether they thought they could get a net in the next two weeks, most of them said they would not be able to raise the money to buy the nets within such a short time.

> "*There is no source of income to buy nets. I don't think I can be able to raise 5,000 shillings just to by a net when there are other pressing needs like food. Maybe if UPHOLD distributes it free or we labor for it afterwards."* (Father, Arua).

> *"Financial problem. We only get money at the end of the tobacco season. So next week is too short for me to acquire a net since I would not have got the money"* (Father, Arua).

Parents who said they could not afford to buy a net in the next week opted for other preventive measures such as closing doors and windows early enough to prevent mosquitoes from entering.

> *"I don't have any money at all. Even right now I have a sick person in the hospital and I am wondering how I will foot the bill. May be I can try other options of reducing mosquito population by smoking the latrine, breaking empty tins, digging a rubbish pit and burning the rubbish"* (Father, Arua).

Although the nets found in the three households were treated, they were washed using soap whenever they get dirty. In the first visits in 4 out of the 6 households that had nets it was reported that it was the mothers and young children who slept under the nets. In one the husband and wife slept under the net possibly because they did not have young children.

## 6.2 Outcome of the agreements

**Table 4A: Use of ITNs - Overall**

| **Recommended Practice** | **Number Asked** | **Number who agreed to try** | **Number who tried** | **Number who planned to continue** |
|---|---|---|---|---|
| 1. Buy a net and treat it | 14 | 9 | 1 | 3 |
| 2. If the net is treated , it should not be washed until going to be treated | 3 | 2 | 1 | 2 |
| 3. Put more children under the net, buy another net | 2 | 2 | 0 | 0 |
| 4. Put a nail near the bed and fix the net | 1 | 1 | 0 | 0 |
| **Totals** | **20** | **14** | **2** | **5** |

**Note:** The difference between those who tried and those were willing to continue is that some parents promised strongly to buy the nets given time. For example one mother hand accumulated up to 4000 shillings as was looking around for more money to top up.

**Table 4B: Use of ITNs by districts**

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Buy a net and treat it | Arua | 6 | 1 | 1 | 1 |
| | Luwero | 2 | 2 | 0 | 0 |
| | Mbarara | 6 | 6 | 0 | 2 |
| 2. If the net is treated, it should not be washed until going to be treated | Luwero | 3 | 2 | 1 | 2 |
| 3. Put more children under the net, buy another net | Arua | 1 | 1 | 1 | 1 |
| | Luwero | 2 | 2 | 0 | 0 |
| 4. Put a nail near the bed and fix the net | Luwero | 1 | 1 | 0 | 0 |
| **Totals** | | **21** | **14** | **3** | **6** |

The TIPS results show that although some families had shown willingness to buy nets only one in all the three districts was able to acquire one within the two weeks. The major reason given for the failure to acquire a net was lack of money. Most of them said the two weeks was too short for them to raise that amount of money. One of the mothers said she had raised about four thousand shillings, which she was planning to top up soon. Others were waiting for their husbands who were away from home to tell them about the message.

"*We wanted to buy a net but failed because I fell sick and used the money to buy medicine. I used 2000 shillings. Even one of my children fell sick. We shall buy it when we get the money*" (Mother, Mbarara)

The few parents who had nets were willing to buy more so that all of the children could sleep under a net. The only parent who bought a net already had one. In absence of enough nets in the households, parents were willing to give priority to the young children to sleep under the nets. They also promised to let the other children sleep near treated nets because of the associated benefits they learnt from the researchers.

> "*Yes, if treated nets can repel mosquitoes then its okay for the children to sleep near the net."* (Father, Arua)

> *"No, I did not get the money to buy the net, my husband was away and came back only yesterday. But we are going to buy."(*Mother, Luwero*)*

In summary, most parents appreciated the importance of ITNs and were willing to acquire nets. However, they were constrained by lack of money. Even those who already had nets were willing to have more so that more family members can sleep under ITNs. They were also willing to have other children to sleep near the available nets as they would also benefit. UPHOLD should therefore promote purchase of nets but this needs to be accompanied by promotion of some income generating activities. Promotion of ITN use must also be targeted towards men who make household decisions.

**7.0 Pneumonia/cough recognition and care seeking**

The TIPS on cough/pneumonia recognition and treatment focused on care seeking and home care for cough/pneumonia. The specific recommendations were: giving extra breast milk and extra fluids with safe water; use of paracetamol, checking the child's breathing several times a day, and in the case of fast breathing or high or persistent fever taking the child to a CORPS or health facility without delay.

### 7.1 Current situation, context and practices

Researchers did not find cases of pneumonia in all the three districts. However, they did find many children with other respiratory problems. Parents reported that respiratory problems, especially cough and flu, were common childhood health problems in their communities.

*"She currently has cough and flu and if the nose is not runny it gets blocked and she breathes with difficulty. But after sneezing she breathes well when the nose is not blocked. When she coughs you find that the chest is squeezed. When it started she also had fever, she could breastfeed but kept on crying. Also when she is breast feeding you hear some noise in her mouth like if you are squeezing a ball to remove air from it. Currently, she even does not defecate normally; she takes like a day or two without. When she does it, the feces are smelly and she cries when defecating"* (Mother, Mbarara).

Parents associated pneumonia with difficult breathing and fever, while they associated cough with chest pain and vomiting. Watery mucus flowing from the nose was said to be a sign of flu. Parents believed that the causes of respiratory problems were cold, rain, dust and poor hygiene during birth.

In case of infection they use both local herbs and bio-medicine. The type of treatment and where treatment was sought for children with respiratory problems depended on the severity of the illness. Children with simple respiratory problems were usually first treated at home either using local herbs or home remedies such as hot water and lemon juice, "*kisakyamuzadde"*. Other remedies commonly used at home include: *'rob'* ointment, pepsi sweets, panadol, pritons and '*vicks kingo'.* Simple respiratory problems were not perceived as life threatening and parents did not seek treatment in health facilities.

> *"We cut a mature banana plant and use the inside part for smearing on the child's nose to cure the flu and cough." (*Mother, Luwero*).*

> *“I have been giving her “tangawuzi” either in milk tea or dry tea. When I give her it makes her comfortable. It has helped her because now she spits a strong saliva and not the watery ones and this means she is getting better (Mother, Mbarara)*

Parents did take children to a health facility without delay when they recognized severe conditions such as difficult breathing.

> “*I felt so concerned that is why I did all I could and latter on took the child to the hospital. I got so concerned because the breathing was too much. You could even see on the chest”* (Mother, Arua)

Parents did not give extra fluids with safe water or extra breastmilk to children with respiratory problems. They were not aware of the need to give extra fluids and breastmilk to children with respiratory problems.

Researchers negotiated giving extra breast milk, other fluids and safe water; use of paracetamol to treat fever in children with respiratory health problems; checking the child’s breathing several times a day; and taking the child immediately to a health facility if they believe the child has difficult breathing.

## 7.2 Outcome of agreements

### Table 5A: Pneumonia/cough recognition and care seeking by district

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Give extra fluids, breast milk, safe water | Arua | 6 | 6 | 6 | 6 |
| | Luwero | 6 | 6 | 6 | 6 |
| | Mbarara | 6 | 6 | 6 | 6 |
| 2. Use paracetamal to treat fever in respiratory infections, | Arua | 3 | 2 | 1 | 1 |
| | Luwero | 6 | 6 | 6 | 6 |
| | | | | | |
| 3. Check the child's breathing several times a day | Arua | 4 | 0 | 0 | 0 |
| | Luwero | 1 | 0 | 0 | 0 |
| | Mbarara | 4 | 4 | 4 | 4 |
| 4. Take the child immediately to a health facility if you believe the child has difficult breathing. | Mbarara | 4 | 2 | 2 | 2 |
| **Totals** | | **40** | **32** | **31** | **31** |

All the 18 parents interviewed were willing and able to give children with respiratory problems extra fluids, breast milk and safe water. The extra fluids included millet porridge, milk, tea and passion fruit juice. The parents said that this was easy to do because the fluids and water were available at home. However, they were concerned about the lack of sugar to make juices. In

such cases they concentrated on breast milk and water. All the parents were happy that after giving the fluids the children recovered and gained strength and promised to keep up the practice for the good of their children.

> "*I gave them safe water, squeezed oranges and sometimes I would give them [orange fruits] to eat directly since I did not have sugar to prepare juice. I think it worked well because right now, none of them has flue or cough."* (Mother, Mbarara).

> "*It was hard to keep giving passion fruits because they take a lot of sugar and I do not have money to buy. Even buying paracetamol was hard because of money." (*Mother, Luwero*)*

> "*I liked the feeling of being a mother and being able to take a leading role in seeking health care for my son. I wished that when you return you should find him well. Now I am happy that you have found him playing with others unlike last time when he could not play.*" (Mother, Mbarara)

All the six parents of children with respiratory problems in Luwero gave them paracetamol in addition to the fluids. They felt that paracetamol worked well because it cooled the fevers and headaches. The most common type of medicine given from health centers, private clinics and drug shops was septrin. However, parents complained that taking children to government health units was hard because the facilities are far away. Checking the child's breathing several times a day was well embraced in Mbarara where all the 4 parents who agreed to try actually tried and were willing to continue with the practice. They reported that checking the child's breathing several times is not difficult since they stay with the children all the time. This practice was however not well accepted in Luwero and Arua.

Two of the parents who agreed to take their children to a health center immediately upon believing that the child has difficult breathing in Mbarara were able to do so. This practice was tried only in Mbarara.

In Summary, giving extra breast milk, fluids and safe water to children with respiratory health problems was well accepted by all parents interviewed in the three districts. This was a great change from the first visits during which parents did not report giving extra breast milk, other fluids and safe water to children with respiratory health problems. UPHOLD should therefore promote this practice. In addition, using paracetamol to treat fever in children with respiratory was well accepted in Luwero where all the mothers who agreed to try were able to do so. Checking the child's breathing several times a day could be promoted in Mbarara where all the 4 parents who agreed to try actually tried and were willing to continue.

## 8.0 Malaria/fever treatment

The initial TIPS plan on fever was to explore current community practices in regard to prevention, recognition and management of fever. Researchers recommended that any child with hot body (fever) be treated for malaria within 24 hours. The intention was to ask parents to visit a CORPS/Drug Distributor to obtain a free Homapak and then give the medicine as instructed. However, contrary to information available, the Homapak program had not begun in any of the three districts. As a result, researchers negotiated with parents to obtain a combination of chloroquine and Fansidar from any nearby health facility or drug seller and give the child the full dosage.

### 8.1 Current situation, context and practices

Malaria was the most commonly mentioned childhood illness in all three districts. Parents demonstrated high knowledge about signs and symptoms and causes of malaria. Parents recognized malaria in children when they presented with body pains, hot body, dehydration, weakness, failure to eat or breast feed, discomfort, crying a lot, vomiting, convulsions, and diarrhea. Other symptoms mentioned were heavy breathing, sores on the lips and loss of appetite. Parents said fever could be associated with yellow fever, malaria and typhoid. Most parents interviewed knew that mosquitoes spread malaria.

"*When she gets sick she loses her strength, stops playing and sometimes she refuse to eat*" (Mother, Luwero).

"*She vomits everything she eats. She can hardly sit, she only sleeps. Sometimes she refuses food completely". At times she gets diarrhea* (Mother, Mbarara).

*"Malaria is caused by mosquitoes but for typhoid fever I am not sure what causes it"* (Mother, Mbarara)

However, knowledge of malaria prevention was mixed. They correctly believed that malaria could be prevented by use of mosquito nets and closing doors and windows early enough in the evenings. However, they also believed that clearing bushes around the home, draining stagnant water and boiling drinking water could prevent malaria.

Parents said that they care for a child with fever by wiping with cold cloth, giving breast milk, giving tablets kept at home or bought from drug shops and clinics and taking the child to a health unit. In general, clinics and drug shops are more preferred than health centers. Mothers first consult husbands and mothers in-law for advice. The drugs that they commonly receive from the health units, clinics and drug shops are paracetamol, chloroquine, fansidar, tetracycline capsules and quinine injections. In a few cases local herbs such as mululuza was given. This is usually obtained from nearby bushes and given initially before outside assistance is sought.

"*The only treatment I get for these twins and my other children is quinine injections. They are always badly off and other medicines such as chloroquine does not work for them. When they inject them chloroquine it does not make any change*" (Mother, Mbarara).

## 8.2 Outcome of agreements

### Table 6: Treatment of malaria by district

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Give the child Chloroquine and fansider in appropriate dosage if it persists, take to health facility | Luwero | 6 | 6 | 6 | 6 |
| 2. Continue to extra breast feed | Luwero | 4 | 4 | 4 | 4 |
| 3. Give extra fluids | Luwero | 6 | 6 | 6 | 6 |
| | Mbarara | 1 | 1 | 1 | 1 |
| 4. Prompt health care seeking within 24 hours | Mbarara | 4 | 4 | 1 | 1 |
| 5. Constant monitoring to see the progress | Mbarara | 2 | 2 | 2 | 2 |
| 6. Continue with the medication the child had received. | Mbarara | 4 | 4 | 4 | 4 |
| 7. Taking back the child for review | Mbarara | 2 | 2 | 0 | 0 |
| **Totals** | | **29** | **29** | **24** | **24** |

All the 6 parents who were interviewed in Luwero were willing and able to give a combination of fancidar and chloroquine to all children with fever. The drugs were mainly obtained from private clinics and drug shops. All the parents interviewed in Luwero and Mbarara reported no problems adhering to the instructions in the treatment of fever. They said that when they got home they followed the instructions given by both the researcher and health workers. The 4 parents in Mbarara whose children were already on treatment continued with the medication until the children completed the dose. They felt that giving the medicine to the children was easy.

> "*When you came and told us to take the child to the clinic, we did. We took him to a clinic near Makenke and after telling the health worker about his hot body and fever, we were given tablets for treatment.*" (Mother, Mbarara)

> "*I followed the instructions given and gave the baby the full close as instructed. She has finished the dose and has not fallen sick again.*" (Mother, Luwero)

> "*I have been monitoring to see if the fever has come back but he improved and has recovered. When you came he had started treatment and we continued. In all he was given 5 injections of chloroquine. He was also given fancidar and other drugs of 3 types (blue, yellow and white) and paracetamol"* (Mother, Mbarara).

Parents were satisfied with the outcomes because they said the children had recovered from fever and regained their normal health. The recommendation that was not followed was to return to the health facility for review. The parents felt that after completing the dose and the children recovered there was no need of taking the children back for review.

> "*I have not gone back because the child recovered and there was no need of going back.*" (Mother, Mbarara)

The parents were motivated to follow the recommended treatment in order to have a healthy family. They confessed that it is always their desire to have their children healthy but sometimes they do not know what to do. They shared their positive experiences on management of fever

with friends and neighbors. They also promised to advise other people to always give a complete dose when their children fall sick.

Like in the treatment of diarrhea and respiratory infections, most parents (6 in Luwero, 4 in Mbarara) were willing and able to give extra fluids and breast milk respectively to children with fever.

In summary, treatment of fever using a combination of fancidar and chloroqine was highly accepted in Luwero following the negotiations with the parents. This was a remarkable improvement from the first visits where no parent mentioned a combination of chloroquine and fancidar for the treatment of fever. Similarly, in the first visits no parent had given extra fluids to children with fever. However, in the follow up visits all the parents interviewed in Luwero had given fluids and were willing to continue with the practice. While in Mbarara during the first visits giving extra breast milk to a child with fever never featured, in the second visits all the 4 parents who indicated willingness to try were able to do so. UPHOLD should therefore promote distribution of a combination of fancidar and chloroqune in the communites, giving extra fluids and breast milk.

**9.0 Feces disposal**

The TIPs was intended to explore feasible practices related to proper feces disposal. Depending on what the researchers found during first visits, they discussed specific recommendations for each family and negotiated improvements. Researchers observed and asked about the type of latrine, condition of the path to the latrine, cleanliness of the latrine, smell, wiping materials, privacy, other uses such as storage or bathing, bugs, vermin, mosquitoes, hole or seat appropriate for child, light to use at night, and if people outside the family use it.

**9.1 Current situation, context and practices**

Researchers found that parents had good knowledge of proper disposal of human feces. Most mothers knew that contamination from feces – both child and adult feces - could cause illnesses like cholera. There were a few mothers, however, who believed that children's feces are less dangerous. Most believed that animal feces other than that of pigs, is harmless. Animal feces are used for several purposes such as smearing houses and baskets, and as manure in the

gardens.

All the families visited in all the 3 districts had latrines. However, the majority of the latrines (14) were reported to be in poor conditions or incomplete. Most of the latrines were constructed of mud and wattle and lacked roofs, walls and doors. In general, they required renovations and finishing. They also lacked wiping materials, a light to use at night and a cover for the latrine hole. All family members in households with latrines, except very young children up to about 3 to 5 years of age, were said to use latrines to defecate when they are at home. However family members complained of lack of privacy.

Asked about the problem with renovations or constructing others mothers accused their husbands of being negligent and lazy while the husbands complained of lack of money and time. Very young children did not use latrines even when they were out of nappies because people fear that they would fall into the pit. However, parents said that they bury children's feces or throw them into the pit latrine.

> "*Every body in this household uses the latrine. But when visitors and other outsiders come they fear using it because of broken walls hence no privacy*." (Parent, Arua)

When people are not near a latrine, such as when they are working in the fields, they defecate in the bush.

## 9.2 Outcome of agreements

### Table 7: Feces disposal by district

| Recommended Practice | Districts | Number Asked | Number who agreed to try | Number who tried | Number who planned to continue |
|---|---|---|---|---|---|
| 1. Avail wiping materials in the latrine. | Luwero | 5 | 4 | 3 | 3 |
| | Mbarara | 4 | 3 | 3 | 3 |
| 2. Put water and soap or other cleansing agent for hand washing near the latrine. | Luwero | 5 | 4 | 2 | 2 |
| | Mbarara | 4 | 2 | 2 | 2 |
| 3. Ensure safe disposal of feces of children below 5 years | Arua | 6 | 5 | 5 | 5 |
| | Mbarara | 4 | 4 | 3 | 3 |
| 4. Ensure privacy by providing some cover on the door a fiber mat door for the latrine | Luwero | 5 | 4 | 4 | 4 |
| | Mbarara | 4 | 4 | 4 | 4 |
| 5. Renovate the toilet by constructing the walls and the roofs properly | Arua | 3 | 3 | 0 | 0 |
| | Mbarara | 3 | 2 | 2 | 2 |
| 6. Smoke the latrine | Mbarara | 1 | 1 | 1 | 1 |
| 7. Provide lighting in the latrine at night. | Mbarara | 1 | 0 | 0 | 0 |
| 9. Regular cleaning of the latrine and surrounding | Arua | 3 | 3 | 1 | 1 |
| | Luwero | 1 | 0 | 0 | 0 |
| 10. Build a latrine and | Arua | 1 | 1 | 0 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| have all above 5 years old use it. | | | | | |
| **Totals** | | **50** | **4o** | **30** | **31** |

Most of the families whose latrines were in poor conditions had not attempted to renovate them or construct another one when the researchers returned for the follow up visit. Six families were asked in Arua and Mbarara, five (5) agreed to try and only two tried. The same constraints mentioned in the first TIPS were cited for failure to construct or renovate the latrines. Only one family in Mbarara had renovated its latrine by smearing it properly and constructed a strong floor using local materials. Another one in Arua had started sinking a pit to construct another toilet.

> "*We have been very busy with other work of sorting tobacco, but given time next week we shall finish drilling the hole for a pit latrine."*
> (Father, Arua)

Like in first visits, feces of young children who could not use the latrine either because they are too young or in the night was disposed of by either putting into the latrine or burying in the ground using a hoe. There was an improvement with regard to the practice because in Arua and Mbarara, ten were asked to try nine agreed to try and eight tried. Parents were able to encourage children to defecate in a specific location to make it easier to collect and dispose more consistently. The children were also advised to inform the parents whenever they felt like defecating so that the parents would show them what to do.

Ensuring privacy by providing some cover on the door using say a mat made out of dry banana fibres was fairly well accepted in Mbarara and Luwero. In the second TIPs nine families were asked to try ways of ensuring privacy for users of latrine in both districts, eight agreed to try and eight tried. This was an improvement since the first visits.

There was an increase in the number of families putting wiping materials in the latrine. These were mainly locally available materials such as soft leaves and rough papers. While in the first

visits no family in Luwero and Mbarara reported having wiping materials. In the follow up visits, 9 were asked, seven agreed to try, six tried and were willing to continue. Similarly, while in the first visits, no family in Luwero and Arua and only two in Mbarara had water and soap for hand washing. In the second visits four were asked to try in Mbarara, two agreed to try and actually tried. In Luwero, Five were asked, four agreed to try and two tried. In Arua, there was none during the first visit and in the second visit, only one had tried.

Given the nature of the latrines in the villages most parents only sweep the latrines using a broom. This is because it is not possible to wash the latrine floor when it is not cemented. It emerged from the discussions that family members use latrines more regularly when it is clean without bad smell.

*In one family in Mbarara in the first TIPS there was a latrine built with mad and wattle. The floor had only logs that were not covered with mad. It lacked a door, had no wiping materials and the hole was not covered. There was a jerry can of water for hand washing but without soap or other cleansing agent. The logs were rotting with feces and urine. There were a lot of flies and bad smell. In the negotiations they agreed to cover the logs with mud and smear the floor, cover the hole and avail wiping materials. In the follow up visit, researchers found that the logs had actually been covered and floor smeared with cow dung. The latrine hole was properly covered with a circular ring made of sticks and banana fibers with a handle. The wiping materials were placed on a stand made of a cassava stem with a bowel like top, which was woven with banana fibers and leaves. It was fixed in one corner of the latrine. The flies and bad smell had gone.*

In summary, the practices that were seemingly accepted that UPHOLD should promote in regard to proper feces disposal, were: availing wiping materials in the latrine, ensuring safe disposal of children's feces and ensuring privacy by providing some cover on the door. The challenge for stakeholders in public health promotion such as UPHOLD is the promotion of the practice of building new latrines and renovating old ones.

## 10.0 School Lunches

The TIPS on school lunch involved discussions on current practices regarding provision of lunch to pupils at school and possible strategies to ensure that all children get lunch at school. The ideas considered in the discussions were: organize community members to contribute food and prepare; ask pupils to bring snacks/food to school; ask community members/pupils to do piece of work to earn money to buy food and have community members to prepare; hire a cook to prepare food at school with funds from parents; and ask parents to give children money to buy snacks/food at school. Researchers negotiated these options with school management, teachers, Parent Teacher Association (PTA) members, other interested parents and pupils representatives.

### 10.1 Current situation, context and practices

The majority of pupils said that they go without lunch or other foods during the school day. Parents and pupils reported several reasons for this. Parents were unwilling or unable to pay money for schools to prepare lunch or to send children with packed lunches. To compound the issue, older pupils were unwilling to bring a packed lunch; they would rather show toughness to 'withstand the hunger' than look like young children carrying a lunch. Some pupils who did bring food left it in a tree or bush away from the school so other pupils would not see.

Two out of six schools visited provided porridge for lunch at a fee. In all cases, only a small proportion of parents had paid for this service. In two schools in Luwero, for instance, less than one-tenth of the parents paid the 1,500 shillings per term. In another school in Arua, where schools charged 8,000 shillings per child per term for a meal of posho and beans, parents said that the scheme had failed due to high costs.

All schools allowed pupils who lived nearby to go home for lunch. However, schools were not satisfied with this arrangement because pupils often returned late for the afternoon classes.

Very few of the children came with money to buy snacks that vendors sell at school such as pancakes, sugar cane, roasted groundnuts and cassava. The explanation was that the parents, most of whom are subsistence farmers, could not afford even that.

In light of the above conditions, researchers negotiated the following strategies: schools reduce the charges for lunch so more parents can contribute money ; encourage parents to give children money to buy snacks at school; and encourage parents to give children food/snacks to bring to school.

### 10.2: Outcome of agreements

**Table 8: School lunches**

| PRACTICES AGREED | NUMBER OF SCHOOLS AGREED | NUMBER OF SCHOOLS THAT TRIED |
|---|---|---|
| Parents to pay money for lunch. | 3 | 3 |
| Encouraging parents to give some little money to buy snacks like pancakes, g.nuts, and roasted cassava during lunch time around the school. | 1 | 1 |
| Encourage pupils to bring snacks e.g. roasted maize, roasted cassava, g.nuts etc. to school. | 3 | 2 |

The researchers visited each school after two weeks to learn what schools and parents had been able to try. In the three schools that had agreed to reduce the cost of lunch in order to increase the number of parents who would be willing and able to contribute money , two had organized meetings to discuss the issue with parents. The other had invited parents for a similar meeting. The parents in two schools had shown willingness to pay for porridge to be prepared at school. In one school, during the meeting when schools announced the reduction in charge, a number of parents paid 1,000 shillings on the spot. However, it commonly featured in the discussions that the government should intervene and provide lunch to all pupils in UPE schools.

In the one school that opted to encourage parents to send small amounts of money each day for children to buy snacks from vendors, it was reported that the number of such children coming increased.

In the three schools that decided to encourage parents to send children with food/snacks to school, in two, it was reported that the number of children bringing food/snacks increased. The food/snacks included roasted ground nuts, maize, cassava and potatoes.

*"We talked to them (children) telling them the importance of having something to eat for lunch. This was done in the school assembly when all the school children and teachers were there. Currently children bring sugar cane, paw paws and banana. This was easy because the children responded immediately. There is a teacher responsible for the children's store. He opens at lunch break and the children pick what they want"* (Headteacher, Kaiho primary school, Mbarara district)

"*Before some of us were not carrying food. So now that we carry food, we get into class in time after lunch. Because going back for lunch we would find when food is not ready"* (Pupil Biharwe Primary school)

*In Bongova primary school in Arua district, during the first visits, there was no any formal arrangement to provide lunch to pupils. Most children did not have lunch at school as they came from far away, they could not come from far away. Researchers negotiated the following in a meeting with the school management, school management committee/PTA members, teachers and pupils representatives:*

*1.To sensitize parents about the importance of providing lunch to pupils at school*

*2.To contribute one thousand shillings or a specified a mount of dried maize for porridge to be prepared at school*

*In the follow- up visits researchers found that a general PTA meeting had been convened to discuss among other things the issue of providing lunch to pupils at school. During the meeting all parents agreed to pay one thousand shillings per child per term for lunch to begin with porridge in the third term. The demonstrate the commitment of parents, some parents paid the charges on the spot. A copy of the minutes of the meeting was also seen by the researchers.*

In summary, convincing parents to support their children take lunch at school was initially very difficult because of the mistaken belief that it is the responsibility of government to provide lunch for the UPE children. The results of the second school visits demonstrated that, dialogue between parents and school managers can lead to fruitful results. This reflects in parents' appreciation of the gesture to reduce fees for lunch and their commitment to encourage and equip their children with school lunch in form of food/snacks or money.

**11.0: School hand washing and toilet use**

The TIPS on school hand washing and toilet use focussed on current practices in regard to hand washing and toilet use and ways to ensure proper hygiene among pupils in the schools. The recommended practices included: regular cleaning of toilets; setting up hand washing facilities

with water and soap or another cleaning agent like ash, sand or leaves; putting wiping materials in the toilet; and teaching pupils proper toilet use.

### 11.1 Current situation, context and practices

Researchers observed sanitation in six schools and discussed hygiene and sanitation with members of Parent Teacher Associations (PTAs), School Management Committees (SMCs), teachers and pupil representatives. Researchers observed that while all of the schools had latrines, the numbers of stances were inadequate for the number of pupils enrolled in four schools. Use of latrines was low, especially for young pupils, because there were no wiping materials and most of the toilets were dirty. Teachers blamed the lack of cleanliness on scarce water as some of the schools did not have bore holes within the compound or in the neighborhood.

Hand washing was rare. Four of the schools also lacked hand washing facilities. The few that were available were either not working well or did not have water or cleansing agents. Researchers negotiated for regular cleaning of toilets, setting up hand washing facilities with water and soap i.e. ash, sand and leaves. Teaching young pupils proper toilet use and putting wiping materials e.g. rough papers and leaves in the toilets.

### 11.2 Outcome of agreements

**Table 9: School hand washing and toilet use**

| Practices agreed | Number of schools agreed to try | Number of schools that tried |
|---|---|---|
| Regular cleaning of toilets | 3 | 3 |
| Setting up hand washing facilities with water and soap or other cleansing agents i.e. ash, sand, leaves etc. | 5 | 3 |
| Teaching young pupils proper toilet use | 5 | 5 |
| Putting wiping materials e.g. rough papers and leaves in the toilets. | 3 | 3 |

The researchers returned to the schools after two weeks to discuss experiences with the recommendations they agreed to try. All three of the schools that agreed to try more regular toilet cleaning had been willing and able to clean toilets better and more consistently. They did this by instituting new cleaning schedules and monitoring by school prefects, teachers on duty and head teacher. As a result the latrines were clean, washed with water and ash more regularly, and swept a couple of times in a day.

*"The checking of the latrines has helped us so much especially to see whether our children are the ones using or other people. This checking is done by teachers on duty prefects in incharge of health and teacher in charge of health. This routine checking has helped to reduce misuse of the toilets by our pupils and students from a neighbouring secondary school. (Teacher Bongova primary school in Arua)".*

Only three of the five schools that had agreed to set up hand washing facilities with a cleaning agent had been able to do this. The school management set up water for washing hands in jerry cans at the toilets with either soap or ash.

In the schools, teachers and the prefects were sensitizing the pupils especially the young ones on proper toilet use. This was done during the school assembly and in class during science lessons. The children were taken to the toilets for demonstrations on proper toilet habits. The school authorities were happy with the improved hygienic conditions in the schools and promised to it up.

All the three schools that agreed to place wiping materials in the toilets had been able to do so. They used papers from exercise books and text books and old newspapers. The materials were mainly collected by pupils from home and within the school.

Three out of the six schools also planned to repair the washing facilities that had broken down or buy new ones once the UPE grants were available.

In terms of school hygiene, the schools were able to institute more regular cleaning rotations of toilets, set up hand wash washing facilities with water and water and ash and put wiping materials in the toilets to keep clean. Although teachers preferred to get soap for hand washing, it was not feasible in most schools. They were able to get and keep ash without difficulty. Schools were not willing to construct tippy taps.

*The toilets in a school in Luwero District were in very unhygienic conditions. They were dirty, had no wiping materials and no facilities for washing hands. Young pupils did not use them properly and defecated on the floor. They cleaned their hands by wiping them on walls and doors. The toilets were not cleaned regularly or well. Teachers said that the lack of water nearby contributed to poor cleaning. As a result, many pupils simply did not use the toilets. Some used the bushes around the school which left bad smells and high risk of diarrheal disease. Through negotiations, teachers and pupils agreed that they would washed toilets more regularly and sweep twice a day. They also agreed to collect wiping materials and provide water and ash for hand washing. After only two weeks, researchers found a big change. The toilets were clean, washed with water every Friday and cleaned using brooms and ash twice a day. There were papers from used exercise books placed inside the toilets for use as wiping materials. However, the papers had been put on the floor so urine would flow and make them wet. The team advised them to improvise a jerry can, cut the top and use it for keeping the papers safely. Water for washing hands after visiting the toilet was also provided. And instead of using soap, they decided to use ash from their kitchen because it had no financial cost implications. As a result most of the children were using the toilet and washed their hands afterwards.*

## 12.0 Conclusions and recommendations

This section presents a number of conclusions and recommendations drawn from the key issues emerging from the trials.

1. Researchers found that families already practice some of the key child and adolescent health recommendations, although not always consistently. This was truer for practices that did not require resources from outside the family. In the first visit, for example, researchers found that mothers give extra breast milk, locally available fluids and foods to children with diarrhea. These

were, in most cases, available in the households and, if not, could be obtained at minimal costs. In the negotiations, participants were more willing to try recommendations that did not require financial resources. Programs should emphasize child and adolescent health practices that families can manage with their own resources.

2. In addition, participants were more willing to try the practices whose benefits they could easily understand and appreciate. For instance mothers readily accepted to give extra fluids because they could see that a child with diarrhea gets dehydrated as it passes stool more frequently. However, when they were told about the benefits of using a mosquito net this did not appeal to them as an urgent need. There is therefore need to emphasize the benefits of the key household practices to ensure that people understand their importance.

3. In the TIPS some useful local practices were found. Mothers were giving millet porridge to children with diarrhea. Instead of ORS sachets from the health centers the mothers were giving mixture of sugar and salt prepared locally at home. Ash was used in the households especially for washing utensils. People use soft leaves as wiping materials in the latrines instead of toilet papers that they can not afford. These local practices could be encouraged.

4. The trials established that there was a wide appreciation among the participants that they were given opportunity to provide a direct input into the selection of the practices they could try. The respondents further appreciated the follow up visit by the researchers to find out what actually happened. Most of the participants promised to continue with what they had tried out as well as sharing their experiences with neighbors and friends. It is thus important for program planners to emphasize follow ups in any intervention that aims at changing behavior. It should be a process and not a one stop activity

5. The trials showed that there was a general lack of effective participation of parents and communities in school activities. It was found that the majority of children do without lunch while at school. Negotiations on school lunch was the most difficult in the trials. The discussions in the schools revealed that parents had a very negative attitude towards contributing towards school activities especially with the advent of UPE. There is a perception that since primary education is now free it should be the responsibility of the government to provide even lunch to the pupils.

There is therefore need for a comprehensive sensitization of parents and communities about the importance of lunch for pupils at school. The recommended practices on school lunch and, school hand washing and toilet use require long term negotiations and follow up. Hence program planning should consider more follow up visits to the schools and communities.

UPHOLD should promote several child health practices with little modification, including:

- Extra feeding and fluids and recuperative feeding for children with diarrhea;
- Extra feeding and fluids and checking for fast breathing and immediate care seeking for children with respiratory problems.
- Setting up hand washing facilities at toilets and hand washing with ash;
- Renovation of toilets, encouraging family members to use toilets and setting up wiping materials;
- Parent-child communication on delaying sex and avoiding risky situations;
- ITN purchase through alternative financing mechanisms. ITN use must be targeted towards men who make household decisions and use nets if families own only one net.

In schools, UPHOLD should promote the following practices:

- Revised toilet cleaning schedules;
- Putting wiping materials in toilets;
- Setting up hand washing facilities with ash;
- Compromises between schools and parents on prices of lunches or encourage pupils to carry snacks to school if they can't bring lunches