Open Journal of Epidemiology, 2015, 5, 65-70
Published Online February 2015 in SciRes. http://www.scirp.org/journal/ojepi
http://dx.doi.org/10.4236/ojepi.2015.51009

Community Education Challenges in Young Adults of South Western Uganda

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Received 22 January 2015; accepted 13 February 2015; published 17 February 2015

Abstract

The aim of this study was to identify the major challenges to community education and any health problem in Bushenyi district of South Western Uganda. Data collection was done through questionnaire and participants were randomly selected. This was a cross-sectional study carried out for a period of three months in 2012. A questionnaire was used to collect data and using onsite observations the responses were validated. A total of 260 participants from 65 homesteads were included in the study from 52 households. 144 were females and 116 males, of which 52.4% of the children were female and the rest male. The mean ± SEM age of females and males was 36 ± 8.6 and 29 ± 8.6 years respectively. In all the homesteads, 71% were headed by an adult male and only 29% were found to be headed by an adult female while none was headed by children. Inferential analysis showed (P = 0.02) that there are more females than male in the homesteads. Majority of the homesteads are being taken care of by women instead of men probably as a result of the high mortalities due to HIV/AIDS in the past decade and above all the movement of most men to urban centers in search of better sources of employment to support their families. Among school going age participant's *i.e.* children and adolescents, only 59.6% were found to be attending school. There was no statistical significance (P = 0.16) between school attendance and age. Family responsibilities such as cooking for younger siblings by female participants, obligations on open

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How to cite this paper: Kasozi, K.I., Echoru, I., Mbiydzenyuy, E.N., Kimwise, A., Nansunga, M., Semuyaba, I., Kalange, M., Ninsiima, H.I., Muggaga, K. and Emorut, S.P. (2015) Community Education Challenges in Young Adults of South Western Uganda. *Open Journal of Epidemiology*, **5**, 65-70. http://dx.doi.org/10.4236/ojepi.2015.51009

market days are thought to be secondary limiting factors for community development and livelihood amongst young persons; thus a follow up study would be conducted to assess their associations in this community as this would raise major child abuse concerns which would need to be reported to the legal authorities for follow up.

Keywords

Community Education in Uganda, Children Education in Sub-Saharan Uganda, Medical Students Rural Education, Rural Public Health

1. Introduction

The World Health Organization (WHO) defines health as not merely the absence of disease or infirmity but as a state of complete physical, mental and social well-being [1] [2]. This however has been a challenge for many countries throughout the globe to achieve since major issues like equity and equality have been and still remain to be major hindrance to achieving this goal [2] [3]. The health gap experienced between the developed and developing countries and particularly the rural and urban communities of Sub-Saharan Africa pose major threats to the attainment of the millennial developmental goals [4]. There is no definite definition for rural health; however, rural health is the interdisciplinary study of health and health care delivery in the context of rural environment or location [1]. People living in rural areas face severe health related challenges than their counterparts in semi/urban settings [5]. According to the WHO, each member state of the United Nations (UN) has a duty to ensure that her people have the basic elements that would enable families and individuals to maintain good health and that they access good health care [6] [7]. In Uganda, the existing gross inequality in healthcare of those living in rural communities is politically, socially and economically unacceptable [8]. The Ministry of Health (MoH) in Uganda, does admit that there are still significant challenges in matching need for health services with available resources hence inequity and inequalities [9] [10]. However over the past decade, considerable effort to restore the function of the health sector, through increasing public health spending, reactivating disease control programs and re-orienting services to Primary Health Care has been implemented [11]. Despite the huge funds provided to improve health facilities and systems in Sub-Saharan Uganda, rural communities are lagging behind and are still lacking basic health requirements and education of children [12]-[14]. This has contributed greatly to the high morbidity and mortality rates in rural areas. Furthermore, it is well known that development and health are interrelated and that good health promotes development, and development promotes good health [1]. Therefore this contributes to the stagnation of development and failure of the country to meet the Millennium Development Goals (MDG's) [15].

2. Materials and Methods

This was a cross-sectional study conducted in Bunyarigi sub-county, Ishaka municipality, Bushenyi district, Uganda for a period of three months (January to March 2012). A total of 260 people from 52 homes were selected randomly. A semi structured questionnaire was used as a basis for the interviews that were conducted with the randomly selected participants in Kashekye, Bushenyi, South Western Uganda. Data collection quality was maintained by ensuring that each visited homestead was tagged with a number after obtaining permission from the household master. Data was coded entered in SPSS version 21. Data was expressed as frequencies and percentages and bivariate analysis was carried out. A $P < 0.05$ was considered statistically significant. The objectives of the study were to determine the challenges facing community education and their major predisposition factor in Bushenyi district of Western Uganda. Ethical clearance was obtained from the Ministry of Health through The Kampala International University Ethical Review Committee (IREC).

3. Results

A total of 260 participants from 65 homesteads were included in the study from 52 households. 144 were females and 116 males, of these 52.4% of the children were female and the rest male. The mean ± SEM age of

females and males was 36 ± 8.6 and 29 ± 8.6 years respectively as shown in **Table 1**. In all the homesteads, 71% were headed by an adult male and only 29% were found to be headed by an adult female while none was headed by children. Inferential analysis showed (P = 0.02) that there are more females than male in the homesteads.

Among school going age participant's i.e. children and adolescents, only 59.6% (84) were found to be attending school as shown in **Table 2**. There was no statistical significance (P = 0.16) between school attendance and age.

Two major elementary schools were identified in the community and one is fully supported by the government through the universal primary education program (UPE) while the second school was privately managed as shown in **Table 3**.

The majority (>70%) people in the village earn < US$ 20 per month The latrine coverage in the community was found to be good with 44 out of all the 52 homes having a latrine, 8 homes were found not to have a latrine and some claimed to be sharing with the neighbors. Of the pit laterines observed, 6 were permanent, 21 semi-permanent and 17 were temporary as shown in **Table 4**.

4. Discussion

The study showed that a majority of the girls of school going age were staying at home (P < 0.05) despite of the fact that the government has endeavored to subsidize educational standards through the Universal Primary Education (UPE) program. This would probably be due to community social challenges that have continuously played a major role in the failure of the educative program in various corners of the country [1]. Majority of the homesteads were taken care of by women instead of men probably as a result of the high mortalities due to HIV/AIDS in the past decade and above all the movement of most men to urban centers in search of better sources of employment to support their families [13] [16].

There were only two schools identified in the community as shown in **Table 3** thus showing a poor distribution of the public resources in this community. School going children living in distant homesteads would definitely find it difficult to get to school especially during the rainy seasons thus further crippling the education services in the rural communities and as a result school dropout rate was observed to be high [4] [17]. The majority

Table 1. Showing demographic distribution in the community.

Variable	Category	Age (Years)	Female	Male
			Frequency (%)	
Demographics	Children	≤12	55 (52.4)	50 (47.6)
	Adolescent	≤18	20 (55.6)	16 (44.4)
	Adult	≤40	52 (57.8)	38 (42.2)
	Elderly	≥41	17 (58.6)	12 (41.4)
Headship	Household		46 (71)	19 (29)

Table 2. Showing participants that attend school in the community.

Education Age	Attending School	Not Schooling
	Frequency (%)	
Children	57 (54.3)	48 (45.7)
Adolescents	27 (75)	9 (25)

Table 3. Showing schools in the community for elementary education.

School Level	Location	Funder	Classes	Pupils
Nursery	Kashekye TC	Private	Kindergarten	Unknown
Primary	Kashekye	Gov't (UPE)	P.1 to P.7	370

Key: TC = Trading centre; Gov't = government; P = Primary; UPE = Universal primary education.

Table 4. Showing livelihood distribution in the community.

Parameters	Variables	Frequency (%)
Occupation	Peasants	34 (65.4)
	Primary School Teachers	3 (5.8)
	Motorcyclists	4 (7.7)
	Sole Proprietors	5 (9.6)
	Builder/Masons	5 (9.6)
	LG Secretary	1 (1.9)
Family Monthly Income (US$)	< 20	39 (75)
	20 to 60	5 (9.6)
	> 60	8 (15.4)
Latrine Condition	Permanent	6 (13.6)
	Semi-Permanent	21 (47.7)
	Temporary	17 (38.6)

Key: LG = local government.

(>70%) people in the village live on < US$ 1 per day probably due to major occupation of plantation farming as well as the low level of education that they attained as a result of limited education facilities. Several factors ranging from domestic, psychological and social economic status were shown to be closely associated with the dropouts from school, but sporadic episodes of malaria infection played a crucial role as well [18]. Family responsibilities such as cooking for younger siblings by female participants, obligations on open market days are thought to be secondary limiting factors for community development and livelihood amongst young persons; thus a follow up study would be conducted to assess their associations in this community as this would raise major child abuse concerns which would need to be reported to the legal authorities for follow up [19].

In a community with limited resources, it's obvious that male counterparts are to be offered first priority such as the chance to attend school, and above all, the ability to be excused from secondary family obligations [20]. The limited resources in the society, coupled with community social economic dynamics are areas worth investigating further so that further intervention approaches are instituted to address community health and provide sustainable solutions to the problems facing these communities [8]. The increasing prevalence of infectious diseases is a major challenge that needs to be addressed for effective utilization of international and government aid in rural communities of Uganda [1] [21]. This is due to the disruptions that are often caused to pupils as they become unable to attend school thus efforts by the Ugandan government on control of infectious and non-infectious diseases in rural communities should be increased with utmost priority being offered to the disadvantaged group.

Conclusion and Recommendations

Improved extension service delivery through improved cooperative between the rural communities and the health centers as well as the political leaders would play a crucial role in improving on livelihoods in this region. This would be done through forging of partnerships with the major health facility in the region (Kampala International University Teaching Hospital) and the local governments to address the demands of these persons for the success of numerous programs at national level.

Acknowledgements

We would like to extend our gratitude to all the community that welcomed and allowed us to carry out this work as well as the scientific research community of Kampala International University Western Campus, Bushenyi, Uganda.

Authors Contributions

All authors contributed equally to the development and approved final submission of the manuscript.

K.I.K., E.N.M., I.S., M.K., I.E., K.M., S.P.E. designed the study, and data collection.

K.I.K., E.N.M., M.N., A.O.M., I.E., I.S., M.K., A.K., O.G.A., H.I.N. carried out literature search, data analysis, manuscript writing.

Competing Interests

The authors declare there exist no competing interests.

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