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UGANDA
DEMOGRAPHIC
AND
HEALTH SURVEY
1988/1989

PRELIMINARY
REPORT

Ministry of Health

Demographic and Health Surveys
Institute for Resource Development/Westinghouse



The Demographic and Health Surveys Program (DHS) is assisting government and private agencies with the implementation of 60 surveys in developing countries. Funded primarily by the United States Agency for International Development (USAID), DHS is implemented by the Institute for Resource Development, Westinghouse, (IRD), with assistance from the Population Council. The main objectives of the project are: (1) to provide decisionmakers in the survey countries with a database and analyses useful for informed policy choices; (2) to expand the international population and health database; (3) to advance survey methodology; (4) to develop in participating countries the skills and resources necessary to conduct high quality demographic and health surveys.

Uganda
Demographic and Health Survey
1988/1989

Preliminary Report

Ministry of Health

In collaboration with
Ministry of Planning and Economic Development
Department of Geography, Makerere University
Institute of Statistics and Applied Economics, Makerere University

and

Demographic and Health Surveys
Institute for Resource Development/Westinghouse

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I. BACKGROUND

A. Introduction

The Uganda Demographic and Health Survey (UDHS) was conducted between September 1988 and February 1989 by the Ministry of Health, with the assistance of the Statistics Department of the Ministry of Planning and Economic Development and both the Department of Geography and the Institute of Statistics and Applied Economics at Makerere University. Financial and technical support for the survey was provided by the Demographic and Health Surveys Program at the Institute for Resource Development/Westinghouse (IRD) in Columbia, Maryland, through its contract with the U.S. Agency for International Development (USAID). In addition, UNICEF provided some of the vehicles used for the listing operation and field work.

This report is designed to provide some preliminary results for the 4730 women who were interviewed in the survey. A more complete presentation of results will appear in the main report which is expected to be completed later in the year. Final results may differ slightly from those presented here. Although differences are expected to be small, readers should view the results in this report with caution.

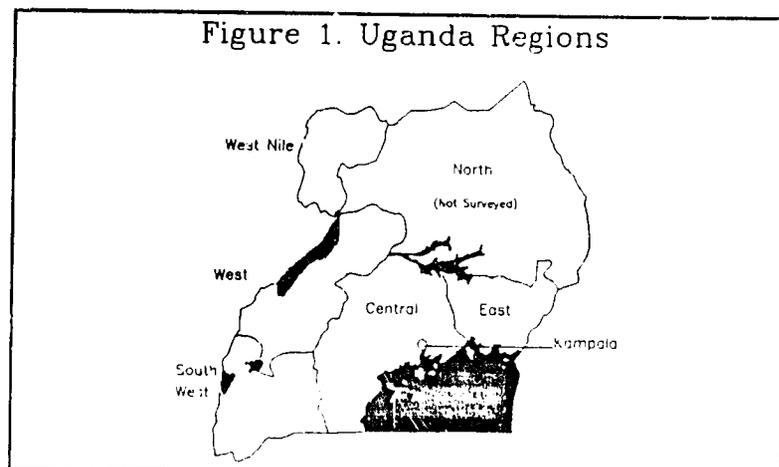
B. Objectives of the Survey

The primary objective of the survey is to provide data on fertility, family planning, childhood mortality, and basic indicators of maternal and child health. Information was also collected on background characteristics such as educational level and literacy, source of household water, and housing conditions. It is hoped that the survey data will form a useful background with which informed policy decisions can be made.

C. Sample Design

The UDHS sample is a stratified, weighted probability sample of women aged 15-49 selected from 206 clusters. Due to security problems at the time of sample selection, 8 of the country's 33 districts, containing an estimated 20 percent of the country's population, were excluded from the sample frame (see Figure 1). Primary sampling units in rural areas were sub-parishes, which, in the absence of a more reliable sampling frame, were selected with a probability proportional to the number of registered taxpayers in the sub-parish. Teams then visited each selected sub-parish and listed all the households by name of the household head. Individual households were

then selected for interview from this list. The South-Western region¹ and the area in Central region known as the Luwero Triangle were each oversampled to provide a sample size sufficient to produce independent estimates of certain variables for these two areas. Figures for Luwero Triangle are shown separately in this report.



Because Ugandans often pay taxes in rural areas or in their place of work instead of their place of residence, it was not possible to use taxpayer rolls as a sampling frame in urban areas. Consequently, a complete list of all urban areas known as Resistance Council Ones (RC1s) was compiled and a sampling frame was created by randomly selecting 200 of these units with equal probability. The households in these RC1s were listed and 50 RC1s were selected with probability proportional to size. Finally, 20 households were then randomly selected in each of the 50 RC1s for a total of 1000 urban households.

Altogether, 4730 women aged 15-49 were interviewed in the UDHS-161 in West Nile, 865 in Eastern, 1392 in Central, 166 in Western, 1619 in South-Western, and 527 in Kampala.

D. Questionnaires

Three questionnaires were used for the UDHS--the household questionnaire, the individual woman's questionnaire, and the service availability questionnaire. The household questionnaire was used to list all usual members of the household and their visitors together with information on their age and sex, as well as information on the fostering of children under 15. In addition it was used to identify women eligible for interview with the individual questionnaire, namely, those aged 15-49 who slept in the household the night before the household interview, whether they normally lived there or were visiting. These women were interviewed with the individual questionnaire, which contained questions on fertility, family planning and maternal and child health. The service availability questionnaire collected information on family planning and health services close to the selected areas and was completed for each rural cluster and

¹ Regions are arbitrarily defined for the purpose of this report according to the boundaries in Figure 1.

once for each urban area.

The household and the individual questionnaires were translated into four languages: Luganda, Lugbara, Runyankole-Rukiga, and Runyoro-Rutoro. Luganda questionnaires were used in the Eastern Region, where there are a number of vernaculars and most people can speak Luganda. The translated questionnaires were pretested in October 1987 by interviewers who took part in a two-week training course.

E. Training and Fieldwork

A three-week training course for the main survey took place in September, 1988. Fifty-six interviewers, six field editors and six supervisors took part in the survey. All interviewers were women although some of the supervisors and field editors were men. Field staff were recruited from the Ministries of Health and Planning and from among people who answered advertisements in the national press and passed selection interviews. A major qualification of the interviewers was a good command of various vernacular languages in addition to those covered by the four translations, as well as educational achievement. All field staff had at least some senior secondary school education and several were university graduates. Senior survey staff came from the Ministries of Health and Planning, as well as Makerere University.

Field work took place between the end of September, 1988 and the middle of February, 1989. Field staff were organized into teams according to language, each of which had a vehicle and a driver. Team supervisors and field editors conducted the height and weight measurements of children under 5, using interviewers as assistants.

F. Data Processing

Completed questionnaires were sent to the data processing room at Makerere University where data entry and machine editing proceeded concurrently with field work. Five desktop computers and the DHS package program, ISSA, were used to process the UDHS data. Of the households sampled, 5101 households were successfully interviewed, a completion rate of 91.3 percent. A total of 4857 eligible women were identified in these households, of which 4730 were interviewed, a completion rate of 97.4 percent. Data entry and editing were completed a few days after field work ended.

II. RESULTS

A. Mortality and Fertility

All women interviewed in the UDHS were asked to report the total number of sons and daughters they had given birth to during their lives. They were also asked to provide a complete birth history, giving the date of birth, sex, survival status and, if appropriate, the age at death of each child. Interviewers were trained in various techniques to elicit the information when respondents were not sure of the dates.

Table 1 shows that fertility in Uganda is high; by the end of childbearing, women have, on average, more than seven children. By the time women are aged 20-24, they have given birth to almost two children, on average, and by the time they reach age 30-34, they have had an average of five children. Comparison of the average number of children ever born to women 45-49 (7.8) with the total fertility rate (TFR) of 7.3 children per woman implies that fertility may have declined somewhat recently, since the TFR is a measure of the number of children a woman would have if she were subject to the prevailing fertility rates throughout her reproductive life. However, comparison of the TFR with that found in the 1969 census, when the TFR was estimated to be 7.1, implies that fertility has remained more or less constant in the recent past. Detailed analysis of fertility patterns may shed more light on this topic.

Table 1. For All Women, the Mean Number of Children Ever Born and Surviving, Proportion Dead, and Fertility Rates for Five Years Preceding Survey, by Age, Uganda, 1988/89 and 1969

Age of Woman	Mean Number of:			Age Specific Fertility Rate	Weighted Number of Women	Proportion Dead 1969 Census
	Children Ever Born	Children Surviving	Proportion Dead			
15-19	0.40	0.34	0.144	0.19	1159	0.135
20-24	1.86	1.53	0.178	0.33	984	0.162
25-29	3.65	3.01	0.176	0.32	559	0.192
30-34	5.04	4.10	0.188	0.27	620	0.226
35-39	6.79	5.55	0.182	0.22	459	0.255
40-44	7.24	5.76	0.204	0.10	345	0.305
45-49	7.77	5.97	0.231	0.04	304	0.348
Total	3.49	2.83	0.191	7.30	4730	

Of the average of 3.5 children ever born to women aged 15-49, 2.8 were still alive at the time of interview. Thus, almost 20 percent of children born to these women had died by the time of interview. The proportion of children who died increases with each successive age group of women, which reflects the longer average exposure time to the chance of dying for children of older women and possibly a decline in infant and childhood mortality over time.

Comparing data on proportions dead among children ever born as reported in the 1969 census (the hitherto most up to date source of data on a national level on mortality in Uganda) and the UDHS, it appears that mortality has remained high. The proportions dead among children born to younger women (under the age of 25) have risen slightly since 1969, while the proportions dead among children of older women have declined substantially. It should be noted, however, that the 1969 data include the whole of northern Uganda, whereas the UDHS excludes most of the Northern region. It is suspected that mortality rates are higher in northern Uganda than in the rest of the country, as was the case in 1969. Presumably the proportions dead found in the UDHS would have been higher than those reported here if the survey had included the whole of Northern Uganda. More detailed mortality statistics will be presented in the final report.

B. Reproductive Intentions

Fertility intentions of Ugandan women were investigated in the UDHS by asking women if they wanted to have another child and, if so, how soon. Table 2 presents results on this topic. Among married women, 23 percent do not want any more children and 33 percent want to wait at least two years before having another child. This implies that well over half of married Ugandan women might be in need of family planning either to limit or to space births.

There are large differentials in fertility intentions by age. Older women are much more likely to want no more children than younger women and, as might be expected, younger women are much more likely to want another child soon than older women. What is somewhat surprising, however, is the fact that over 40 percent of women under age 30 want to wait at least two years before having another child.

Table 2. Percent Distribution of Currently Married Women Aged 15-49 by Desire for Children, According to Age, Uganda, 1988/89

Age	Want No More	Want More Later*	Want More Soon**	Want More But Don't Know When	Don't Know If Want More	Total Percent	Weighted No. of Women
15-19	2.0	43.7	47.9	3.1	3.3	100.0	424
20-24	4.4	48.4	43.3	2.3	1.6	100.0	708
25-29	12.5	41.9	41.1	1.6	3.0	100.0	705
30-34	25.7	30.6	36.8	2.4	4.5	100.0	506
35-39	41.3	17.1	34.7	2.9	4.0	100.0	362
40-44	57.8	9.3	27.7	0.9	4.4	100.0	252
45-49	77.3	0.4	20.5	0.4	1.5	100.0	223
Total	22.8	33.4	38.6	2.1	3.1	100.0	3180

* Want another child 2 or more years from now

** Want another child within 2 years from now

C. Immunisation of Children

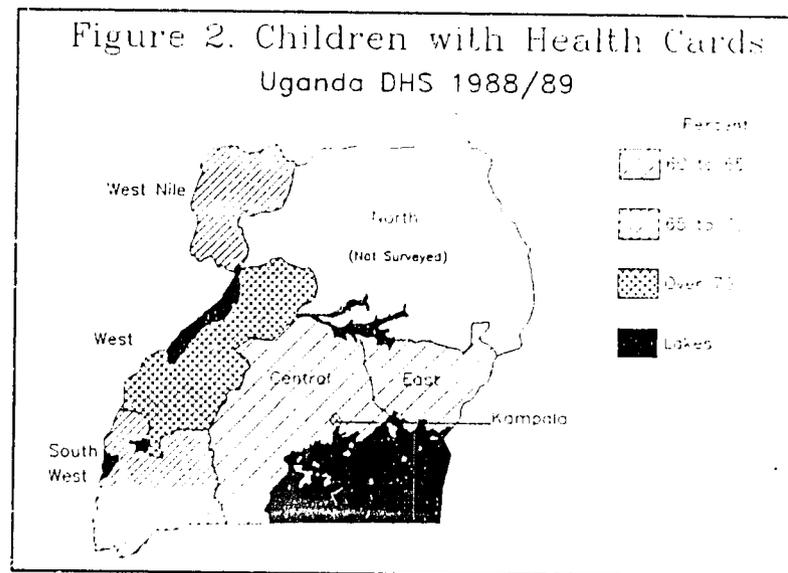
In the UDHS, women who had children in the five years prior to the survey were asked whether they had health cards for those children and, if so, to show them to the interviewer. For those who could produce health cards, interviewers recorded the dates on which the following vaccinations were given: BCG, first, second and third doses of both DPT and polio, and measles.

Data presented here exclude children less than one year of age at the time of interview since they are not expected to be fully immunised until at least nine months of age. Children without health cards, a third of the children in the sample, are not considered in this table. As health cards are routinely given out when a child is immunised, it must be assumed that the level of immunisation amongst these children is considerably less than among those with health cards. A good indication of immunisation coverage, therefore, is the proportion of children reported to have health cards. Figure 2 shows this information by region.

Table 3 shows that overall, two-thirds of Ugandan children have health cards and that approximately 60 percent of these health cards were seen by the interviewers. Therefore, data on specific immunisations received refer to the 42 percent of children for whom health cards were seen.

One can see from the table that almost all children for whom a health card was produced have been vaccinated against BCG. There are almost no variations by background characteristics, with about 95 percent or more of children in each group being vaccinated for BCG.

Coverage for DPT1 and Polio1 is also high, at almost 95 percent overall and few differences by background characteristics. However, approximately 20 percent of children who receive DPT1 do not receive DPT2 and approximately 25 percent of DPT2 receivers do not complete the course with DPT3. There is a similar drop off in coverage with the three doses of polio (Figure 3). Consequently, only 55 percent of children with cards are completely immunised against diphtheria, pertussis (whooping cough), tetanus and polio. There are large regional differences; only about 40 percent



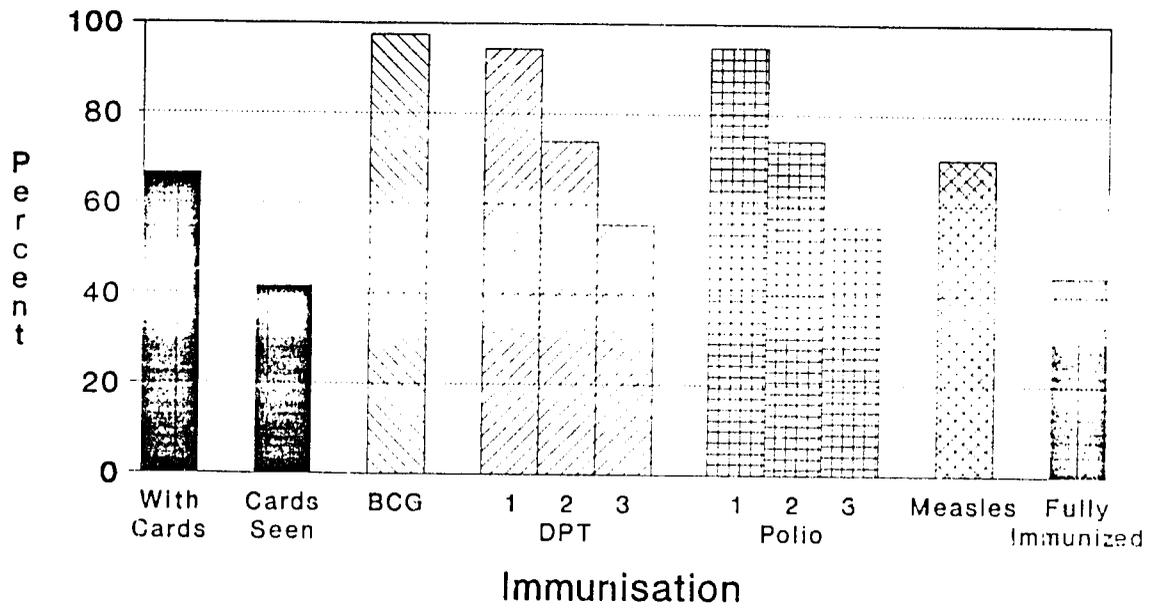
of children in West Nile and the East receive all three doses of DPT, compared to 73 percent of children in Kampala and 67 percent of children in South-West. Course completion improves considerably by level of education²; 50 percent of children of women with no education completed the full course of DPT immunisation, compared

Table 3. Percent of All Children 1-4 Years of Age with Health Cards and with Health Cards Seen by the Interviewer, and, Among Those with Health Cards Seen, the Percent Who Received Specific Immunisations by Background Characteristics, Uganda, 1988/89

	Percent With Health Cards	Percent With Health Cards Seen	Among Children With Health Cards Seen, Percent With:							Fully Immunised	All Children 1-4	
			BCG	DPT1	DPT2	DPT3	Polio 1	Polio 2	Polio 3			Measles
AGE OF CHILD												
12-23 months	65.1	45.2	97.4	93.2	74.6	55.6	93.8	75.6	56.2	66.9	44.4	1226
24-35 months	68.8	44.9	97.2	95.4	74.2	57.2	95.9	75.2	57.7	71.3	46.6	1251
36-47 months	66.0	38.3	97.8	95.8	73.6	55.1	95.6	73.4	54.3	73.5	43.2	1474
48-59 months	66.7	38.5	97.3	92.2	72.8	53.7	93.7	72.0	52.3	69.4	43.6	1107
AGE OF MOTHER												
Less than 20	61.3	40.1	99.0	86.1	58.4	41.7	85.1	61.8	42.8	48.8	29.8	393
20-29 years	68.8	41.6	97.3	95.0	75.4	59.4	95.5	75.9	59.0	72.0	47.4	2737
30 or more	64.6	42.1	97.3	94.8	74.8	52.6	95.7	74.2	52.6	72.2	43.3	1928
RESIDENCE												
Urban	81.3	44.3	96.6	93.4	80.1	70.3	93.4	81.1	70.6	68.0	56.2	484
Rural	65.1	41.4	97.5	94.4	73.2	53.8	95.0	73.4	53.6	70.6	43.2	4574
REGION												
West Nile	69.3	49.2	94.3	95.5	54.5	38.6	93.2	54.5	39.8	73.9	33.0	294
East	64.1	34.0	97.1	91.3	63.6	40.0	92.9	65.3	41.8	62.7	30.8	1395
Central	63.1	35.8	97.8	92.9	74.9	56.1	94.0	73.8	55.2	71.0	44.8	1251
West	71.7	58.0	98.9	96.7	77.5	57.1	97.3	78.0	56.0	73.6	46.2	630
South-West	66.6	48.7	97.9	96.5	82.6	66.8	96.5	82.6	65.7	74.1	54.5	1233
Kampala	82.3	44.3	94.5	92.0	80.1	73.1	92.5	81.6	73.6	66.2	56.2	255
Luwero Tri.	67.0	43.0	97.7	94.7	77.5	60.7	95.5	78.0	61.0	74.7	51.5	523
EDUCATION OF MOTHER												
No Education	62.5	39.9	97.4	94.0	70.7	50.3	94.1	70.3	50.6	70.5	40.2	2094
Some Primary	65.3	40.6	96.6	94.5	74.6	56.1	96.0	75.8	55.5	69.4	43.9	2070
Primary Compl.	75.1	47.8	98.5	95.2	74.5	59.8	95.0	75.5	60.1	70.3	50.1	464
Middle	81.8	48.1	99.6	91.4	83.5	65.4	90.7	81.7	64.3	70.9	54.1	308
Higher	87.9	49.6	100.0	98.1	80.8	79.0	98.1	81.7	77.6	79.2	66.5	122
Total	66.6	41.7	97.4	94.3	73.9	55.5	94.8	74.2	55.3	70.3	44.5	5058

² For this report, women who completed Junior 1 were tabulated with women who completed primary education. Those with Junior 2 or 3 were tabulated with those who completed secondary education up to level 4 ("Middle"). Women with more than secondary 4 education were tabulated in the Higher category, which also includes women who went on to complete at least one year of vocational training after secondary 4 or who completed at least two years of such training after secondary 3.

Figure 3
Immunisation Status of Children
1-4 Years Old



Note: Data on immunisations received refer to children with cards seen.

Uganda DHS 1988/89

to almost 80 percent of children of women with "Higher" education. Coverage rates for the three rounds of polio vaccine are almost identical to those for DPT.

Overall, 70 percent of children with health cards have been vaccinated against measles. Perhaps because this vaccination requires only one dose, measles coverage rates vary less by background characteristics than for other immunisations. Children of women with higher education have a coverage of approximately 80 percent, against about 70 percent for the other groups. By region, the East has the lowest coverage (63 percent) and surprisingly, Kampala has the second lowest coverage (66 percent).

Children who are fully immunised are defined as those having all the basic childhood vaccinations offered by the Ministry of Health. Overall, 45 percent of children whose health cards were seen, received the full course of vaccines. This figure

should be considered the upper limit of the proportion of children fully immunised. If one assumes that the children who do not have health cards (about one third) have not received any immunisations, the proportion fully immunised would drop to 30 percent, which could be considered the lower limit.

Completion rates by age groups of children are very similar, indicating no major change in the EPI coverage in recent years. While there is not much difference by age of the child, the age of the mother does have an influence. Teenage mothers are less likely to have their children completely immunised than older women, 30 percent for teenagers compared to almost 50 percent for women aged 20-29. As expected, children living in urban areas have more complete immunisation histories than rural children. The urban-rural differences are due entirely to the fact that rural children are less likely to receive second and third doses of DPT and polio vaccines than urban children; the proportion receiving BCG and measles vaccines are almost identical for rural and urban children. There are also considerable differences by region. Only 31 percent of children in the East and 33 percent of children in West Nile receive the complete course of immunisations, compared to 56 percent of children in Kampala and 55 percent of children in the South-West. By level of education there is a monotonic rise as education increases, from 40 percent full coverage for the children of women with no education to 67 percent coverage for women with higher education.

D. Diarrhoea in Children

One of the most important causes of illness and mortality amongst young children in Sub-Saharan Africa is diarrhoea; in the UDHS, women were asked whether their children under the age of five had suffered from diarrhoea in the 24 hours or the two weeks preceding the survey and what treatment, if any, they sought for the diarrhoea. Table 4 shows the prevalence of diarrhoea by background variables and the percent of these children who received oral rehydration therapy. Just over 20 percent of the children were reported to have had diarrhoea in the two weeks preceding the survey. The only major differences by background variables are that diarrhoea is more prevalent among children of teenaged mothers (33 percent) and less prevalent among children of women with higher education (12 percent).

Only nine percent of children experiencing a recent episode of diarrhoea were treated with oral rehydration therapy (ORT). Mothers in Kampala are twice as likely than average to use ORT, while mothers with higher education are almost three times more likely to do so. Clearly, the Control of Diarrhoeal Diseases (CDD) Programme, the primary objective of which is to increase use of oral rehydration to 60 percent, has a long way to go in order to fully achieve its potential for reducing deaths among young children due to diarrhoeal disease in Uganda.

Table 4. Among Children Under 5 Years of Age, the Percent Having Diarrhoea in the 24 Hours and the Two Weeks Preceding the Survey and Among the Latter, the Percent Receiving Oral Rehydration Therapy (ORT) by Background Characteristics, Uganda, 1988/89

Background Characteristics	Percent with Diarrhoea		Percent with Diarrhoea Receiving ORT**	Weighted Number of Children	No. of Children With Diarrhoea in Past 2 Weeks
	In Past 24 Hours	In Past 2 Weeks*			
AGE OF MOTHER					
Less than 20	19.8	33.3	8.6	404	135
20-29	11.9	20.8	10.4	2816	585
30 or more	11.4	19.9	6.6	1987	395
RESIDENCE					
Urban	9.8	17.9	19.0	434	78
Rural	12.6	21.7	8.1	4773	1036
REGION					
West Nile	12.8	20.7	8.1	304	63
East	18.4	29.4	5.6	1441	424
Central	9.0	16.9	11.8	1278	216
West	11.6	20.2	7.8	651	131
South-West	9.6	18.0	10.1	1276	230
Kampala	10.2	19.4	21.6	257	50
Luwero Tri.	8.2	17.7	17.0	527	94
EDUCATION OF MOTHER					
No Education	12.1	20.4	6.6	2162	441
Some Primary	13.1	23.1	7.7	2130	492
Primary Comp.	12.5	22.0	16.7	477	105
Middle	12.5	19.2	16.4	315	61
Higher	2.8	11.9	26.9	124	15
Total	12.3	21.4	8.9	5207	1114

Note: As reported by mothers of children aged 1-59 months

* Includes children with an episode of diarrhoea in the past 24 hours.

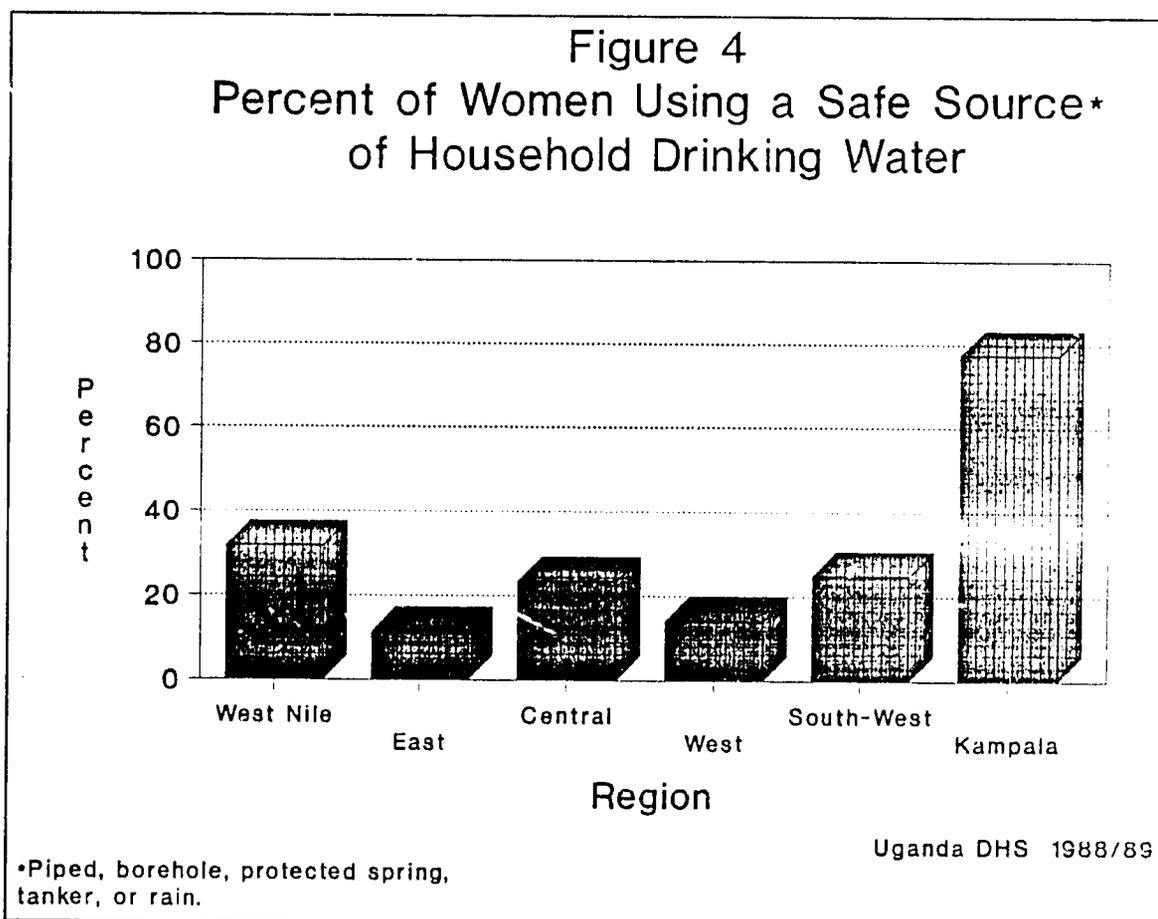
** Includes children given a home prepared salt-sugar solution as well as those given a solution prepared with an ORS packet.

E. Water and Sanitation

A major determinant of the prevalence of diarrhoea in a population is the cleanliness of the water and the sanitary facilities; the survey included questions on main sources of drinking water and on toilet facilities for the respondent's household.

Less than a quarter of the respondents derive their drinking water primarily from what is usually considered a safe source³ (piped, borehole, protected spring, tanker or rain). The majority--over three-quarters--obtain water from wells, rivers or springs (Table 5). In urban areas, however, the situation is reversed--almost three quarters of women obtain their drinking water from safe sources.

The effects of borehole drilling programmes are clearly seen. Of the areas surveyed, West Nile has the best access to borehole water, while women in the East, West, and South-West have little access to boreholes. The population of Luwero Triangle enjoys significantly better access to borehole water than those in Central region overall. Water piped into residences or public taps is almost nonexistent outside of Kampala. The South-West has the greatest access to protected springs, closely followed by Kampala, but few springs appear to be protected in other parts of the country. As expected, women in Kampala have greatest access to safe water, followed by those in West Nile, with women in East having the least access (Figure 4).



³ Of course, these sources can also be contaminated with disease-causing organisms.

By education of mother there is no variation in use of boreholes or protected springs, although better educated women are much more likely to benefit from a piped water service, since educated women are more likely to live in Kampala. Nevertheless, only just over 50 percent of women with higher education obtain their drinking water from a piped supply and only one-third have piped water in their house. Women who have not completed primary education have minimal access to piped water.

Table 5. Percent Distribution of All Women by Source of Household Drinking Water, by Background Characteristics, Uganda, 1988/89

Background Characteristics	Piped Into Residence/Yard	Public Tap	Bore-hole	Well	River, Lake or Spring	Protected Spring	Tanker Truck or Rain	Per-cent	Weighted Number of Women
RESIDENCE									
Urban	25.2	28.7	1.3	17.6	9.3	15.2	2.5	100	542
Rural	0.3	1.8	5.7	45.9	37.3	7.8	1.1	100	4188
REGION									
West Nile	0.0	0.0	26.1	24.8	43.5	5.0	0.6	100	265
East	2.9	2.6	2.6	52.4	36.2	3.2	0.1	100	1305
Central	1.6	4.9	9.1	42.0	34.6	4.9	2.9	100	1177
West	0.0	0.0	5.7	56.6	29.2	7.2	1.3	100	548
South-West	1.2	4.0	0.1	37.0	38.3	18.8	0.7	100	1139
Kampala	26.8	32.1	1.5	15.2	7.2	14.4	2.8	100	296
Luwero Tri.	1.7	1.0	14.2	40.7	35.9	3.4	3.1	100	491
LEVEL OF EDUCATION									
No Education	0.7	2.7	4.8	45.4	37.4	7.8	1.1	100	1788
Some Primary	1.5	4.3	4.5	44.5	35.3	8.7	1.2	100	2048
Primary Comp.	5.1	6.9	7.9	37.4	30.4	11.0	1.3	100	410
Middle	12.9	12.0	8.4	33.4	22.8	8.9	1.6	100	367
Higher	33.4	20.0	5.1	16.2	10.3	10.6	4.3	100	118
Total	3.2	4.9	5.2	42.7	34.1	8.6	1.3	100	4730

Data on toilet facilities (Table 6) show that approximately 80 percent of women rely on latrines or pit toilets and about 15 percent have no facilities. Only 4 percent of women report having flush toilets in their households. Women living in urban areas such as Kampala, and those with more education are more likely to have flush toilets, while women living in East and West Regions are more likely not to have any toilet facilities at all.

Table 6. Percent Distribution of Women by Type of Toilet Facilities in Household, by Background Characteristics Uganda, 1988/89

Background Characteristics	Flush Toilet	Latrine or Pit	Other	No Facilities/Not Stated	Total Percent	Weighted Number of Women
RESIDENCE						
Urban	26.9	71.0	0.4	1.7	100	542
Rural	0.5	81.9	1.0	16.6	100	4188
REGION						
West Nile	0.6	82.0	9.3	1.1	100	265
East	2.4	71.8	0.2	25.6	100	1305
Central	1.1	89.6	0.7	8.6	100	1177
West	0.3	76.5	1.5	21.6	100	548
South-West	2.3	86.3	0.1	11.3	100	1139
Kampala	30.9	68.1	0.2	0.6	100	296
Luwero Tri.	1.8	84.1	0.1	14.0	100	491
EDUCATION						
No Education	0.7	76.6	1.3	21.3	100	1788
Some Primary	1.5	83.4	1.0	14.1	100	2048
Primary Comp.	5.8	88.0	0.3	5.9	100	410
Middle	11.9	85.1	0.2	2.8	100	367
Higher	45.8	53.2	0.0	1.0	100	118
Total	3.5	80.6	1.0	14.9	100	4730

F. Prenatal Care and Assistance at Delivery

The UDHS collected information on the health care received by women during pregnancy and at the time of delivery. Results are shown in Table 7. Respondents who had births in the five years preceding the survey were asked whether they had received a tetanus toxoid injection during pregnancy. Immunity against tetanus is passed on to the baby and protects the child against neonatal tetanus, one of the most common causes of neonatal mortality. For about 56 percent of births in the past five years, the mother had received this injection. Younger women and especially urban women are more likely to receive this injection--three quarters of urban births occur to mothers who have received a tetanus toxoid injection, compared to just over half of rural births. Outside Kampala, tetanus immunisations are more common in the East Region, followed by West Nile. By education of mother, there is a clear trend; coverage increases with the level of education, from 50 percent among births to mothers with no education to 75 percent among births to mothers with higher education.

Table 7. For Births in the 5 Years Preceding the Survey, Percent Whose Mothers Received Tetanus Toxoid, Prenatal Care From a Doctor, Nurse/Midwife, or Birth Attendant, and Assistance at Delivery by a Doctor, Nurse/Midwife, or Birth Attendant, by Background Characteristics, Uganda, 1988/89

Background Characteristic	Received Tetanus Toxoid Injection	Prenatal Care From:			Assistance at Delivery From:			Number of Births
		Doctor	Nurse/Midwife	Trad. Birth Attendant	Doctor	Nurse/Midwife	Trad. Birth Attendant	
AGE OF MOTHER								
Less Than 20	60.8	14.5	78.4	0.7	4.9	43.3	7.4	447
20-29	57.0	10.8	76.1	0.5	2.8	37.4	5.8	2768
30 or Over	52.9	10.7	74.4	0.7	2.3	30.2	7.2	1834
RESIDENCE								
Urban	75.7	29.4	65.9	0.1	12.1	67.5	2.4	491
Rural	54.7	9.1	76.8	0.7	1.8	31.8	6.9	4557
REGION								
West Nile	58.6	11.8	54.7	2.4	1.2	17.1	22.9	279
East	69.1	7.0	88.1	0.6	1.9	45.4	4.8	1394
Central	48.1	20.0	70.7	0.2	3.8	47.6	7.2	1275
West	45.3	3.9	70.2	1.3	0.5	17.2	6.6	625
South-West	48.0	4.7	77.7	0.5	1.2	16.9	4.7	1207
Kampala	81.1	34.5	60.9	0.0	17.4	68.8	1.3	269
Luwero Tri.	51.1	16.5	72.1	0.1	4.5	38.5	6.7	529
EDUCATION OF MOTHER								
No Education	49.8	6.8	74.4	1.0	1.1	22.0	7.9	2091
Some Primary	56.3	10.3	78.3	0.5	2.9	37.9	6.0	2077
Primary Comp.	65.0	17.1	78.7	0.4	3.5	54.5	5.4	450
Middle	73.1	23.5	70.8	0.0	8.0	66.4	1.8	314
Higher	75.1	44.4	53.7	0.0	16.4	70.1	4.2	117
Total	55.8	11.1	75.7	0.6	2.8	35.3	6.4	5048

Table 7 shows that prenatal care in Uganda is most likely to be given by a nurse or a midwife. For more than three-quarters of recent births, the mothers were checked by this group. Doctors provide prenatal care for only 11 percent of births overall, although there is great disparity on a regional basis. In Kampala, for 35 percent of births, women receive prenatal care from doctors, whereas the figure is less than 5 percent of births in Western and South-Western. Births to well-educated women are much more likely to benefit from prenatal care from a doctor--44 percent compared to 7 percent for births to those with no education.

Over half of the births in the survey area are delivered with no assistance from trained personnel. Over a third (35 percent) are delivered by nurses or midwives, 6 percent by traditional birth attendants and only 3 percent by doctors, although doctors deliver 17 percent of children in Kampala and 16 percent of the children of women

with higher education. Traditional birth attendants (TBAs) play an important role only in West Nile, where almost one quarter of births are delivered by TBAs. The proportion of births attended by any kind of trained personnel varies widely from 88 percent in Kampala to 23 percent in South-West. There are also great disparities by level of mother's education. More than 90 percent of births to women with higher education are attended by trained personnel, compared to just over 30 percent for women with no education.

G. Family Planning Knowledge and Use

Most women in Uganda have heard of at least one method of family planning (Table 8) and there is little difference in knowledge between married women and all women. Over 80 percent of all women have heard of a method of contraception and over 75 percent have heard of a modern method. The contraceptive pill (66 percent) is the most widely known modern method, followed by female sterilisation, injections, condoms, and the IUD. Less than 10 percent have heard of male sterilisation. Women are more likely to have heard of modern methods than traditional methods such as periodic abstinence (43 percent) and withdrawal (20 percent).

Table 8. Among All Women and Currently Married Women, the Percent Knowing Any Contraceptive Method, Knowing a Source for Any Method, Ever Using Any Method, and Currently Using Any Contraceptive Method, by Method, Uganda 1988/89

Method	Percent Who Know Method ^d		Percent Who Know Source*		Percent Who Ever Used		Percent Currently Using	
	All	CM	All	CM	All	CM	All	CM
Any Method	81.9	84.0	73.7	76.0	20.9	21.5	5.5	4.9
Any Modern Method	76.5	77.9	70.5	72.2	7.4	7.0	2.7	2.5
Pill	66.4	67.7	53.2	54.0	5.5	5.0	1.4	1.1
IUD	20.2	21.1	15.8	16.2	0.5	0.5	0.2	0.2
Injection	39.7	40.8	34.7	35.2	1.3	1.3	0.4	0.4
Diaphragm/Foam	11.3	11.6	8.8	8.7	0.2	0.2	0.0	0.0
Condom	32.5	31.1	21.7	20.7	0.8	0.7	0.0	0.0
Female Sterilisation	59.1	62.6	51.4	59.7	0.7	0.8	0.7	0.8
Male Sterilisation	8.2	8.8	7.5	8.2	0.0	0.0	0.0	0.0
Any Traditional Method	58.6	62.4	34.3	35.7	16.5	17.4	2.9	2.4
Periodic Abstinence	42.6	45.0	31.4	33.1	13.1	13.6	2.2	1.6
Withdrawal	20.5	22.0	0.0	0.0	4.2	4.8	0.3	0.3
Other	31.1	33.4	0.0	0.0	2.6	3.0	0.4	0.4

All - All women

CM - Currently married women

* For periodic abstinence, this refers to a source of information or instruction.

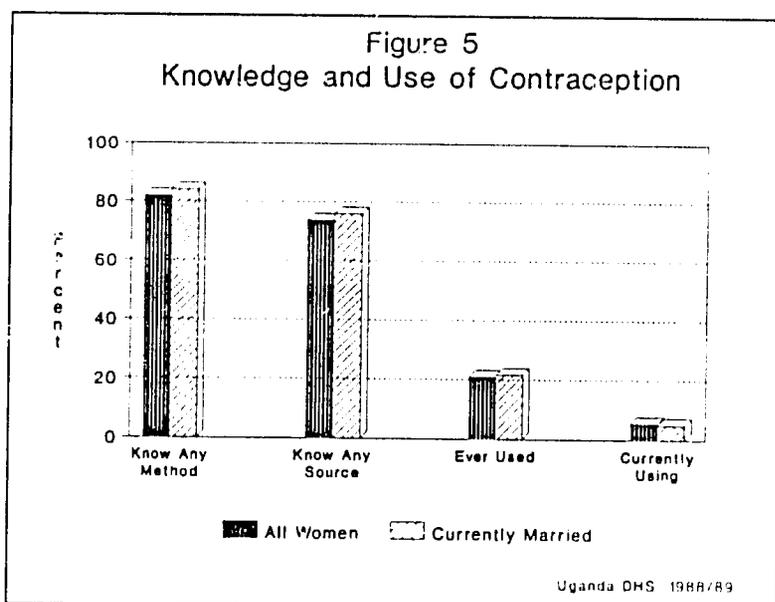
Knowledge of places where contraceptive methods can be obtained is a precondition for their use. Table 8 indicates that almost three-quarters of Ugandan women know where they could obtain a contraceptive method if they wanted to use it. Over half of all women know where they can obtain contraceptive pills or female sterilisation, but only 35 percent know a source of injections, 22 percent a source of condoms, and 16 percent a source of IUDs. Only 8 percent know of a source of male sterilisation. These figures closely mirror those for knowledge of the methods themselves, indicating that almost all women who know specific methods also know a source for obtaining them.

While 21 percent of all women report having ever used a method of contraception, only 7 percent have ever used a modern method, compared to 17 percent who have used a traditional method. The pill (6 percent) has been the most widely used modern method, while periodic abstinence (13 percent) has been the most widely used traditional method.

Only 6 percent of all women report that they are currently using contraception. Periodic abstinence and the pill are the main methods used, accounting for 40 and 25 percent of all users, respectively. Data on current use of condoms are discouraging. Although one third of respondents say they have heard about condoms, only 1 out of 4730 respondents said she was a current user, and less than 1 percent said they had ever used them. This

is in spite of the fact that millions of condoms have been distributed in Uganda in the last year in an attempt to curb the spread of Acquired Immune Deficiency Syndrome (AIDS). Condoms have traditionally been associated with use with someone other than a regular partner which could lead to reluctance on the part of respondents to discuss use of condoms with interviewers. A survey of Ugandan men might be a better way of getting reliable data on condom use. Figure 5 summarizes data on knowledge and use of family planning.

Table 9 shows the percentage of currently married women using contraception by several background characteristics. Current users are concentrated in urban areas; in Kampala, one quarter of married women are using contraception and in all urban



areas combined, the figure is 18 percent. By contrast, in rural areas only 4 percent of women are using contraception and the figure declines to 2 percent for modern methods.

There is also marked variation in contraceptive use by level of education. Use rises steadily as education increases, from only 2 percent of women with no education to 34 percent of women with higher education. Among the latter, almost 25 percent are using a modern method of contraception.

Table 9. Percent of Currently Married Women Currently Using Any Contraceptive Method and Any Modern Method by Background Characteristics, Uganda, 1988/89

Background Characteristic	Any Method	Any Modern Method	Weighted No. of Women
AGE			
Less than 20	1.7	1.0	424
20-29	3.5	1.4	1413
30 or more	7.3	4.1	1344
RESIDENCE			
Urban	18.0	12.2	290
Rural	3.6	1.6	2890
REGION			
West Nile	0.8	0.0	194
East	3.5	2.0	979
Central	4.7	2.4	777
West	5.7	3.4	355
South-West	3.4	0.7	725
Kampala	24.6	17.9	151
Luwero Triangle	5.0	2.1	313
NUMBER OF CHILDREN			
0-2	2.6	1.4	1404
3-4	4.8	2.4	792
5 or more	8.1	4.1	984
LEVEL OF EDUCATION			
No Education	1.9	0.9	1409
Some Primary	4.8	2.3	1294
Primary Comp.	9.1	3.7	241
Middle	12.7	7.1	172
Higher	34.1	22.7	64
Total	4.9	2.5	3180

All respondents in the UDHS who were currently using contraception were asked where they obtained the method last time. Responses to this question are shown in Table 10. The Family Planning Association of Uganda is the primary provider of pills and injections, followed by government hospitals. Government hospitals are the source for over 90 percent of female sterilisations. Knowledge about periodic abstinence is mainly derived by word of mouth from friends and relatives.

Table 10. Percent Distribution of All Women Currently Using Modern Methods of Contraception by Source for Method, According to Specific Method, Uganda, 1988/89

Source	Pill	Injec- tion	Female Steril- isation	Periodic Abstin- ence	All Methods*
Government Hospital	25.3	22.8	90.3	5.1	25.9
Govt. Health Centre	4.4	17.0	0.0	0.8	3.1
FPAU Clinic	42.5	48.9	0.0	1.2	19.6
Private Doctor	7.8	0.0	0.0	0.6	2.5
Priv Hospital or Clinic	5.3	2.9	9.7	2.0	4.4
Pharmacy or Shop	5.6	0.0	0.0	0.0	1.6
Church	0.0	0.0	0.0	3.1	1.4
Friends or Relatives	5.2	0.0	0.0	62.4	28.8
Other	4.0	8.5	0.0	17.4	9.5
Nowhere	0.0	0.0	0.0	7.4	3.3
Total Percent	100.0	100.0	100.0	100.0	100.0
Weighted Number of Women	64	19	34	97	222
Actual Number of Women	89	21	36	116	274

* Includes 7 IUD users and 1 condom user

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Peru	March	1987	(Spanish)
Ecuador	July	1987	(Spanish)
Sri Lanka	July	1987	(English)
Ondo State, Nigeria	August	1987	(English)
Morocco	October	1987	(French)
Burundi	December	1987	(English)
Thailand	February	1988	(English)
Mali	February	1988	(French)
Guatemala	March	1988	(Spanish)
Mexico	March	1988	(Spanish)
Indonesia	April	1988	(English)
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