

Final Study Report

An Impact-driven Baseline Study of Safe Water and Sanitation Practices in Singla Fishing Village, Nebbi District, Uganda



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Dr. Alfred Lakwo

EXECUTIVE SUMMARY

About the project

Singla fishing village is located on Lake Albert in Panyimur sub county, Nebbi district. It is currently the central fish market in the region serving traders from within Uganda and those from Southern Sudan, Democratic Republic of Congo, and Kenya. Fishing and fish mongering are the main sources of livelihood of the people. But, the area is prone to bi-annual cholera outbreak side by other poor health conditions. It is in this regard that AFARD developed the project proposal and the Royal Netherlands Embassy funded it. The project objective is, 'to promote safe water and sanitation chain management for improved health status of the fisher community in Panyimur sub county by increasing household access to safe water (by 39%) and improving utilization of safe sanitation and hygiene practices.'

Why the study

Given that the project was formulated without a baseline status, this study aimed at setting a baseline status (incorporating community views) for the project monitoring and evaluation purposes. Thus, the study explored access to, and utilization of safe water; individual, household and community sanitation and hygiene practices; and community health status.

Methodology

Data collection involved **household surveys** conducted using open ended questions; **direct observations** of facilities and practices; and **community feedback meeting** where the preliminary survey findings were discussed in-depth and desired solutions were proposed.

Findings 1: Access and utilization of safe water

Almost all households (9 in 10) use safe water (from a borehole) for drinking. To the contrary, only 1 in 10 households use safe water for cooking and other domestic consumption. This is because demanding for use of safe water for also other uses (as cooking, bathing and laundry) would mean walking more distance and spending longer time to access the same source. Thus, the few number of safe water source (only one borehole) is the cardinal factor prohibiting comprehensive use of safe water.

Findings 2: Sanitation and hygiene practices

- Only 46% of the households have latrines. Compared to 59% who use latrines, 13% are sharing latrines and the remaining 41% simply use the bush and/or defecate in the lake. This is worsened by having only 56% of the latrines clean, 28% with pit-covers, 60% with anal cleaning materials and only 37% of households with hand washing facilities.
- Only 53% of the households have garbage pits. And, 1% share garbage pits meaning 46% simply don't have such facility. This is made worse by 31% who scatter their solid wastes and 53% who do not keep their garbage pits clean.

- Only 39% of the households have soak pits of which only one third are clean. Majority of the households reported that they scatter bath, kitchen, and laundry liquid wastes.
- Safe personal hygiene was found to be better practiced. Because of the pressure from exposure during trading with foreign communities, people keep their hairs, nails, bodies, clothes, and skin clean.
- Home hygiene was however lacking. On the whole, many households lack: kitchen houses (43%), bathing shelters (32%), utensil drying racks (52%), cloth lines (45%), mosquito nets (71%), and raised beds for sleeping (37%).
- Food hygiene is also poor. Many people (45%) do not wash their hands with detergent before cooking or even before eating (29%). While 81% still wash their hands communally before eating, 81% eat collectively from the same plate/bowl.
- As a result, the sanitation and hygiene status is low as 0.7 was the score of the simple sanitation and hygiene index constructed using personal, home and vector control practices parameters. While personal hygiene (0.8 score) is better observed, home and vector control practices (with each having 0.5 score) are not.

Findings 3: Community health status

It was further found that, within one month prior to the study, 77.1% of household members fell sick mainly (50%) from malaria. They were mainly treated in clinics (48.5%) and at the health centre (42.3%). However, the health costs met included an average of 3 productive days lost to sickness per person and an average of Ushs 18,716 spent per person who fell sick.

Recommendations

Given that (i) there is already a high access to safe water use for drinking; (ii) good personal hygiene is embedded in the community; and (iii) that the project will provide safe water and latrines for public use, the remaining concern to address should focus on improving:

- the poor safe water chain management.
- the poor home hygiene and vector control practices.

The below issues should, therefore, form the main **education** and **standards compliance system development** focus.

Areas of fair hygiene (34-66%)	Areas of poor hygiene (0-33%)
<ul style="list-style-type: none"> • Having latrines • Having anal cleaning materials • Washing hands with detergent after defecating • Having soak pits • Constructing kitchens, bath shelter • Washing hands with detergent before cooking 	<ul style="list-style-type: none"> • Having latrine pit-hole covers • Having hand washing facilities • Liquid wastes management • Having no mosquito nets • Bathing in the lake • Washing hands communally before eating

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1.0 INTRODUCTION

1.1 About Singla Fishing Village

Singla fishing village is located on L. Albert in Panyimur sub county, Nebbi district. It has 3 villages and is currently the central fish market in the region. People come to it from as far as Southern Sudan, Democratic Republic of Congo, Kenya, and the Ugandan districts of Gulu, Lira, Bulisa, Hoima, Masindi, Arua and Koboko. This makes the market days (Sunday – Tuesday) population more fluid and can at times reach more than 10,000 people. However, the permanent projected population is about 5,000 people (60% females).

The main sources of livelihood are fishing and fish mongering. Petty trade is also common in all households. Farming is only practiced at the foot of the rift valley. There is no school located in this area save for a few clinics. However, a number of schools and a health centre are in its neighbouring villages. There is also a good road network. Reception of mobile phones and local FM radio communications is equally good.

1.2 Singla Safe Water and Sanitation Project

Panyimur Sub County in general and Singla fishing village in particular is known to exhibit a worst health condition largely attached to the bi-annual cholera outbreak that occur every rainy season. As a central fish market where traders from far and near converge weekly, such a health condition predisposes not only the local population but also acts as a catalyst for the spread of cholera in the region.

Basing on this, AFARD developed a project proposal (Singla Safe Water and Sanitation Project) and the Royal Netherlands Embassy has funded it. The project objective is, ‘to promote safe water and sanitation chain management for improved health status of the fisher community in Panyimur sub county by increasing household access to safe water (by 39%) and improving utilization of safe sanitation and hygiene practices.’

The envisaged effects of the projects are:

- Use of safe water for drinking, cooking, bathing, and laundry.
- Improved sanitation index (personal hygiene, home hygiene, and vector control practices).
- Reduction in productive days lost to illnesses.
- Reduction in school absenteeism among children.
- Reduction in household medical care budget allowing for (time and money) savings for other livelihood security building.
- Improved social harmony through self-esteem and reduced ‘bewitching tags’.

2.0 OBJECTIVES AND METHODOLOGY

This section presents the justification, objectives and the methodology used in the study.

2.1 Why the study

To be noted from the on-set is that Singla Safe Water and Sanitation Project was formulated without a baseline status to which it can be solely held to account in terms of performance monitoring and evaluation. A proxy data from Dei fishing village, 8 Km away, was used to exemplify the conditions of unsafe water and sanitation in fishing villages.

This study, therefore, aimed at setting a baseline status for the project monitoring and evaluation purposes. The baseline would also incorporate community views on safe water and sanitation chain management practices because their knowledge informs their attitudes and practices and hence its wrongness and/or inadequacy directly affects their health status.

To achieve this objective the study explored:

- The access to, and utilization of, safe water.
- Individual, household and community sanitation and hygiene practices.
- The community health status in view of the existing water and sanitation practices.

2.2 Methodology

Data collection involved:

- **Household surveys** conducted using open ended questions administered by trained enumerators. Questions captured by the survey covered both individual and household behaviors. For a description of the study population see annex 1.
- **Direct observations** of facilities and practices at various points.
- **Community feedback meeting** where the preliminary survey findings were discussed in-depth and practical interventions were proposed, analyzed and prioritized.

2.3 Report structure

This report is organized into 6 parts. While part 1 and 2 presents the introduction to the study in terms of the project and the methodology, part 3 focuses on water access and utilization. In part 4 sanitation and hygiene practices are shown and part 5 dwells on community health status. Finally part 6 provides the study recommendations.

3.0 ACCESS AND UTILIZATION OF SAFE WATER

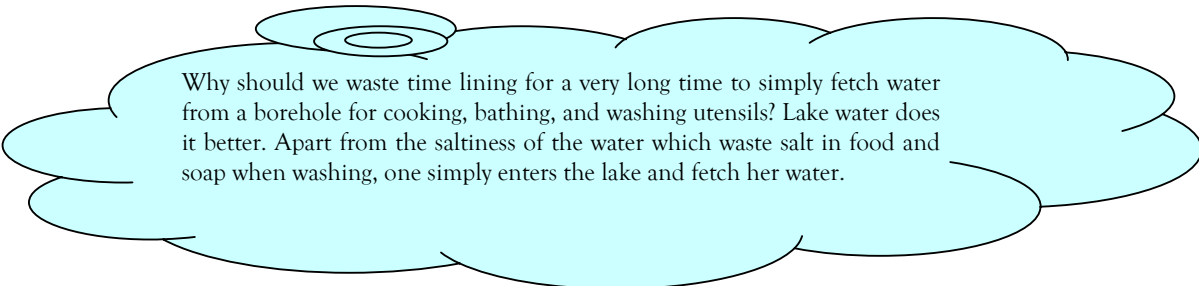
Table 1 below presents a summary of safe water access and utilization. It reveals that while overall 9 in 10 households are using safe water (largely from a borehole) for drinking, to the contrary only 1 in 10 are using the safe water for cooking and other domestic consumption.

The table further shows that according to SPHERE Standards (of access time under 30 minutes, distance of less than a kilometer, and on average using 20 liters), Singla has better access conditions to safe water source especially for drinking. The contrary is true for access and utilization of safe water for cooking.

Table 1: Household status (%) of safe water access and utilization

Domains	Singla A	Singla B	Singla C	Total
A: Proportion using safe water for:				
Drinking	89.9	90.9	88.6	89.7
Cooking	10.1	20.6	4.8	11.2
B: Proportion using safe water within <1km for:				
Drinking	89.2	89.7	88.3	89.0
Cooking	6.1	7.2	2.2	3.1
C: Proportion consuming over 20 liters of safe water per day for:				
Drinking	96.8	97.3	95.5	96.4
Cooking	10.5	23.0	4.2	11.3
D: Proportion accessing safe water within 30 minutes for:				
Drinking	89.0	90.3	87.8	88.8
Cooking	9.0	19.8	4.1	10.2
E: Proportion that process unsafe water for:				
Drinking	0.0	97.2	78.9	91.8
Cooking	100.0	95.5	100.0	97.6

Asked why there is preference to use safe water only for drinking and not other domestic use, the women present in the feedback meeting echoed that,



Why should we waste time lining for a very long time to simply fetch water from a borehole for cooking, bathing, and washing utensils? Lake water does it better. Apart from the saltiness of the water which waste salt in food and soap when washing, one simply enters the lake and fetch her water.

This response points to two things. First, the only available water point deters comprehensive safe water use. And second, the attitude towards safe water use for other domestic purposes is embedded in lack of adequate information on the health implications of unsafe water.

4.0 SANITATION AND HYGIENE PRACTICES

This section presents the sanitation and sanitation practices in Singla fishing village. It covers the aspect of waste management, and personal, food, and home hygiene. The findings finally are presented in a basic sanitation and hygiene index.

4.1 Excreta disposal

The first focus on sanitation and hygiene was on waste management. Starting with human excreta disposal, the study recognized that pit latrines, in our conditions, are the safest way of disposing human excreta. It thus asked households about the availability, use and condition of pit latrines. It was found that only 46% of the households have latrines. Compared to 59% who use latrines, this finding indicates that many household (13%) share latrines while 41% simply defecate in the bush or the lake.

Further, while only half of the latrines (56%) are clean, only 28% had pit-cover, 60% had anal cleaning materials (of predominantly rough paper 63%), and only 37% of households with latrines had hand washing facilities. Our observations corroborated by the feedback meeting pointed that most of the latrines stinks and harbor houseflies. These facts added to disposing children's feces in the open makes the community unhygienic and largely predisposed to poor sanitation related disease infections.

Table 2: Excreta disposal practices (%) by village

Domains	Singla A	Singla B	Singla C	Total
Have latrines	58.4	44.0	39.0	45.8
Latrines has pithole covers	37.6	18.3	30.3	28.4
Latrines has privacy	58.4	74.9	79.4	72.3
Latrines are clean	48.1	74.2	47.1	56.0
Latrines have anal cleaning materials	41.6	68.0	66.7	60.3
Use latrines	62.4	62.9	54.4	59.2
Have hand washing facility	54.4	16.6	45.2	38.6
Wash hand with detergent after defecating	78.5	73.1	41.2	61.4

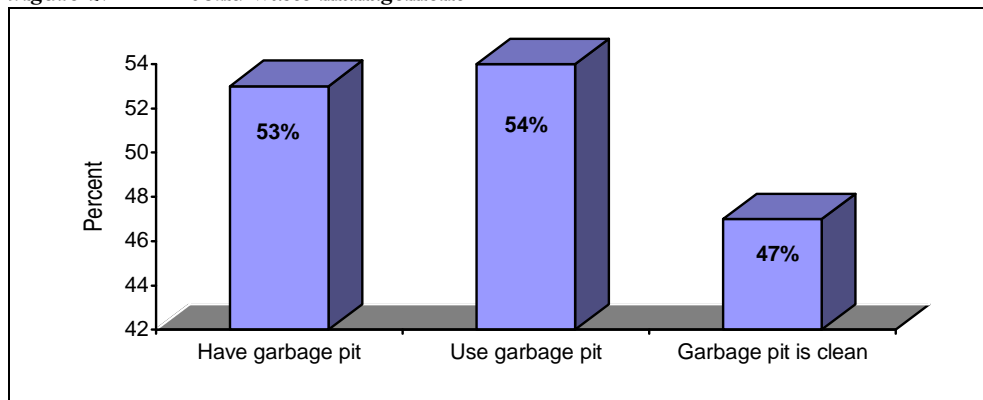
It was pointed out during the feedback meeting that the lack of latrines is because many of the temporary people are either unconcerned with digging one or they lack the land on which to dig one. This means that they largely rely on unsafe 'free-range' excreta disposal practices or they share with their landlords. And in the event that there are many tenants this joint use heighten the pace of the dug pit getting filled. It was also noted that sharing of latrines have been a cause of conflict as those who have latrines demand that people without latrines should construct their own.

4.2 Solid waste management

Safe hygiene was also seen from how homes handled solid waste management. Again, all households were expected to construct garbage pits where they should deposit and destroy household wastes. The study finding as shown in figure 1 below reveals that only 53% of the households had garbage pits. One percent of the households share pits with other households.

The low score (47%) of the households with clean garbage pits is because it was found that only 69.2% burn garbage after the pits are full. The remaining 30.8% reported that they simply scatter their garbage because of lack of a dumping ground. Direct observation revealed that even for the dug pits many are shallow leaving rubbish heaps to spill right back into the compound. As such, the sight of rodents and flies were common.

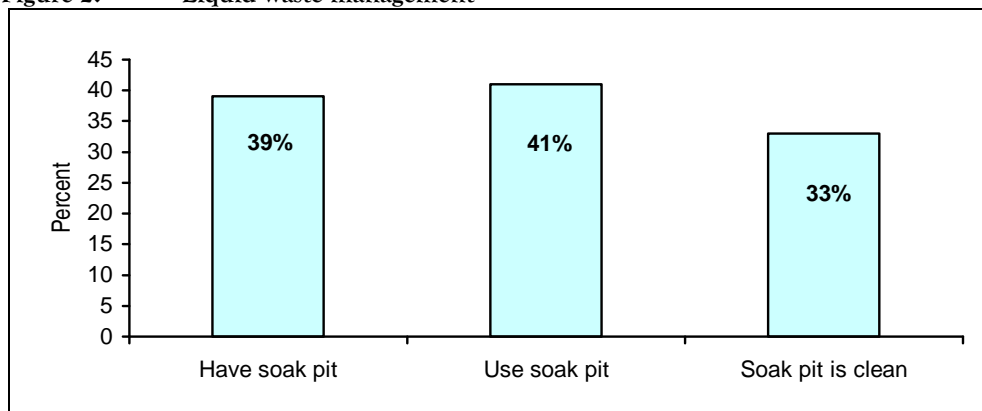
Figure 1: Solid waste management



4.3 Liquid waste disposal

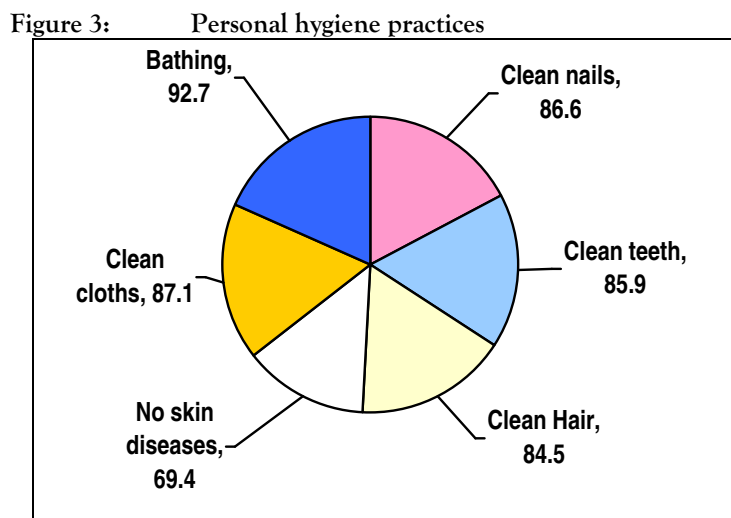
Households are also expected to dig soak pits where they can dispose liquid wastes. However, it was found out that only 39% of the households had soak pits of which only one third are clean. Majority of the households however reported that they scatter bath, kitchen, and laundry liquid wastes. A woman frantically asked, 'what is wrong with pouring dirty water on the compound?' This presents lack of knowledge on health risks of safe solid waste management.

Figure 2: Liquid waste management



4.4 Personal hygiene

For better sanitation and hygiene to have meanings in the life of the people, the concerned people must practice safe personal hygiene. This is because ones' hygiene directly correlates with her/his health. As such, the survey asked key questions on personal hygiene and figure 3 presents the summary. From the figure it can be seen that generally the people of Singla fishing village are clean. They keep their head, mouth, and body clean.



4.5 Home hygiene

Improved health from waste management and personal hygiene have more gains when people keep their homes and its surrounding clean. However, this means that there must be an acceptable home facility standard as well as the practices of keeping them clean. What were considered in the household survey were facilities including the living houses and those that prevents contamination by disease vectors.

It was found that majority of the population (86%) live in temporary housing structures as compared to those living in permanent (9%) and semi permanent (6%) houses. With 87% of the houses having grass-thatched roofs and 85% mud and wattle walls of earthen floor, keeping a house clean is difficult.

Table 3: Basic safe home facility coverage (%) by village

Domains	Singla A	Singla B	Singla C	Total
Have kitchen	70.5	53.7	51.8	57.4
Have bath shelter	67.8	72.6	64.0	67.8
Have utensil drying rack	57.0	48.6	41.2	47.8
Have cloth line	64.4	57.7	47.8	55.4
Sleeps on raised bed ('Kitanda')	72.5	52.0	64.5	62.7
Have mosquito nets	47.0	30.9	15.4	28.8

Beyond the housing types, many homes lack the basic facilities to keep them and the inhabitants clean. Only 29% had mosquito nets and 32% bath in the lake. The women during the feedback

meeting pointed out that, ‘we cook under our main house verandah given that most of us lack kitchen structures. During rainy seasons, the main house also doubles as kitchens’. This together with the other facilities indicated in table 3 reveal that control of disease vectors through safe home practices is low.

4.6 Food hygiene

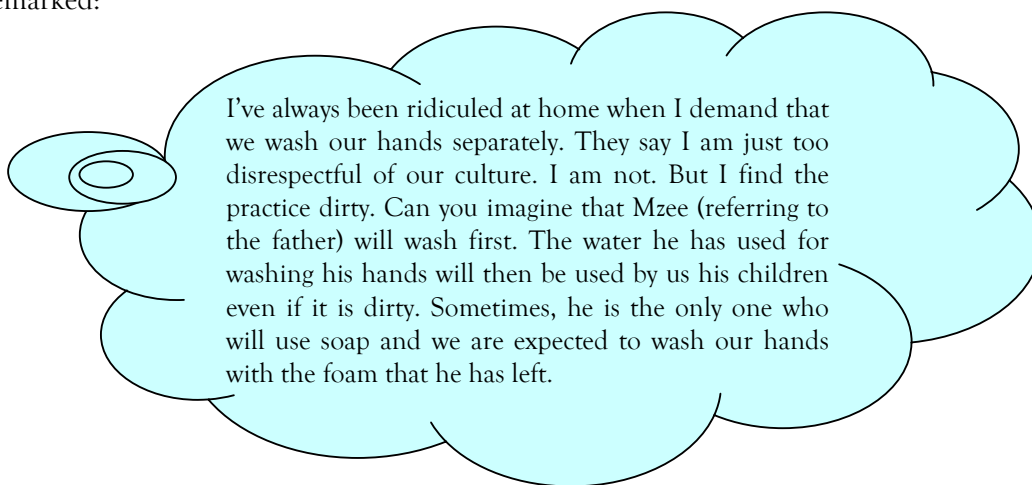
The study finally looked at food hygiene practices and the findings are summarized in table 4 below.

Table 4: Basic safe home facility coverage (%) by village

Domains	Singla A	Singla B	Singla C	Total
Wash hand with detergent before cooking food	71.8	53.7	44.7	54.9
Wash hand with detergent before eating food	88.6	78.9	54.4	71.4
Wash hand before serving food individually	23.5	19.4	16.2	19.2
Serves food on individual plate	9.4	14.3	9.2	10.9

It is evident from the table that many women do not keep good food hygiene. A majority (45%) of them do not wash their hands before cooking. Meanwhile, only 29% of household members don’t wash their hands with detergent before eating. Compounded by the communal eating habits as well as washing hands in turns even with water that has already been contaminated by elders leaves many people prone to contracting diseases.

A male youth remarked:



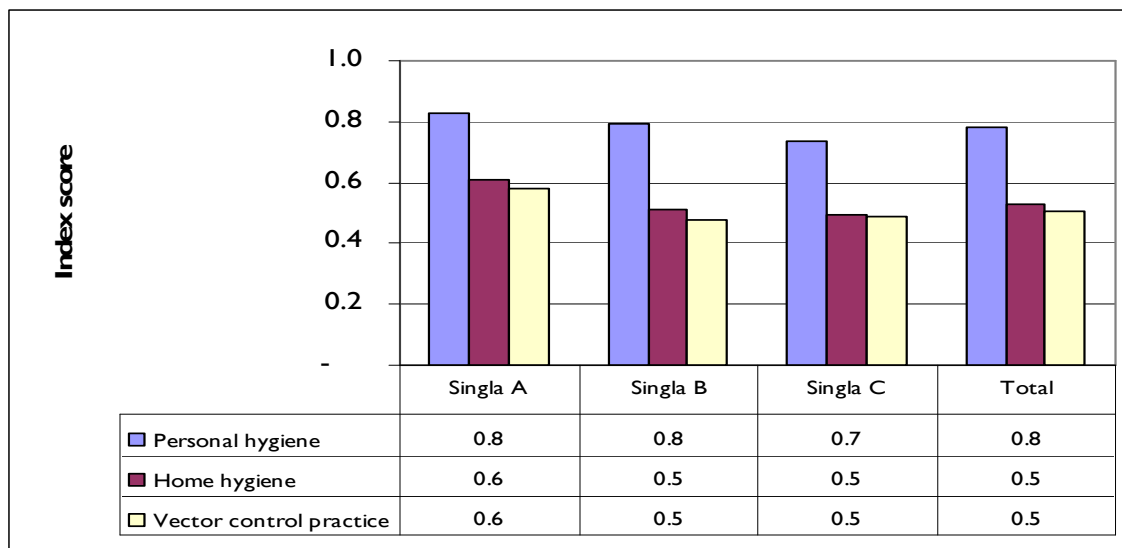
4.7 Community sanitation index

In order to take an umbrella view of the sanitation and hygiene status, the study took three parameters of personal, home and vector control practices to assess how Singla community was performing.¹ Figure 4 below presents a summary of the findings.²

¹ These variables were used to construct a simple sanitation and hygiene index. The index is developed from a weight of 1 for those with and 0 for those without the required safe sanitation and hygiene practices. The overall observed total is then summed and divided by the expected total and thus the higher the value (i.e., being closer to 1) the safer the sanitation and hygiene condition and vice versa.

Overall, the sanitation index of Singla fishing village is 0.7 is above average. Personal hygiene (0.8 score) was found to be better practices when compared to both home and vector control practices (with each having 0.5 score).

Figure 4: Sanitation and hygiene index



This high score was attributed by the community feedback meeting to the weekly market as a woman reiterated:

Who would not to be smart when every Saturday to Wednesday there are foreigners all over the place. We also want to match with the Congolese women who come around on trade (not only of produce and fish but also of their bodies) but starts despising us as if as we don't have money. You can see that many adults and youths are struggling to be smart by shaving/braiding their heads routinely, ensuring that their nails and clothes are also neat.

But for what takes place in the homes many people do not bother. This is because the traders simply stops at the trading centre.

² For details see annex 2.

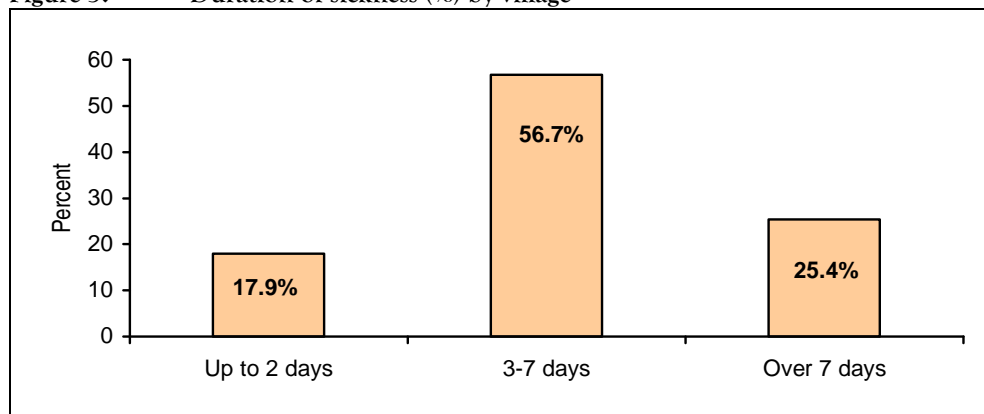
5.0 COMMUNITY HEALTH STATUS

The overall goal of the project under study is inclined on improving beneficiary community health. This is measured by reduced burden imposed by exposure to unsafe water and sanitation related diseases. As such, the study focused on disease type, magnitude and effects in terms of productive days lost to and cost incurred on seeking health services. These parameters are presented below.

5.1 Fell sick and duration of sickness

Household members were asked whether or not they fell sick in the month that preceded the survey. On the whole, 77.1% reported having fallen sick. Of these 38% were school-age children 5-19 years. Majority of the people (57%) fell sick for between 3-7 days although on average every sick person lost 3 productive days to sickness. That for the children within the same duration was 60%. Children also lost 2 days due to sickness.

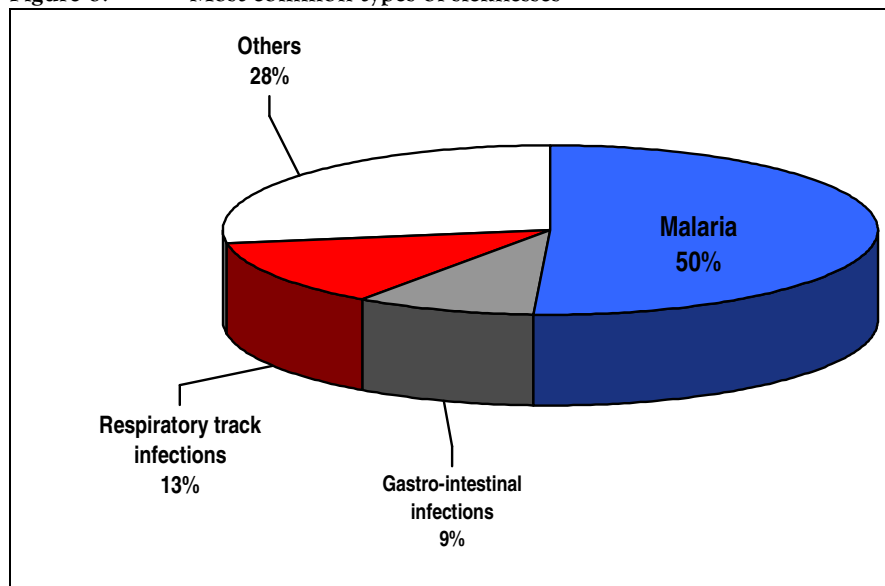
Figure 5: Duration of sickness (%) by village



5.2 Type of sickness

The most common type of sickness reported by those who fell sick was malaria. This was followed by other types among which were HIV/AIDS, blood pressure, and ulcers. This finding indicates that with poor water and sanitation chain management, malaria as a sickness is being enabled to affect the lives of the people. For instance, a fisherman echoed that, 'for us who rarely sleep in the house, it is useless to buy mosquito nets. We simply sleep like that.' Such a weird justification presents the lack of knowledge about the risks mosquitoes pose to the lives of fishermen.

Figure 6: Most common types of sicknesses



5.3 Where treated and the cost of medication

Household members who answered that they fell sick were also asked about their health seeking behavior as well as their health budget. It was found that only 9.2% sought treatment from a hospital facility. While 48.5% and 42.3% were treated in clinics and at the health centre respectively. However, in terms of cost, an average of Ushs 18,716 was spent per person who fell sick although almost a similar proportion spent up to Ushs 5,000 and over Ushs 10,000 on treatment. Such a spending pattern followed the types of sickness (see figure 6 and table 5).

Table 5: Types of sickness by cost incurred

Type of sickness	Up to Ushs 5,000	Ushs 5,001 - 10,000	Over Ushs 10,000	Total
Malaria	19.7%	11.8%	17.7%	49.2%
Gastro-intestinal infections	2.0%	2.5%	4.2%	8.7%
Respiratory track infections	5.4%	3.0%	5.5%	13.9%
Others	11.2%	7.8%	9.1%	28.2%
Total	38.3%	25.1%	36.6%	100.0%

During the feedback meeting, the community was asked why their health seeking behavior prefer clinics where there are mainly unqualified personnel compared to the health centre that is simply very near than in case the hospital was 'considered far and should be reached only when the magnitude of the sickness is too high, as a member pointed. The responses indicated that:

It is a waste of time going to the health centre. The staffs are too arrogant to deal with people who are sick. Besides, the unit has no medicine. You go there with your sickness, they either don't simply attend to you or they will refer you back to the clinic to buy drugs. So, why waste time in the first place to go there?

6.0 RECOMMENDATIONS

This study was set to establish a baseline on the safe water and sanitation chain management practices in Singla fishing village. It paid attention to access to and utilization of safe water and personal, home, and food hygiene. The key findings, rated on a performance scale is summarized in Table 6 below. The table reveals that there are both good and bad practices in regards to the safe water and sanitation chain management. For instance, the lack of a comprehensive safe water use presents a limited risk prevention from predisposition to disease vectors. Just like having a latrine that is not safely managed hasten disease spread.

Therefore, to give meaning to the strengths existing in the community, it is recommended that the project implementation, beyond the provision of public facilities, should focus on the core weak points. It should address:

- The poor safe water chain management by ensuring a comprehensive safe water utilization beyond drinking.
- The promotion of safe home hygiene and vector control practices.

Therefore, the **community education** and **standards compliance system development** should focus on areas of poor and fair hygiene practices as are indicated in Table 6.

Table 6: General sanitation and hygiene performance

Areas of good hygiene (67-100%)	Areas of fair hygiene (34-66%)	Areas of poor hygiene (0-33%)
<ul style="list-style-type: none"> • Using safe water for drinking • Having latrines with privacy • Burning garbage • Having clean hair, teeth, nails, cloths, body and having no skin diseases • Constructing bath shelters • Washing hands with detergent before eating 	<ul style="list-style-type: none"> • Having latrines • Having anal cleaning materials • Washing hands with detergent after defecating • Having soak pits • Constructing kitchens, bath shelter • Washing hands with detergent before cooking 	<ul style="list-style-type: none"> • Using unsafe water for other uses other than drinking • Having latrine pit-hole covers • Having hand washing facilities • Scattering liquid wastes • Having no mosquito nets • Bathing in the lake • Washing hands communally before eating

Annex 1: Demographic characteristics of respondents

This study was conducted covering 552 households composed of:

- 79.3% households in Ganda and 20.7% in Nyakagei parishes.
- 41.3%, 31.7%, and 27.0% from Singla C, B, and A villages respectively.
- A mean household size of 6 persons with 66.5% of the households having 2-6 people and 32.4% more than 6 people.
- 85.7% are temporary housing structures compared to only 8.5% that are permanent.

The households had 2,372 people of which:

- 51.4% females and 48.6% males
- 85% are under 30 years and 50% under 20 years.
- 53.5% have primary education and 28.2% have no education.
- 57.7% are singles while only 26.4% are formally married.
- 41.1% are farmers and 25.7% are engaged in fishing and fish mongering.
- 49.1% are permanent residents as compared to 46.5% temporary residents.
- 13.4% are persons with disabilities.

Annex 2: Sanitation index by village

	Singla A			Singla B			Singla C			Singla fishing village		
	Observed	Expected	Index	Observed	Expected	Index	Observed	Expected	Index	Observed	Expected	Index
Personal hygiene												
Have smart hair	578.0	619.0	0.9	652.0	779.0	0.8	775.0	974.0	0.8	2,005.0	2,372.0	0.8
Brush teeth once a day	579.0	619.0	0.9	695.0	779.0	0.9	764.0	974.0	0.8	2,038.0	2,372.0	0.9
Have clean nails	548.0	619.0	0.9	691.0	779.0	0.9	814.0	974.0	0.8	2,053.0	2,372.0	0.9
Bath once a day	614.0	619.0	1.0	712.0	779.0	0.9	872.0	974.0	0.9	2,198.0	2,372.0	0.9
Have no skin disease	183.0	619.0	0.3	236.0	779.0	0.3	306.0	974.0	0.3	725.0	2,372.0	0.3
Have clean cloth	573.0	619.0	0.9	711.0	779.0	0.9	782.0	974.0	0.8	2,066.0	2,372.0	0.9
	3,075.0	3,714.0	0.8	3,697.0	4,674.0	0.8	4,313.0	5,844.0	0.7	11,085.0	14,232.0	0.8
Home hygiene												
Have kitchen	105.0	149.0	0.7	94.0	175.0	0.5	118.0	228.0	0.5	317.0	552.0	0.6
Have bathroom shelter	101.0	149.0	0.7	127.0	175.0	0.7	146.0	228.0	0.6	374.0	552.0	0.7
Have utensil drying rack	85.0	149.0	0.6	85.0	175.0	0.5	94.0	228.0	0.4	264.0	552.0	0.5
Have cloth line	96.0	149.0	0.6	101.0	175.0	0.6	109.0	228.0	0.5	306.0	552.0	0.6
Have soak pit	66.0	149.0	0.4	61.0	175.0	0.3	89.0	228.0	0.4	216.0	552.0	0.4
Have garbage pit	85.0	149.0	0.6	105.0	175.0	0.6	105.0	228.0	0.5	295.0	552.0	0.5
Have pit latrine	106.0	149.0	0.7	115.0	175.0	0.7	133.0	228.0	0.6	354.0	552.0	0.6
Have hand washing facility	81.0	149.0	0.5	29.0	175.0	0.2	103.0	228.0	0.5	213.0	552.0	0.4
	725.0	1,192.0	0.6	717.0	1,400.0	0.5	897.0	1,824.0	0.5	2,339.0	4,416.0	0.5
Vector control practice												
Use safe drinking water source	134.0	149.0	0.9	159.0	175.0	0.9	202.0	228.0	0.9	495.0	552.0	0.9
Cover water storage facility	111.0	149.0	0.7	101.0	175.0	0.6	161.0	228.0	0.7	373.0	552.0	0.7
Use 2 cups for drinking water	94.0	149.0	0.6	81.0	175.0	0.5	112.0	228.0	0.5	287.0	552.0	0.5
Have separate sleeping room	104.0	149.0	0.7	123.0	175.0	0.7	139.0	228.0	0.6	366.0	552.0	0.7
Sleeps on a raised bed (Kitanda)	108.0	149.0	0.7	91.0	175.0	0.5	147.0	228.0	0.6	346.0	552.0	0.6
Cover latrine pits	56.0	149.0	0.4	32.0	175.0	0.2	69.0	228.0	0.3	157.0	552.0	0.3
Sleeps under a mosquito net	70.0	149.0	0.5	54.0	175.0	0.3	35.0	228.0	0.2	159.0	552.0	0.3
Serves food individually	14.0	149.0	0.1	25.0	175.0	0.1	21.0	228.0	0.1	60.0	552.0	0.1
	691.0	1,192.0	0.6	666.0	1,400.0	0.5	886.0	1,824.0	0.5	2,243.0	4,416.0	0.5
Overall Index	4,491.0	6,098.0	0.7	5,080.0	7,474.0	0.7	6,096.0	9,492.0	0.6	15,667.0	23,064.0	0.7