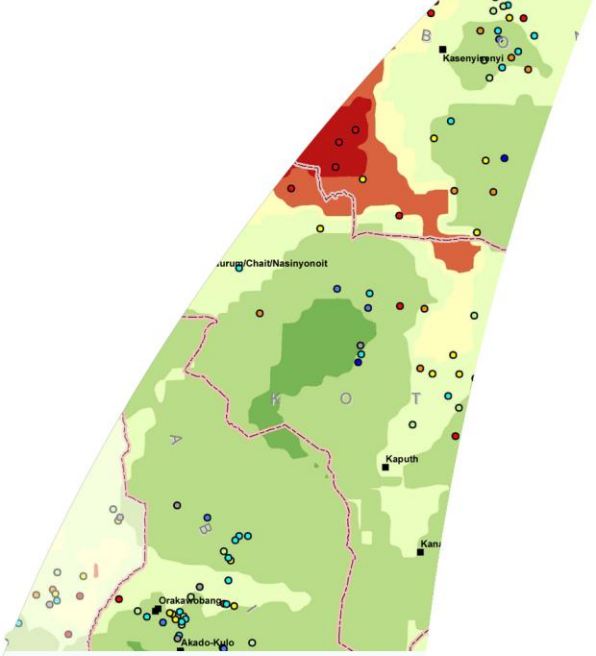

Ministry of Health

Sanitation and Hygiene

Situation Analysis for the Uganda Sanitation Fund

Programme in 15 Districts

Final Report

JANUARY 2014
Project 2013-16

WE Consult

Chwa II Road Plot 40 Mbuya
P.O. Box 22856, Kampala
Uganda

www.we-consult.info
uganda@we-consult.info

Phone: +256 (0) 312 265 130
Fax: +256 (0) 414-505798
Mobile: +256 (0) 772-222049/10

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Client:
Prepared by: PL
Quality Control: CM

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Executive Summary

This report provides an analysis and evaluation of the current and retrospective sanitation and hygiene situation in the 15 districts that benefit from the Uganda Sanitation Fund (USF) since 2011. The 15 USF districts targeted are Dokolo, Amolatar in Northern Uganda, Amuria, Katakwi, Kaberamaido, Soroti, Serere, Kumi, Ngora, Bukedea, Kibuku and Pallisa in Eastern Uganda, and Mbarara, Sheema and Bushenyi in Western Uganda.

Following the signing of the Grant Support Agreement between the Government of Uganda and UNOPS in August 2011, the Uganda Sanitation Fund, as part of the Global Sanitation Fund was established. The aim of the Fund is to create a robust demand for sanitation, to the point that people seek out creative ways to install toilets in their communities. According to information provided by USF, the majority of the 6,000 programme area villages were at the beginning of the programme not Open Defecation Free (ODF) (source, CPP). At least 32% of the households did not use sanitation facilities. At the time of undertaking this study, the Uganda sanitation fund programme was already two years into implementation.

The main aim of the study was to establish the current sanitation and hygiene situation in the 15 USF districts. The specific objectives were to assess the level of knowledge of sanitation and hygiene in the programme area, determine and document current sanitation and hygiene practices in terms of numbers, types, designs, maintenance and hygienic usages, determine and document level of access to service providers, different components of a safe facility and masons, and finally, determine the current access to sanitation financing.

The data collection methods used to conduct the sanitation and hygiene situation study were household surveys, Focus Group Discussions at village level, and Key Informant Interviews at National level with the Programme Coordination Mechanism (PCM) and the Executing Agency (EA). Key Informant Interviews were also held at district level with the district leadership and Health Officers. At the sub-county level interviews were held with the sub-county leaders, personnel in the health sector, the Village Health Teams, Community Development Officers, masons and primary school teachers.

In total, 969 household questionnaires were completed, and 15 Focus Group Discussions at community/village level were conducted. A total of 55 Key Informants were interviewed in the 15 districts and 9 Key Informants (Programme Coordinating Mechanism and Executing Agency) at national level, making a total of 64 respondents.

The methods applied were both qualitatively and quantitatively utilized in order to establish in-depth, statistically viable and reliable information about sanitation and hygiene from both community and national levels.

Findings of the study have been presented according to community and , institutional levels as well as themes.

Main findings of the study

Table 1 Sanitation and hygiene indicators

S/N	District	Latrine Coverage			Hand washing			Knowledge on importance of latrine		Financing	Masons
		Not acceptable standard	Acceptable standard*	Total coverage	Hand washing facility	Water & soap	Wet ground	Management of faeces	Cleanliness	Accessed financing	Total No. Trained
1	Mbarara	51%	44%	95%	23%	7%	17%	87%	17%	2%	No data
2	Bushenyi	55%	34%	89%	58%	15%	37%	64%	49%	12%	40
3	Sheema	62%	33%	95%	27%	2%	23%	91%	24%	17%	No data
4	Pallisa	57%	30%	87%	12%	7%	10%	90%	87%	2%	No data
5	Kibuku	73%	27%	100%	17%	3%	10%	100%	90%	7%	No data
6	Bukedea	57%	23%	80%	7%	4%	4%	100%	90%	3%	36
7	Kumi	75%	20%	95%	7%	4%	11%	93%	90%	7%	21
8	Ngora	66%	17%	83%	28%	4%	16%	90%	79%	0%	No data
9	Serere	68%	17%	85%	4%	0%	4%	85%	78%	0%	16
10	Soroti	80%	13%	93%	24%	6%	15%	80%	88%	0%	66
11	Katakwi	63%	11%	74%	10%	0%	11%	100%	90%	60%	7
12	Amuria	62%	10%	72%	14%	4%	11%	62%	72%	0%	No data
13	Kaberamaido	69%	7%	76%	13%	4%	12%	77%	73%	0%	No data
14	Dokolo	93%	7%	100%	13%	7%	13%	67%	93%	13%	6
15	Amolatar	70%	0%	70%	9%	3%	3%	76%	85%	3%	No data

* For standard latrine definition refer to page ix.

Knowledge and awareness on sanitation and hygiene

Communities seem to have knowledge on the importance and aspects of improved sanitation and hygiene, especially in areas where the USF programme is being implemented. Communities are aware of the importance of having and using a latrine and why a latrine should be kept clean.

Access to sanitation facilities

Many households at 77% do not have latrines of an acceptable standard (page ix) in areas without USF intervention. Introduction and implementation of the USF programme in all the 15 USF districts has led to an increase of acceptable latrines constructed (37%)which has resulted in a reduction of faeces in the environment.

Outside the area covered by the USF programme, most households have some form of latrine, with about 12.3% on average not having any latrines at all. However, 80% of all latrines are below acceptable latrine standards (Page ix, operational definitions)

Table 2 Availability of latrines

	Benchmark	Progress
No Latrine	10%	13%
Not acceptable standard	62%	63%
Acceptable standard*	28%	22%

Benchmark means found in villages without USF intervention. Progress means found in villages with USF intervention. * For standard latrine definition refer to page ix.

Sanitary facility construction and related factors

The construction of sanitary facilities, especially latrines is considered challenging in some areas due to adverse environmental conditions. These conditions including the presence of hard rock at shallow depths, collapsing and loose soils, and high water tables, among others. This results in a lack of latrines in some households/communities, especially in water-logged and flood-prone areas.

Access to financing

Very few people at 7% have ever accessed financial assistance for the construction of sanitary facilities. Costs for latrine construction are fully met by the household members, the head of the household in particular.

Funding for national sanitation policies and strategies

The Ugandan Government has various sanitation policies and strategies to address sanitation and hygiene in the country. Due to limited funding for the sub-sector however, implementation of these sanitation policies has not been adequate and effective, especially at Local Government Level (CPP).

Role of Development Partners/NGOs in the sanitation and hygiene sector

There are various Development Partners/NGOs active in sanitation and hygiene in the USF districts. The Development Partners support the sanitation sector through provision of training and sensitization and provision of sanitary materials. In addition most of them supplement district sanitation budgets. Although NGOs share their reports and plans with the National Sector Working Group, there are reporting and coordination gaps between the NGOs and other sector players. Some NGOs do not seem to be transparent and do not share their work plans and budgets.

Sanitation and hygiene situation before commencement of the USF programme

Upon commencement of the USF programme, the sanitation and hygiene situation in most districts, especially in the Northern and Eastern regions was considered challenging; latrine coverage was as low as 45%, especially in Northern and Eastern districts before the commencement of the USF programme in 2011. The introduction and gradual implementation of the USF programme has enabled improvement in sanitation levels in all the USF districts, with latrine coverage increasing by 5% to 28% across the USF districts. There were still many communities lagging behind, and many (20% Bushenyi to 97% Bukedea) of the latrines constructed were below desirable standards (Page ix, Operational definitions and figure 47 presence of latrines).

Availability of health staff and masons

All the 15 USF districts have health staff at all levels who manage the USF programme. The Health Inspectorate staff, however, do not have the means of transport to go to all the villages for monitoring. Communities rarely accessed masons who were scattered throughout the sub-county and villages . Although some masons were trained especially under the USF programme, most of them do not carry out latrine construction. This is due to various reasons like lack of support from the sub-county headquarters and lack of tools. Some of the masons are not affordable to hire by the community. Additionally the majority of the masons do not have the construction skills necessary to construct latrines.

Conclusions and main recommendations of the study

Knowledge and awareness on sanitation and hygiene

There is a need to intensify community mobilisation, training and sensitisation on improved sanitation and hygiene practices, especially in the villages in the USF programme districts that have not yet been reached by the programme. Health Assistants should continuously monitor and follow communities to ensure continuity of improved behaviour.

Access to improved sanitation facilities

There is need to improve the quality of sanitary facilities constructed in communities by applying various approaches such as sanitation marketing.

Sanitary facility construction challenges

Communities should be sensitised on different latrine options that are suitable in the different soil conditions. The USF guidelines should consider subsidies for vulnerable groups with regard to latrine construction, i.e. provision of San Plats, and meeting the costs for pit excavation.

Access to sanitation financing

The USF programme should consider hardware activities i.e. public latrine construction, slabs and San plat subsidies, in addition to software activities in line with the three pillars of the Improved Sanitation and Hygiene financing strategy.

Role of Development partners/NGOs in the sanitation sector

NGOs should provide their progress reports and work plans to the MoH/EHD/Executing Agency for coordination and improved policy formulation.

Management of the USF

The capacity of sub-grantee staff receiving and implementing the USF should be regularly strengthened and monitored, in order to enable them effectively and efficiently manage and utilise the USF.

It is recommended that an independent monitoring team or a Consultant be identified to monitor and verify sub-grantee reported progress and output, since some of the reporting appears to be unrealistic.

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Operational definitions

Standard acceptable latrine

For the purpose of this study an acceptable/standard pit latrine is a pit, ideally not less than 3 feet deep if it is in use (Public Health (Drainage and Sanitation) Rules Sec. 67 (12) with a slab fitted with a squat hole through which users defecate into the pit and a superstructure, sufficient to ensure privacy and provide protection from the weather. It must be possible to clean the slab. The slab could be traditional that is of smoothened earth on logs or plastic or could be of concrete;

a) If the squat hole is of smoothened earth on logs; it is referred to as a traditional pit latrine
b) If a SanPlat is placed over the squat hole to improve on the cleanliness; it is referred to as an improved traditional pit latrine
c) If a reinforced concrete slab is placed over the entire pit: it is referred to as an improved pit latrine
d) If the pit is fitted with a vent pipe to effectively ventilate the pit; it is referred to as a Ventilated Improved Pit (VIP) latrine

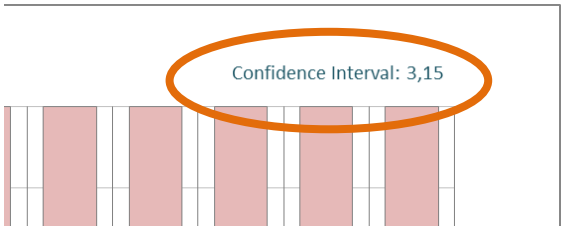
Ecosan (Ecological Sanitation) Latrine

This is an approach to excreta management where the excreta are regarded as a resource that should be recycled into the environment to provide plant nutrients. The main principle in ecological sanitation is that human excreta are temporarily stored in a vault/cubicle for some time to cure/sanitize before being released to the environment. This means the vault can be reused. The most common type of Ecosan in Uganda is the Urine Diversion Dry Toilet (UDDT). For this type of Ecosan, the squat hole is fitted with a urine diversion device such that the two (urine and faeces) do not mix. The urine is diverted to a soak pit or collected to be used as a fertilizer while the faeces, which are usually mixed with ash or saw dust are allowed a period of time say, 6 months to cure or sanitize before they can be released to the environment. It should be noted that there are several other types of Ecosan toilets for example; Fossa Alterna, Arbor-loo, Enviro-loo amongst others.

Confidence level and interval

A confidence interval (CI) is a form of interval estimation of a population parameter and is typically used to indicate the reliability of an estimate. It is calculated from the observations and in principle different from sample to sample. The number of times the observed interval contains the searched for parameter is determined by the confidence level.

Figure 1 Confidence interval example



If, for example, a confidence interval of 4 is indicated and 50% of your sample picks an answer, you can be "sure" that if you had asked the question to the entire relevant population between 46% (50-4) and 54% (50+4) would have picked that answer. The confidence interval is indicated above each graph in this report in the upper right corner. This confidence interval assumes the relevant population to be

the inhabitants of all 15 USF programme districts, regardless of whether they have been have been influenced by the USF programme or not. It does not indicate the confidence interval for the individual districts.

The confidence interval consists of a range of values or intervals that act as good estimates of the unknown population parameter. The level of confidence of the confidence interval indicates the probability that the confidence range captures this true population parameter given to a distribution of samples. It does not however describe any single sample. The value of the confidence level is presented as a percentage. For example when it is said "we are 95% confident that the true value of the parameter is in our confidence interval", it is expressed that 95% of the observed confidence intervals will hold the true value of the parameter.

The desired level of confidence is set by the researcher and is not determined by data. For the purposes of this study the confidence level has been set at 95%. The confidence level is typically indicated in the upper right corner of the graphs in this report.

Figure 2 example of confidence level

For Confidence intervals, greater levels of variance yield larger confidence intervals, and hence less precise estimates of the parameter. There are three factors that determine the size of the confidence interval for a given confidence level: Sample size, Percentage, and Population size.

The relevant population is typically indicated in the bottom right corner of the graphs in the report. Since the sampling unit is a household the population is indicated as number of households. The exception is when questions are not directed to an entire household, typical for demographical questions. Here the population is based on individual inhabitants of all 15 districts. The percentage before the number of households or inhabitants in the population indicates for which part of the population the question is relevant. For example if 50% indicates not to have a latrine, certain follow up questions can only be asked to those who have latrines. The population is based on projections for 2013 from UBOS and the assumption that an average household holds 5 inhabitants.

The sample size (n) is indicated in the bottom left corner of the graphs in the report. The sample size is depending on whether the households in question have seen USF intervention or not. For the demographics the sample size is all households who participated in the survey.

Figure 3 example of population and sample size

A larger sample size normally will lead to a better estimate of the population parameter. The relationship is not linear however, doubling the sample size does not halve the confidence interval.

To calculate the confidence interval the following equation was used, assuming a confidence level of 95% and using a known sample size and relevant population.

$$SS = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Z = Z value (e.g. 1.96 for 95% confidence level)

p = percentage picking a choice, expressed as decimal (0.5)

c = confidence interval, expressed as decimal (e.g., .04 = ±4)

SS = Sample size

Benchmark and Progress

Benchmark refers to the results gathered from villages that have not yet seen intervention from the USF programme. The "Benchmark" results can therefore be used as the true baseline and the main findings of the study. The study aimed to target 2/3 of its sample population to be without USF intervention.

Progress refers to the results gathered from villages that have seen intervention from the USF programme and can therefore be used as a preliminary indicator for improvement when comparing to the situation in villages without USF intervention. The progress is considered a secondary objective. The study aimed to target 1/3 of its sample population to be with USF intervention.

List of Abbreviations

CAO	Chief Administrative Officer
CBO	Community Based Organization
CLTS	Community-Led Total Sanitation
CPP	Country Programme Proposal
DHI	District Health Inspector
DHO	District Health Officer
EA	Executing Agency
EHD	Environmental Health Department
EHP	Environmental Health Policy
FGD	Focus Group Discussion
GSF	Global Sanitation Fund
HA	Health Assistant
ISH	Improved Sanitation and Hygiene 10-year financing strategy
KDS	Kampala Declaration on Sanitation
KI	Key Informant
KII	Key Informant Interviews
L.C.I	Local Council I
L.C.V	Local Council V
LITEA	Long Term Institutional Arrangement framework
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MWE	Ministry of Water and Environment
NGO	Non- Government Organisation
NSWG	National Sanitation Working Group
ODF	Open Defecation Free
PCM	Programme Coordination Mechanism
PHA	Public Health Act
PHC	Primary Health Care
PWD	People With Disabilities
RUWASA	Rural Water And Sanitation
SPR	Sector Performance Report

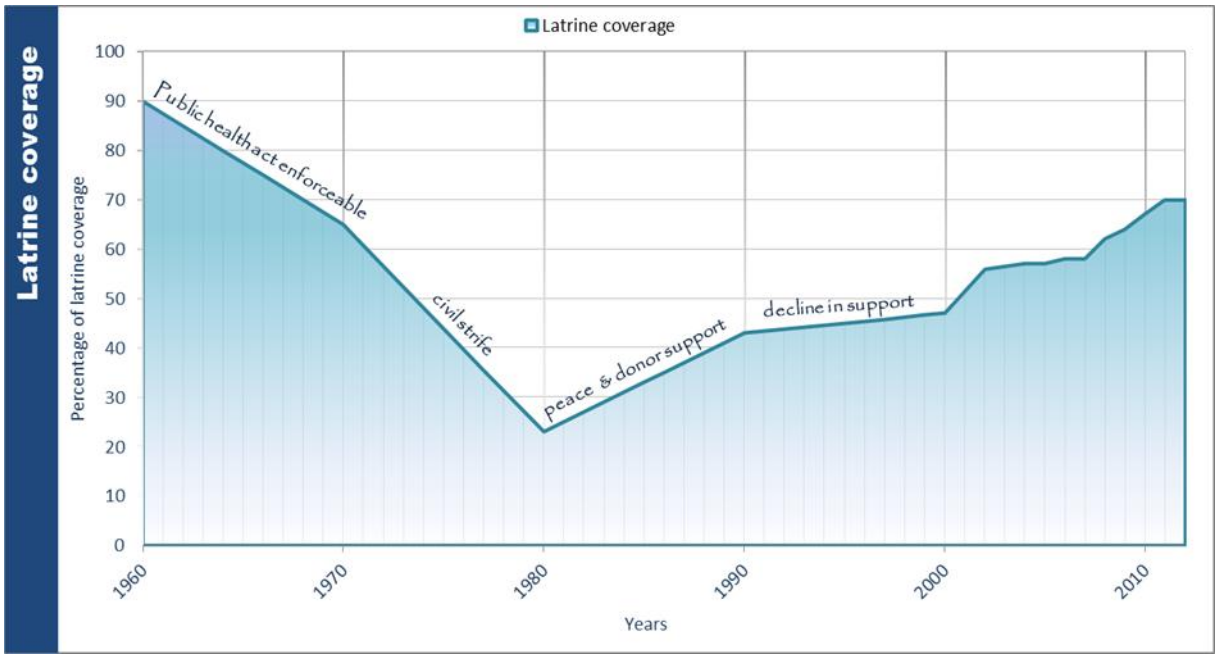
SPSS	Statistical Package for Social Scientists
TEDO	Teso Development Organisation
UNOPS	United Nations Office for Project Services
USF	Uganda Sanitation Fund
VHT	Village Health Team

1. Introduction

The annual sector performance reviews of Water and Environment sector and the Health Sector as well as other reports present the trends in national latrine coverage over the years. Latrine coverage was high in the 1960s through to the early 1970s. This was possible because the population at that time was small, local chiefs and elders were respected, and the extension staff was well motivated and facilitated. In addition, the prevailing law, the Public Health Act (PHA) was applicable and enforceable. During the 1970s through to the early 1980s, there was civil strife in the country that led to economic decline and destruction of social services including sanitation facilities. Morale degeneration among the populace followed, resulting in a drop of the previously high latrine coverage. During the late 1980s, there was again relative peace in the country; a number of donors picked interest in sanitation and hygiene promotion and provided funding to support government efforts to boost latrine coverage. When however the support reduced again, coverage stagnated.

Figure 4 shows the trend in latrine coverage in Uganda from 1960 to present. The graph shows that latrine coverage was at 90% in the 60s but dropped in the 70s to 23%. Currently it seems to be stagnating at 70%. The improvements are reportedly related to increase in funding and implementation of innovative strategies.

Figure 4 Latrine coverage trend in Uganda



Source: MoH EHD

Working successfully with the international community to increase the availability of clean water in the country, the Government of Uganda found that the sanitation and hygiene subsector was falling behind. Though the government has developed policies and strategies and put personnel in place to address that challenge, money has been lacking for actual implementation. Some examples of the existing legislation, policies and strategies are summarised in Table 3.

Table 3 Sanitation policies, Strategies and major milestones

Name	Acronym	Year	Description
Public Health Act	PHA	1964	Updated 2000. Primary legal basis for preservation of public health. It is the main law that addresses sanitation.
Kampala Declaration on Sanitation	KDS	1997	Recognition of sanitation as a basic right and responsibility of every Ugandan citizen
Ministerial Memorandum of Understanding	MOU	2001	Signed between MoH, MWE and MoES to improve inter-ministerial cooperation with respect to sanitation
National Sanitation Working Group	NSWG	2003	Formed mainly to raise the profile of sanitation in the sectors. It support sector coordination, policy development and hygiene and sanitation services among other things
Environmental Health Policy	EHP	2005	Establishes environmental health priorities of Government
Improved Sanitation and Hygiene (Financing Strategy)	ISH (FS)	2006	Built around 3 pillars: i) enabling environment; ii) Demand creation; iii) improved supply chain of sanitation commodities

According to the Water and Environment Sector Performance Report 2012, access to improved sanitation in the rural households was 70% while in the urban areas it has increased to 81%. The pupil to latrine stance ratio in primary schools has declined from 66:1 to 69:1.

The Uganda Sanitation Fund

Following the signing of the Grant Support Agreement between the Government of Uganda and UNOPS in August 2011, the Uganda Sanitation Fund, as part of the Global Sanitation Fund was established. The Uganda Sanitation Fund works with the Ministry of Health and the Ministry of Finance, Planning and Economic Development to implement a programme making maximum use of existing capacity set up at central and district level. The aim is to create a robust demand for sanitation and hygiene, to the point that people seek out creative ways to install toilets in their communities. The USF districts in Uganda are composed of 15 district local governments, supported by NGOs active in their respective geographical areas. There is still a possibility of increasing on the number of USF districts as implementation of the programme continues. According to CPP the USF programme area has a total target population of 3.8 million. The majority of the 6,000 programme area villages were at the beginning of the programme not Open Defecation Free (ODF) (CPP). A total of 200,000 (32 %) households did not use sanitation facilities (CPP). At the time of undertaking this study, the Uganda Sanitation Fund programme was two years into implementation.

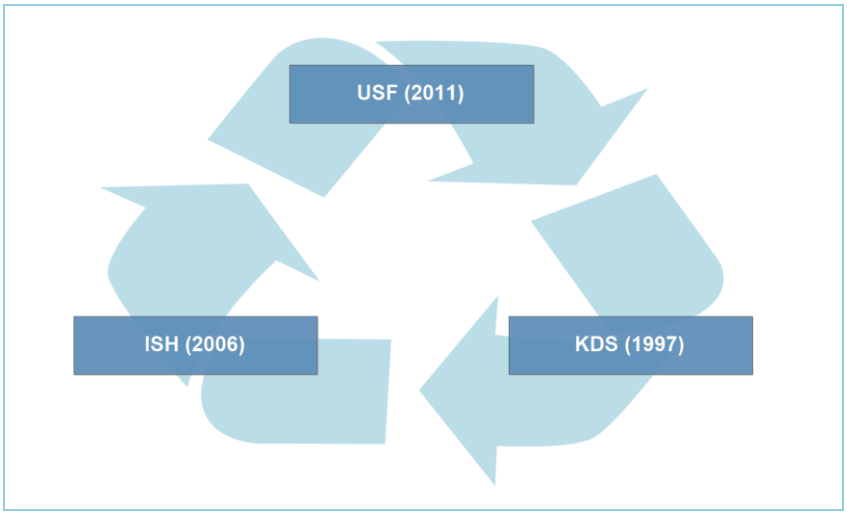
The work in these 15 districts consists of government, NGO and private sector actors promoting demand-led approaches (including but not limited to the promotion of the concept of Community-led Total Sanitation (CLTS)), carrying out home improvement campaigns and sanitation and hygiene marketing. The main purpose is to scale up efforts to generate demand for improved sanitation and hygiene, and to strengthen the supply chain for appropriate sanitation products and services to meet this demand, while creating an enabling environment for sustainable change.

Kampala Declaration on Sanitation (KDS) 1997, Improved Sanitation and Hygiene (ISH) 2006 and Uganda Sanitation Fund 2011

In October 1997, the Ministry of Health organised the first ever national forum on sanitation and hygiene. Leaders of all districts in Uganda together with members of parliament, permanent secretaries, directors and commissioners of all relevant ministries, NGO representatives, the private sector, cultural leaders and the donor community (over 300 participants) came together in a two-day meeting. The primary objective was to decide on a way forward for halting the increasing negative health and mitigating economic and environmental impacts of poor sanitation and hygiene in the country.

Following the two-day deliberations, a high level commitment for sanitation and hygiene promotion was achieved as the then 45 district local authorities (Local Council and chairpersons) signed the Kampala Declaration on Sanitation (KDS) 1997, endorsing the guiding principles for sanitation improvement in the country and a 10-point strategy plan for action at district level. Since 1998, the Ministry of Health has produced and distributed guidelines for implementing KDS, and a number of promotional materials for the school sanitation component of KDS. Although it has been over 10 year since KDS was made, its 10-point strategy is still as pertinent today as it was in 1997 when it was made. The KDS is still a good discussion starter for sanitation discussions in districts. Additionally it is a useful tool for NGOs or individuals who may be called upon to initiate sanitation and hygiene projects especially at district level. KDS is the basis on which the 10-year Improved Sanitation and Hygiene (ISH) Financing Strategy was developed (KDS+10).

Figure 5 Relation KDS, ISH and USF

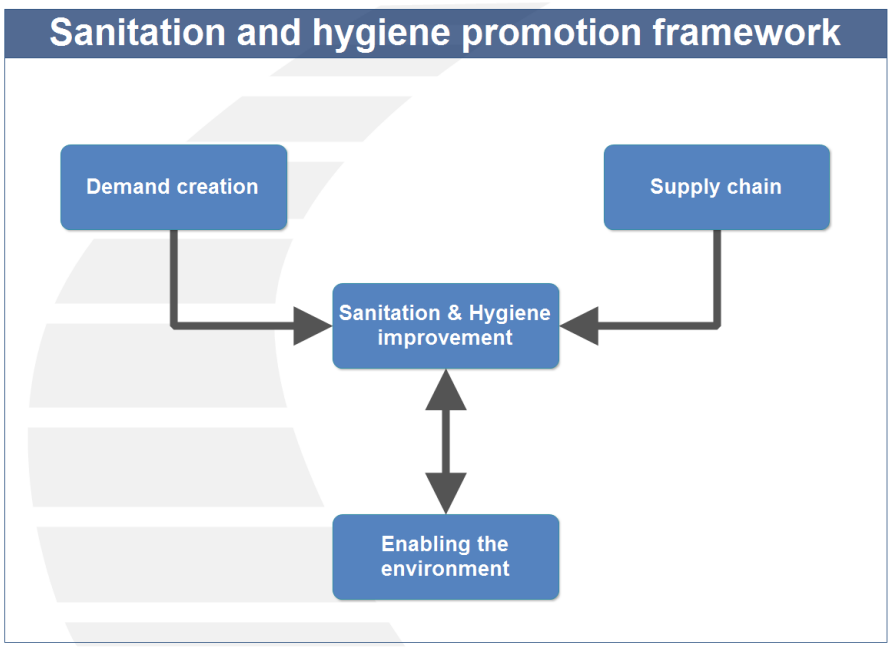


The main feature of ISH includes the three pillars of

- Demand creation
- Supply chain and
- Enabling environment

The three pillars are proposed by ISH as the most important strategies for effective sanitation and hygiene promotion in Uganda. Accordingly, the USF is structured around the three ISH pillars and the three pillars therefore form integral components of the USF programme. The three pillars are summarized in the diagram in Figure 5.

Figure 6 Sanitation and hygiene promotion framework



Demand Creation: This involves implementing a wide range of activities that target creating demand for sanitation and hygiene. These include but are not limited to sanitation marketing, participatory approaches as in Community Led Total Sanitation (CLTS), home improvement campaigns and competitions and social marketing of hand washing with soap.

Supply Chain: This involves activities to ensure availability of affordable technology options and an improved private sector supply chain for sanitation commodities.

Enabling environment: This aims to support and facilitate an accelerated scaling up through increased funding, policy and legislation, coordination, monitoring and learning.

1.1 Objectives of this study

The purpose of the study was to establish the current levels and patterns of hygiene and sanitation in the programme area. The survey was therefore to provide benchmarks against which behavioural change during and after the Uganda Sanitation Fund programme would be measured. The information should provide a clear picture on the status of sanitation coverage and hygiene behaviour in the sampled areas of the 15 districts. The 15 programme districts were:

- Mbarara, Bushenyi and Sheema in South-West Uganda
- Dokolo and Amolatar in Northern Uganda
- Pallisa, Kibuku, Bukedea, Kumi, Ngora, Serere, Soroti, Katakwi, Amuria, Kaberamaido in Eastern Uganda.

The study objectives were to:

i. Assess the level of knowledge of sanitation and hygiene in the programme area

ii. Determine and document current sanitation and hygiene practices in terms of numbers, type, design, maintenance and hygienic usage

iii. Determine and document level of access to service providers, different components of a safe facility and masons

iv. Determine current access to sanitation financing

The research consultants utilized both qualitative and quantitative methods of data collection and, as much as possible worked in close collaboration with Ministry of Health (MoH) staff, both at the central and lower local governments.

1.2 Report structure

The report is structured as follows:

1.0 **Introduction**: Highlights the general background of the study and its objectives.

2.0 **Methodology**. This explains the sampling procedures, tools used, field operations and data management.

3.0 **Secondary data**: data gathered from district and national level institutions.

4.0 **Findings at community level:** From non USF covered villages. This is considered to act as the true baseline survey. From USF covered villages. This is considered as a progress report.

As agreed with the USF team during the inaugural meeting for this study, two-third of the household surveys have been carried out in villages that were not yet covered by the USF programme, even though the USF programme is well underway, and has sometimes even reached the sub-county in which the particular village is situated. These findings are considered to constitute the true baseline survey. The findings from Focus Group Discussions and Key Informant Interviews have not been further disaggregated for villages covered by USF, and villages not covered by USF. They are included in Chapter 4 to provide a deeper insight in the findings of the household questionnaires.

Findings USF villages: Findings from USF areas are compared with secondary baseline data to establish retrospective information. Both findings from villages covered by the USF programme and villages not (yet) covered by USF shall present the current situation and progress of programme implementation.

One-third of the household surveys have been done in villages that are being covered by the USF Programme. The findings from this part of our database will present an initial feedback on the progress of implementation and results of the USF, though it should be noted that it is too early to see whether the objectives are being reached. In these villages, some questions have been raised regarding the situation before the USF programme started in their village. Answers to these questions provide a retrospective insight in the progress made in improving the sanitation and hygiene situation in the

area due to the USF programme, and may act as supporting information to the true baseline survey

5.0 **Findings at institutional level**: which are both actual and retrospective. These findings have been derived from the Key Informant Interviews, and unlike the household surveys and Focus group discussions do not yield information at village level. These findings are not disaggregated since they provide an overview of perspectives from an institutional level.

6.0 **Conclusions and recommendations:** This chapter presents the conclusions drawn by the consultants basing on the analysis of the data collected. It also contains recommendations based on the consultants' experience in the sector as well as reflecting the views of the respondents

2. Methodology

The materials and methodology used during this baseline study were based on the Terms of Reference supplied by the Ministry of Health, and have were finalized using experience of the consultants with similar projects, such as the "Ex-Post Review of Water and Sanitation Interventions in South-West Uganda since 1996", in coordination with Hydrophil, for Austrian Development Agency.

In order to meet the objectives stipulated in the terms of reference, the consultants employed the following tools:

- Desk study of relevant documents
- Household Survey at community level
- Focus Group Discussions (FGD) at community level
- Key Informant Interviews (KII) at national, district and sub-county levels

2.1 Desk study

The desk study included a review of documents like the Water & Environment Sector performance reports and Health Sector performance reports among others.

The terms of reference and suggestions from the meeting with the ministry of health were studied, leading to the inception report.

Additionally the areas included in the USF programme were studied and maps were made to support in the field work and to create a general overview.

2.2 Design of community tools

With reference to the documents studies during the desk study and the terms of reference supplemented by the meeting with the MoH the community tools were designed. The community tools included household surveys which were subjected to the sampling procedures to be described in this chapter and Focus Group Discussions to supplement the information gathered from the household surveys.

2.2.1 Household survey

Indicators

The household survey tool was designed to cover comprehensive information on the key indicators specified in the terms of reference and also as agreed with the client in the inception report and inaugural meeting. The consultant was also mindful of the indicators in the Monitoring and Evaluation Framework and log frame for the USF programme. The variables were categorised as

a) Demographic,
b) Knowledge/ awareness of sanitation and hygiene in the programme area
c) Current sanitation status (access) and hygiene practices
d) Social and cultural taboo/beliefs
e) Construction related factors
f) Current access to sanitation financing/Source funding for sanitation

The variables in the study are:

a) Demographic variables and these include;
- Sex, Age, Marital status, Education, Number of children, tribe and religion

b) Knowledge/awareness of sanitation and hygiene in the programme area variables include the following
- Importance of latrines
- Knowledge about faecal disposal
- Knowledge of latrine cleanliness
- Hand washing facilities
- Cleansing materials in latrines
- Diseases related to poor latrine use

c) Current sanitation status (access) and hygiene practices in terms of numbers, type, design, maintenance and hygienic usage
- Availability of a latrine
- Type of latrine being used (traditional, SanPlat, slab, VIP, Ecosan, others)
- Observation of sanitation practices through transect walks
- Source of information on faecal disposal

d) Social and cultural taboo/beliefs – targeting to harness data on
- Cultural beliefs
- People's beliefs
- By Laws on latrines use

e) Construction related factors, such as
- Type of soil
- Environmental factors
- Physical and technical constraints
- Affordability/cost issues
- Availability of materials and labour

f) Current access to sanitation financing/Source funding for sanitation
- Public (such as central government grants)
- NGOs
- Private (self-supply initiatives)

Sample population

The study population is the entire population in the 15 districts of Mbarara, Bushenyi and Sheema, Dokolo and Amolatar, Pallisa, Kibuku, Bukedea, Kumi, Ngora, Serere, Soroti, Katakwi, Amuria and Kaberamaido. Based on the Census 2002 population, and incorporating anticipated population growth levels, at present there are 3.929 million people living in these districts.

The extent of the sampling and scope of coverage has been established based on the terms of reference and in light of the available budget for the survey. The sample and scope of coverage was agreed during the inaugural meeting with the Ministry of Health in which the inception report was also presented. It was agreed that both USF covered communities and non USF covered communities were to be surveyed to assess the status of sanitation and hygiene in homes.

Sample size

The initially planned sample size for this study was 700 households as communicated to the client during the inaugural meeting. The district size was viewed to be proportional to the number of sub-counties in that district (Population Proportional to Size). A minimum of 3 vil-

lages per district would be surveyed in each of the 15 districts. The minimum number of villages to be surveyed should increase according to district size, with the actual number of sub-counties in the district taken as a measure of size. Villages would be selected based on whether intervention by USF programme took place or not. Villages were selected based on a 2:1 ratio, whereby $^2/_3$ of the villages had not seen active intervention by the USF programme, while $^1/_3$ of the villages had seen intervention by USF programme and the villages that had not seen intervention by the USF programme respectively. The number of households to be surveyed as stated in the initial plan of approach was 700 households.

During data collection, the team had an opportunity to increase the number of households surveyed, raising the sample size from 700 to 969 as shown in Table 4.

Table 4 Actual number of households surveyed

District	Villages	Total No. of HH
Mbarara	9	149
Sheema	4	75
Bushenyi	4	76
Katakwi	5	46
Kaberamaido	5	50
Amuria	5	48
Bukedea	3	51
Amolatar	3	61
Dokolo	3	38
Ngora	3	49
Kumi	4	50
Kibuku	4	50
Pallisa	8	100
Soroti	6	79
Serere	4	47
Total	**70**	**969**

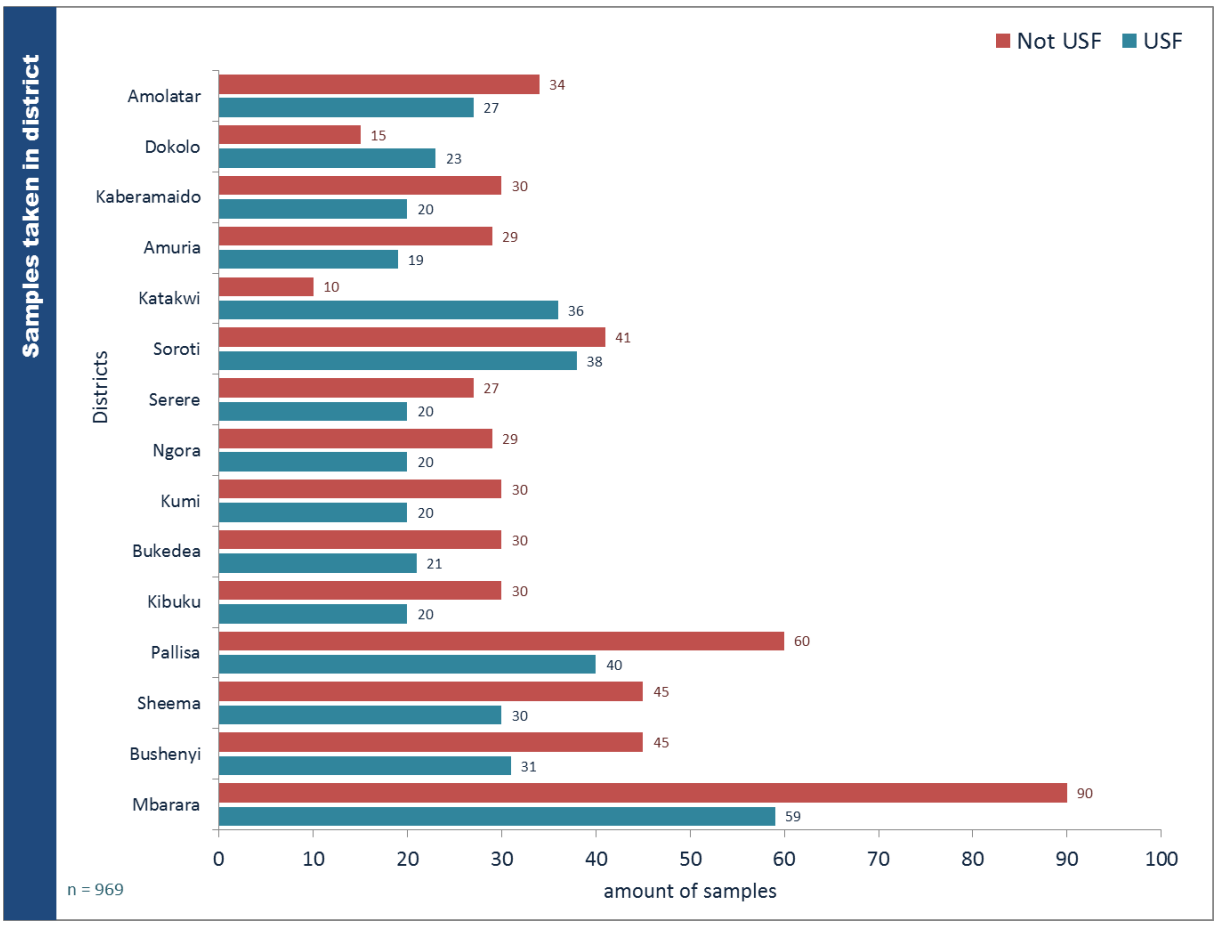
The sampling procedure was guided by the District Health Officers (DHO). The District Health Inspector (DHI) and Health Assistants (HA) identified both the USF and non USF villages for survey.

The procedure was guided by the principle of 2:1, whereby more non USF than USF villages were selected for the survey. At the village level, village leaders i.e. Local Council 1 Chairpersons informed the enumerators about the number of households in the village, and the village set up.

Based on village size as stipulated by the community leaders, the interval for household selection was determined. This meant the interval between households was linked to village size, increasing coverage in bigger villages if possible. In each village (both USF and non USF), an average of ten (10) households in the Northern and Eastern region, and a total of fifteen (15) households were surveyed in the Western region.

The household head was aimed to be the main respondent for the interview. Figure 7 summarizes the household samples in each district, categorized on whether they have received USF intervention.

Figure 7 Households sampled in each district with distinction in USF intervention (USF: Intervention occurred, Not USF: No intervention occurred)



In the graph in Figure 7 one can see that the difference between Not USF and USF is not that clear as intended by the study (Not USF 2/3, USF 1/3). Main reason for this is that some District Health Inspectors could not nominate or point out enough villages that have not seen intervention by the USF programme. Another reason is that not all villages are the same size, and to get a representative sample bigger villages had more households sampled than relatively smaller villages. This difference in samples taken among villages causes the scale to tip more to the side with the bigger villages.

Sampling procedure

The procedure was formed keeping in mind the available funds for the survey, while ensuring that both the in the USF covered communities and non USF covered communities were to be surveyed. The sampling procedure was guided by the District Health Officers (DHO). The District Health Inspector (DHI) and Health Assistants (HA) who identified the USF and non USF villages surveyed. At the Local Council 1, the LC1 Chairperson informed the Enumerators about the number of Households in the village.

Based on village size as stipulated by the community leaders, the interval for household selection was determined. In each village (both USF and non USF), a total of ten(10) households in the North and Eastern region and a total of fifteen (15) households were surveyed in the Western region.

The size of the samples taken was:

- All: 969 samples
- Without USF intervention: 545 samples
- With USF intervention: 424 samples

With a 95% confidence level, the confidence interval per sample cluster would then be on average:

- All: 3.15
- Without USF intervention: 4.2
- With USF intervention: 4.76

Though there might be slight fluctuations depending on independent questions, the above confidence intervals will generally dictate the certainty of the data presented from the household survey.

Data collection procedures

Within each household sampled in the field, the research assistants/enumerators asked for the head of the household as the target respondent. However, if the head was not around, they sought to interview the spouse of the head of the household, or another adult within the household.

The villages, spread out of different sub-counties where the household questionnaires were administered, were chosen in collaboration with the DHI of the representative district.

The research assistants/enumerators could speak the local language, which increased efficiency and ensured correct interpretation of the answers. In addition, a research assistant/enumerator was always accompanied by a local guide, appointed by the LC1 to ensure that the research assistants/enumerators were received in a hospitable fashion when conducting the surveys.

The surveys were always conducted in the same order, and always gave the same options for choices in multiple-choice questions. Only when asking for sub-county, parish, and village names, open questions were used. The data were entered in a tailor-made questionnaire, administered through a tablet, where each enumerator had a tablet.

With the multiple-choice questions there were multiple responses as well as single response questions. The enumerators had been explained when to note down multiple responses and when to note down a single response. This was also visually indicated on the computer tablet with each question.

The flow of the questionnaire depended on the answers given by the respondent. For example, if a respondent would indicate they do not have any form of latrine, questions concerning latrines would be skipped automatically.

Each enumerator conducted 10-15 household questionnaires in one day, and sampled the homes following the earlier stated sampling method.

At the end of each day, the research assistants/enumerators sent the collected data to a central web server from where the data was exported to a SPSS software programme for analysis.

2.2.2 Focus Group Discussion (FGD)

Indicators

The Focus Discussion Groups addressed the following areas:

- Knowledge/awareness on sanitation &hygiene.
- Current sanitation (access) and hygiene practices.
- Social and cultural taboo/beliefs that hinder sanitation improvement
- Latrine construction of related factors.
- Strategies to improve sanitation and hygiene in the community
- Access to sanitation financing
- Sanitation Initiatives and Innovations

A total of 15 Focus Group Discussions at community/village level were conducted. The purpose of FGDs was to provide in-depth qualitative information on the status of sanitation before USF and during implementation of USF. The FGDs were also used to propose measures to address the challenges. Each FGD had an average of 10 to 15 respondents, though a small number of communities attended in bigger numbers, i.e. up to 25 respondents in Agwenopentingtine in Amolatar district. The participants included the local village leaders and opinion leaders, selected and prepared by the sub-counties' Health Assistants.

2.3 Design of institutional tools

In order to establish information from key stakeholders, Key Informant Schedules were designed and administered. At national level, the tool targeted the members of the Programme Coordination Mechanism (PCM) and the core team of Executing Agency as Key Informants. At the district level, the study targeted Chief Administrative Officers (CAOs), District Health Officers, District Health Inspectors, and the Local Council V (LCV) Chairpersons, while at the sub-county level, the study targeted Health Assistants, Sub-county Chiefs, Village Health Teams, Masons and a small number of primary teachers.

Since the situation analysis was largely quantitative, only a limited number of qualitative discussions were held. A total of 55 key informants were interviewed in the 15 districts and 9 Key Informants (Programme Coordinating Mechanism and Executing Agency) at national level; making a total of 64 respondents. At district level, these included the CAOs, District Health Officers, LCV Chairpersons/ Secretary for Social Services and Health, and District Health Inspectors/USF focal persons. The purpose was to understand the local issues associated with promotion of sanitation and hygiene as well as the management of the USF programme.

2.3.1 Key informant interviews National level

Indicators

The key informant interviews at national levels focused on the followings indicators:

- Funding for National sanitation policies and strategies.
- Technical advice and support on sanitation and hygiene improvement.
- Role of Development Partners/NGOs in the Sanitation and Hygiene sector.
- Strategies to achieve ODF status.
- Management and Utilization of USF.

The focus of the discussions at this level was to capture views, perceptions and proposals at this level with regard to USF operations in the country.

The Participants/Respondents were:

i) Executing Agency/MoH core team
ii) Programme Coordinating Mechanism
iii) NSWG/WSP
v) MOFPED- Desk Officer-USF

2.3.2 Key informant interviews District level

The key informant interviews at national levels focused on the followings indicators:

- Sanitation and hygiene situation before commencement of the USF programme
- Criteria for selection of villages for the USF programme
- Comments about the USF guiding principles
- Roles of district leadership in the implementation of the USF programme
- Availability of health staff for the programme
- Availability of masons
- Sustainability of the ODF status.

2.3.3 Key informant interviews Sub-county level

Indicators

- Community Mobilisation and Sensitisation
  - Staff
  - Strategies
  - Challenges in community mobilisation
  - Costs involved
- Sanitation Facility Construction
  - Latrine coverage
  - Challenges
  - Hand Washing Facilities
  - Bath shelters
  - Refuse pits
  - Drying racks
- Technical advice and support on latrine construction
  - Availability of masons
  - Mason service charges
- Sanitation Facility Operation and Maintenance
- Access to financial support by households.
- Other sanitation innovations and initiatives

The Key Informants at sub-county level were Health Inspectors, Health Assistants, Local Council III Chairpersons, Community Development Officers, Masons, Village Health Teams and some primary school teachers; these are the key extension staff who are responsible for the grass root implementation of the programme. Their responses are therefore considered important.

2.4 Field work

The fieldwork was carried out between 13 June 2013 and 12 July 2013, starting with the Northern and Eastern regions, and ended with the South-Western region. While in the field household surveys, Focus Group Discussions and Key Informant Interviews were conducted. The fieldwork commenced with training of data collectors and pre-testing of the tools.

2.4.1 Training and pretesting

Fieldwork was preceded with training and orientation of the enumerators on the tools and the equipment/computer tablets to be used for data collection. Data collectors were trained on the various key components such as types and desired standard of latrines, hand-washing facilities, access to sanitation financing and technical support on sanitary facility construction. The enumerators had a theoretical training on use of the computer tablets and as well a practical training during the pre-testing of the tool in the field.

2.4.2 Organisation

The field team held a meeting with the CAOs and the District Health teams to discuss the study and its proceedings in their respective districts. The District Health teams guided the selection of the villages to be surveyed. The field team was composed of the Team Leader, the Social Scientist, the Quality Control and Logistics officer and 10 enumerators. The team was facilitated with two vehicles and drivers to move amongst the villages in the 15 districts.

2.5 Data processing and analysis

Data was collected using the computer tablets and was sent to the central server. The data was then obtained from the central server and rounds of checks of the generated tables with the same data set was carried out to ensure accuracy of the tables, and done using SPSS software. The final analysis of the information generated from the survey data was carried out to obtain the desired results as regards percentages and frequencies for the different variables.

2.6 Quality control

Research Assistants/Enumerators: In order to collect quality data within a specific timeframe, 10 research assistants/enumerators were employed as stated earlier. In order to overcome the challenge of the language barriers, 5 enumerators were carefully identified who spoke the languages in the Northern and Eastern districts. Another group of 5 enumerators speaking the languages in the South-Western districts were identified. They were all trained on the use of the computer tablets and on the contents and way of implementation of the household assessment tool.

This being a sample survey, it was likely to be affected by sampling and non-sampling errors. The following measures were therefore taken to minimize the errors at different stages on implementation:

a) Using a standard questionnaire adjusted to national requirements

b) Ensuring effective supervision during data collection by the social scientist

c) Having a well programmed computer tablet for data collection with relevant checks ensuring quality data was obtained

d) Undertaking editing of the captured data before data analysis

e) Use of well qualified enumerators who also had knowledge of the local languages. Majority were graduates of social sciences and development studies, while a few were senior six leavers waiting to join university.

3. Secondary data

3.1 The Uganda Sanitation Fund Country Programme Proposal (CPP)

The CPP presents the sector targets for sanitation as percentage of people with access to improved sanitation (households) at 77% for the rural population, and 100% for the urban population by the year 2015. The CPP indicates that the national average sanitation coverage stands at 70% for the rural, and 81% for the urban population. It estimates the latrine coverage in the 15 programme districts by the year 2011 to be as indicated in Table 5.

Table 5 latrine coverage in the programme districts as per 2011 (CPP)

District	Latrine coverage %		District	Latrine Coverage %		District	Latrine Coverage %
Mbarara	92.3		Kaberamaido	49		Amolatar	62.6
Ngora	52		Sheema	89		Kibuku	67.9
Serere	62.6		Kumi	52		Bushenyi	89
Pallisa	67.9		Soroti	62.6		Katakwi	49.3
Amuria	70		Bukedea	65		Dokolo	56

Source MOH/CPP

The table reflects a relatively high latrine coverage, ranging from 49% in Kaberamaido to 92.3% in Mbarara. Monitoring of sanitation and hygiene has always been a challenge, with inconsistencies in data obtained from different sources or otherwise from the same source but at different times. The findings of this study confirm the relatively high latrine coverage in the programme area both before introduction of the USF programme and after the introduction of the programme. However, the majority of the latrines were found to be below the required standard.

3.2 Sector performance report 2012 (SPR)

3.2.1 Eleven Golden Indicators

In an effort to improve on monitoring of sector performance, the water and sanitation sector developed a set of Golden Indicators to assess eleven performance themes. The indicators were worked out through consultations and collaboration efforts with sector stakeholders to measure overall sector performance. The detailed analysis of performance in terms of golden indicators has become increasingly central to overall management of the sector. The indicators provide not only a way to assess current performance but also a framework for comparison over time.

The Golden indicators that are relevant for this study are indicators 4.1, 4.2 and indicator number 8 as explained below:

Golden indicator No 4.1: Percentage of people with access to improved sanitation (household level)

The water sector performance report of 2012, covering the financial year starting July 2011 to June 2012, estimates the national latrine coverage in rural areas at 69.6%. The report further indicates that only 16% of the rural population in Uganda has access to improved latrines, while 65% use unimproved latrines. According to the same report, 41 districts have met the national sanitation target of 77% coverage, but the report urges these districts to increase efforts to make sure their districts acquire open defecation free status. According to the report, only the five districts of Sheema, Serere, Pallisa, Mbarara, and Amuria in the USF programme area reported having triggered some villages towards aspiring ODF status; even then,

the coverage in terms of triggered villages was still very low, at only 23% in Amuria. It is Mbarara that attained a good coverage at 80% of the villages triggered. Table 6 Summarises the performance of the 15 USF districts with regard to selected key sanitation indicators

Table 6 Status of selected indicators in the USF districts

S/N	District	Pupil: Latrine Stance Ratio	% HH San Coverage	% HW Coverage	No of ODF villages	% of Triggered villages that are ODF
1	Amolatar	84.0	72.7	55.0	-	-
2	Amuria	66.0	56.8	33.0	105	23%
3	Bukedea	-	65.0	-	-	-
4	Bushenyi	56.0	91.0	51.9	-	-
5	Dokolo	60.0	78.0	56.0	-	-
6	Kaberamaido	-	63.0	-	-	-
7	Katakwi	64.0	69.9	15.8	-	-
8	Kibuku	76.0	75.6	61.3	-	-
9	Kumi	76.0	65.0	19.0	-	-
10	Mbarara	44.0	94.0	38.0	98	80%
11	Ngora	82.0	77.0	28.0	-	-
12	Pallisa	63.0	65.6	36.7	19	-
13	Serere	-	65.1	7.0	10	28%
14	Sheema	61.0	81.2	19.0	52	50%
15	Soroti	65.0	69.7	25.0	-	-

Source: Annual Water Sector Performance Report 2012

Golden indicator No 4.2: Pupil to latrine stance ratio in schools

The SPR 2012 indicates that the data availed by the districts show the pupil to stance ratio of 69:1, while according to the provisional data from the MoES the pupil: stance ratio was 35:1 in primary schools, and 25:1 in secondary schools. This inconsistency points out the need to harmonize and/or improve the monitoring system for school sanitation. There are irregularities in the collection and reporting of school sanitation data. As regards the USF programme areas, the worst performing district is Amolatar, with a pupil to stance ratio of 84:1; the district of Mbarara performed better with a ratio of 44:1. It should be noted that the required ratio is 40:1 (Public Health Act 2000).

Golden indicator No 8: Hand washing

At national level, the average access to hand washing (HW) facilities in the rural areas is 27% (103 districts reporting). Only 8 districts attained the national goal of 50% access to hand washing facilities. Even then, these 8 districts need to do more to ensure actual use of the facilities, i.e. hand washing with soap especially at critical times.

The national level access to hand washing facilities in primary schools was estimated at 35% (95 districts reporting), although some districts reported that many of the hand washing facilities had no water; therefore the actual rate of hand washing after using the toilet (% HW coverage) was much lower. As for the USF programme area, it can be seen from Table 6 that Serere district reported the lowest rate of HW coverage at 7%, while Kibuku had the highest at 61.3%. The districts of Kaberamaido and Bukedea did not report.

4. Findings at community level

Findings displayed in this chapter have been derived from the answers gained from the household questionnaires and have been supplemented by information from the Focus group discussions held at representative villages.

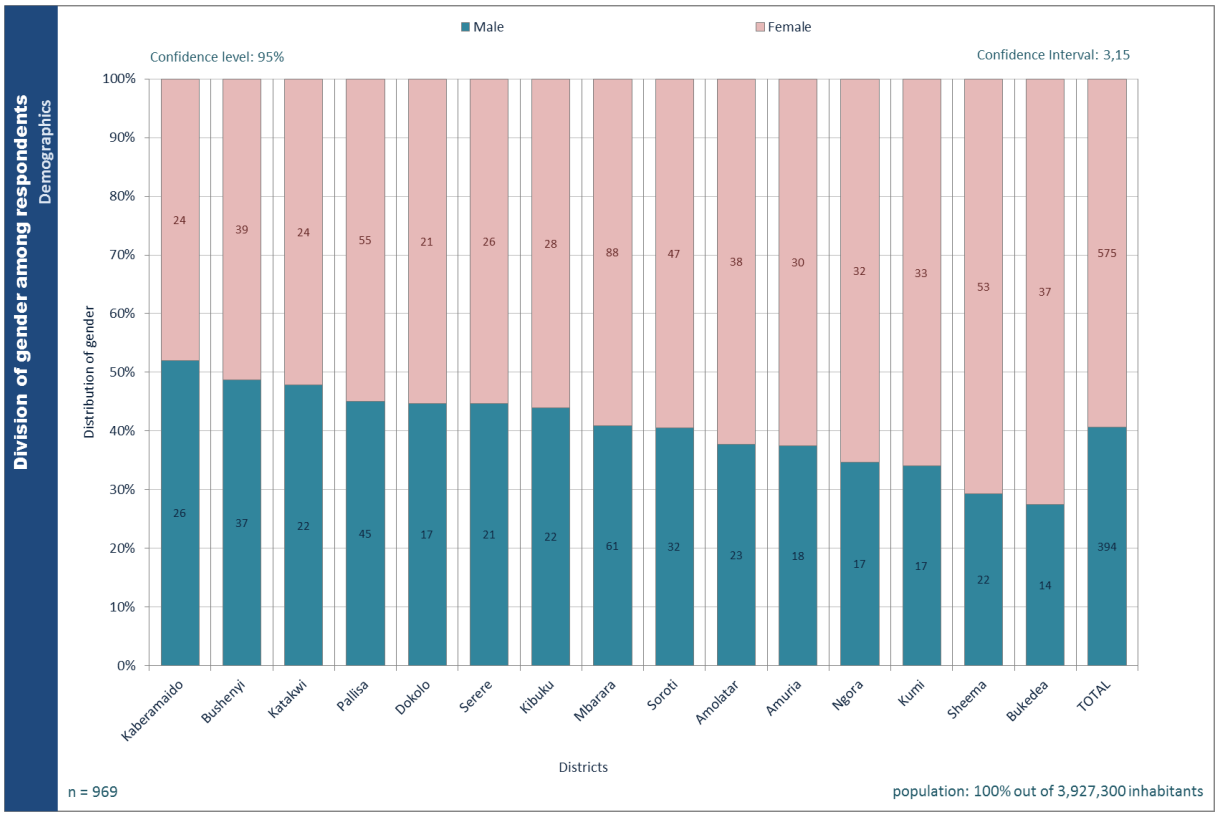
4.1 Demographic data

The Demographic data typically displays statistical data not directly sanitation and hygiene related, still relevant and can provide insight to fluctuations in sanitation and hygiene indicators. The demographic data has been based on the entire population of USF and non-USF areas combined.

Gender

As can be seen in figure 8, in most districts the majority of the respondents interviewed was female. Figure 8 shows an overview of gender encountered among the respondents and shows that of the total population of the 15 districts together more women (60%) were interviewed than men (40%).

Figure 8 Distribution of gender among respondents

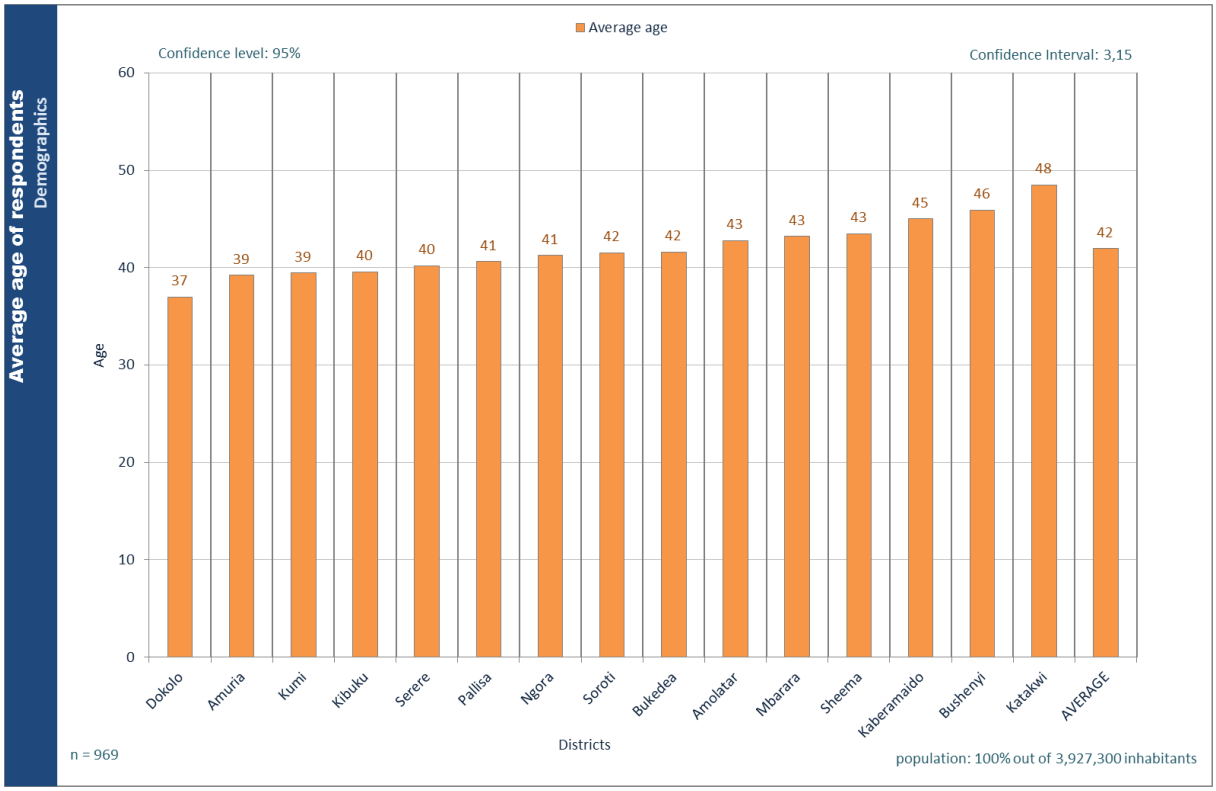


Age

The respondents interviewed for the purpose of the study were aged between 37 and 48 years. Outliers could be found in districts such as Kaberamaido and Sheema, where respondents in

cases were aged 90 years and above. For an overview of the average age per district and overall, refer to Figure 9.

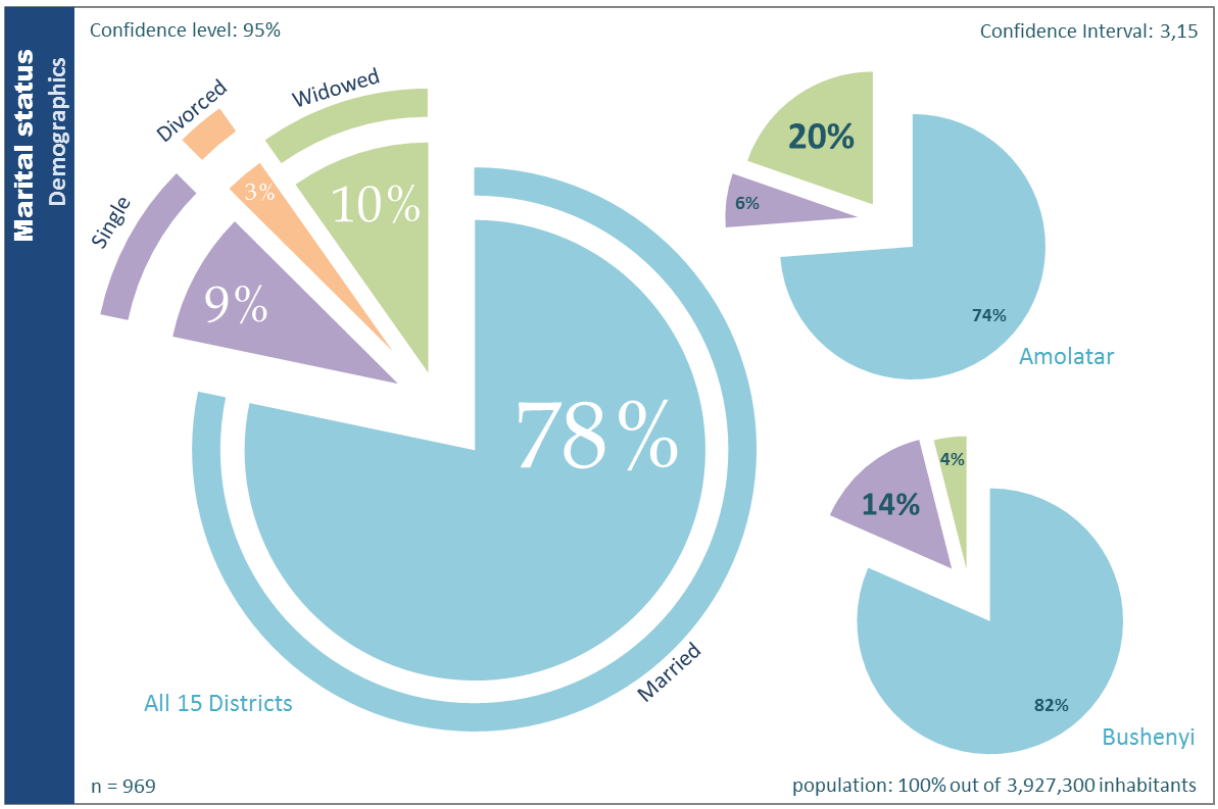
Figure 9 Average age encountered among respondents



Marital status

The majority of the respondents at 78% in all 15 districts together were married with the highest percentage encountered in Bushenyi (82%). Amolatar has the highest percentage of widowed encountered (20%). For an overview of marital status encountered in the different districts refer to Figure 10.

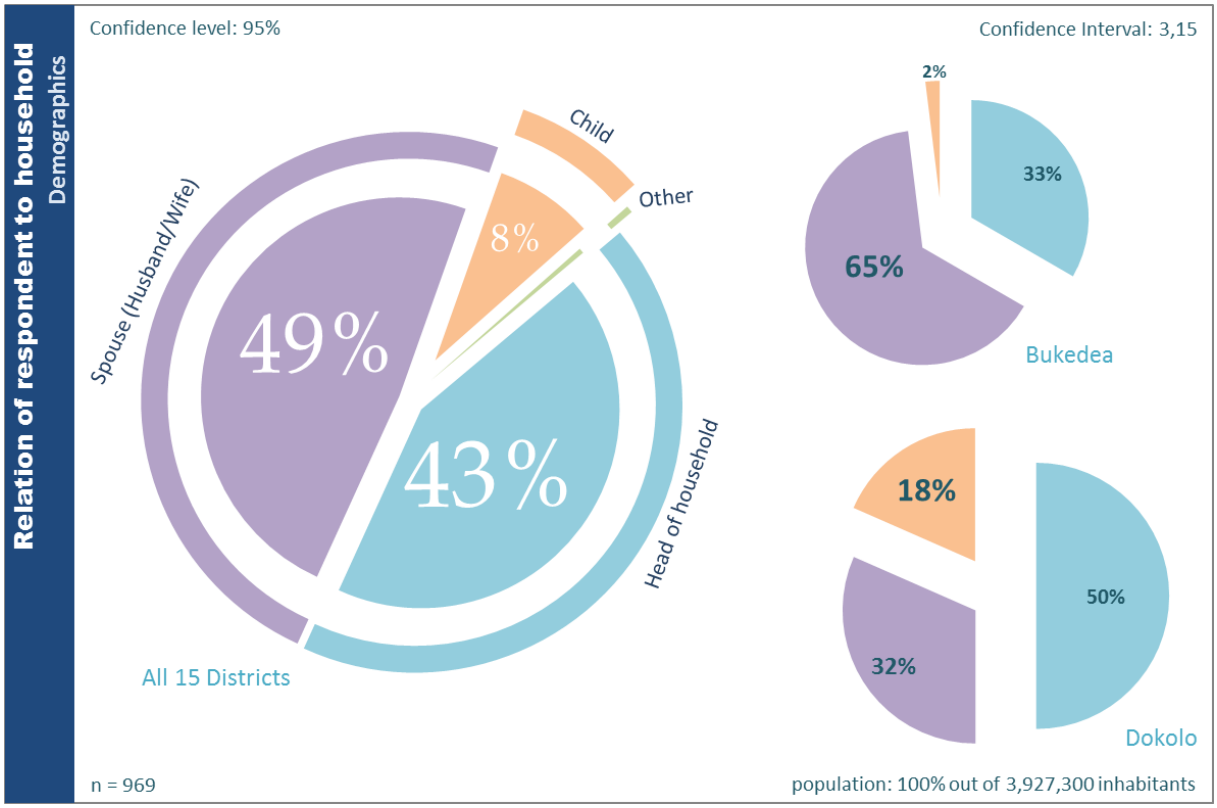
Figure 10 Distribution of marital status among respondents encountered



Relation to household

One aim of the study was to interview the heads of the households in the different villages. While in many cases the head of the household was not available, the spouse usually was available, and was interviewed in their stead. Overall for 43% of the surveys conducted, the household head was interviewed. In 49% of the cases the spouse was interviewed. For an overview of the different 'kind' of respondents interviewed refer to Figure 11.

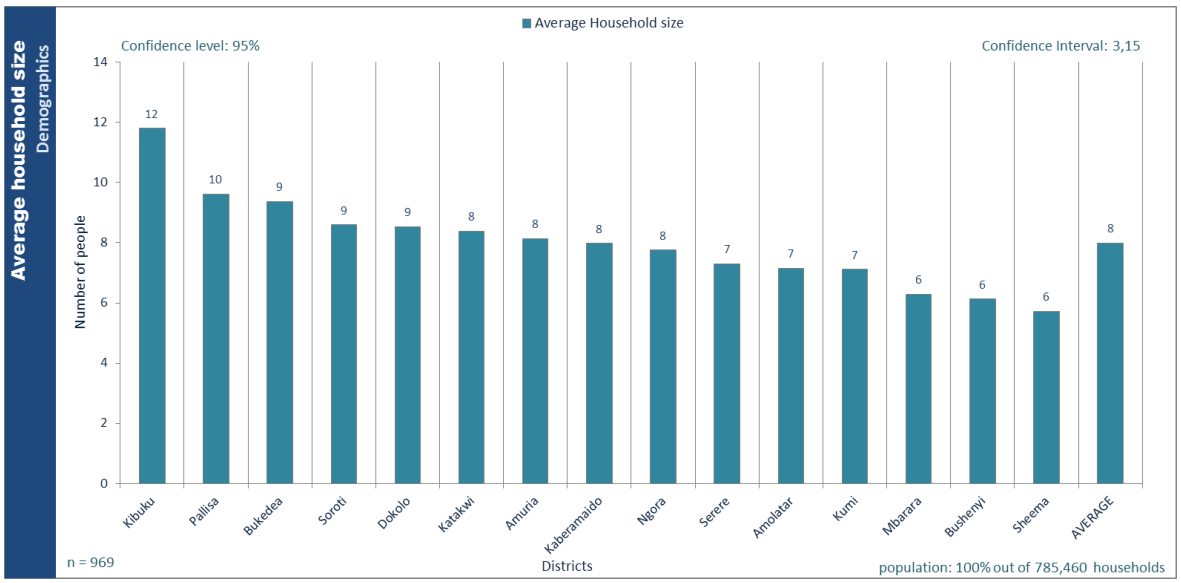
Figure 11 Distribution of relation to household among respondents



Household size

The average household size encountered across the programme area was 8 people. The highest average household size encountered at district level was 12 people in Kibuku. The lowest average household size encountered at district level was at 5 people per home in Sheema. For an overview of the average household size per district refer to Figure 12.

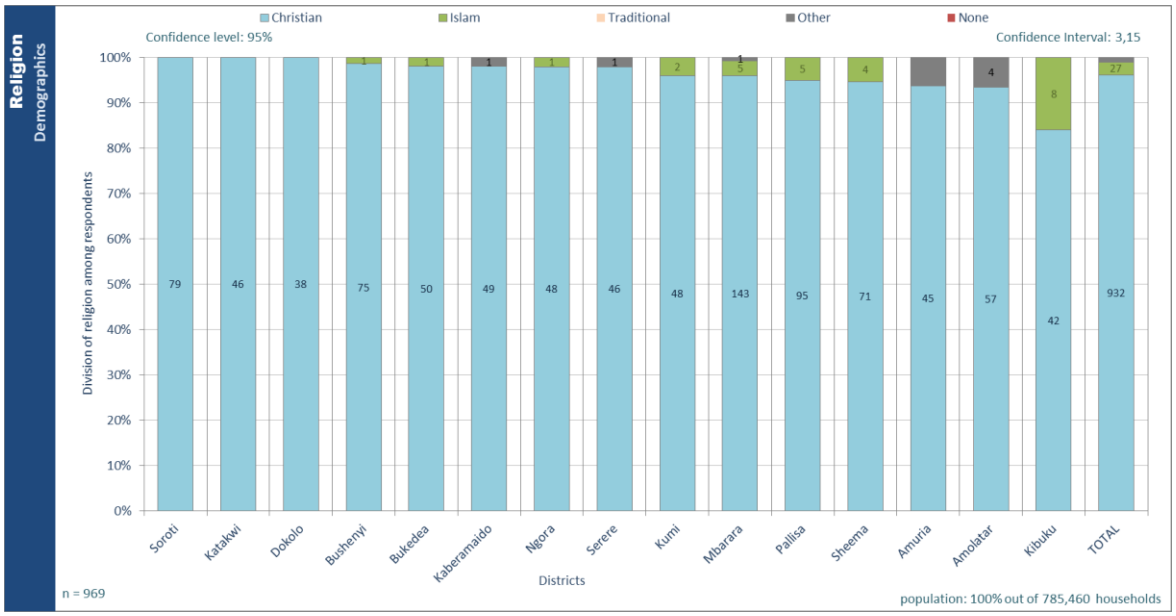
Figure 12 Average household size encountered among respondents



Religion

The main religion encountered was Christianity (96%). No traditional religions were encountered and only a vast minority of Islam (3%). In Kibuku district the highest percentage of Islam (16%) was encountered, and the lowest percentage for Christianity (84%). For an overview of the religions encountered in the different districts refer to Figure 13.

Figure 13 Distribution of religion among respondents/households

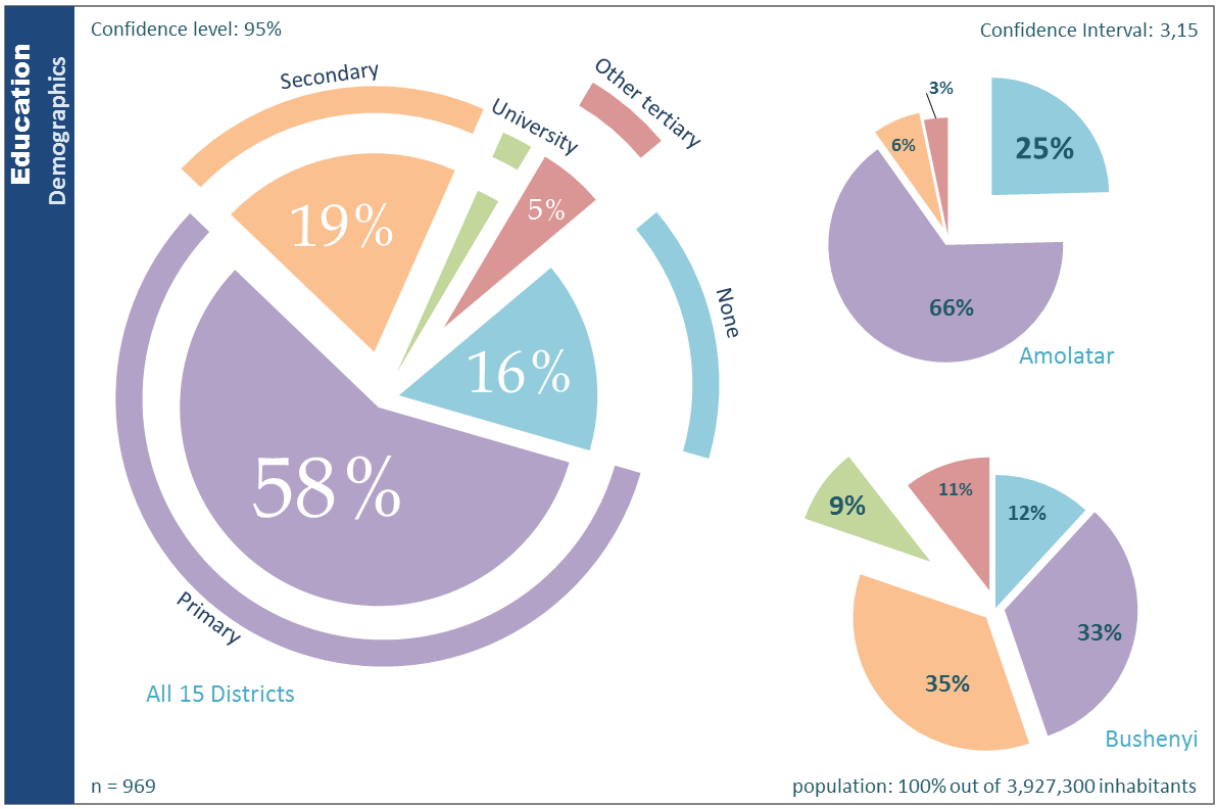


Education

The majority at 58% of the respondents in the programme area had only primary education. In Bushenyi 55% of the respondents had education above primary level, and 20% above second-

ary level. Amolatar had the highest number of respondents without education (25%). For an overview of the different educational levels encountered refer to Figure 14.

Figure 14 Distribution of level of education of respondents



Income

Of the respondents interviewed in the programme area the majority (51%) is considered to have a low income. Based on the living conditions Ngora was considered the district with the lowest income (49% absolute poverty, 45% low income) among the 15 USF districts. Bushenyi was considered to have the highest income (16% high income, 53% middle income). The main source of income in the USF districts is crop growing (82%). For an overview of the different income ratings and means of income encountered refer to Figure 15 and Figure 16 respectively.

Income rating was established in the field based on the interpretation of the enumerator and their interpretation of the following guidelines:

High income: GI/Tile roofed, 3+ bedroomed, own house, evidence of vehicle

Middle income: GI roofed, 2 bedroomed, not plastered –owned/rented house, m/cycle +10- 20 animals.

Low income: grass thatched roofed, unburned bricks, not plastered –owned/rented house, bicycle, 2-3 animals.

Absolute poverty: less than the above.

Low income household

Middle income household

Figure 15 Distribution of income rating among respondents

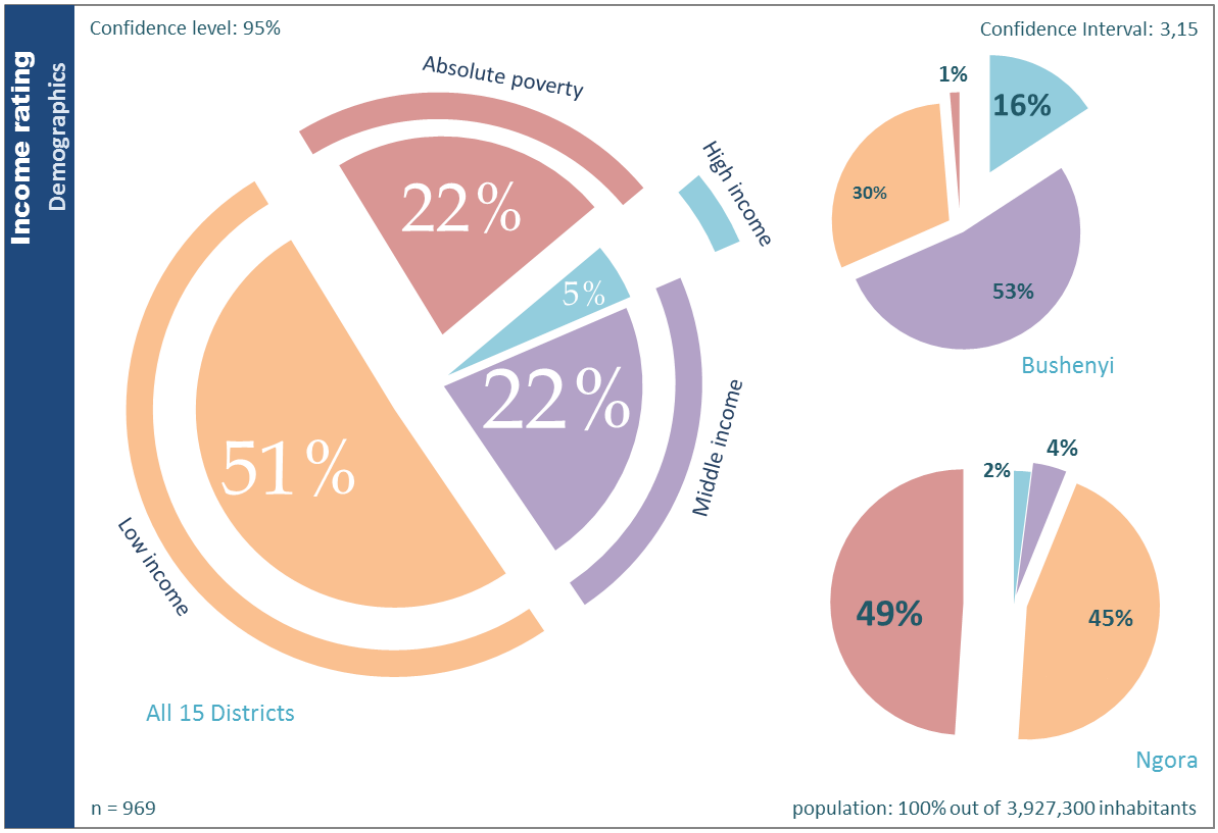
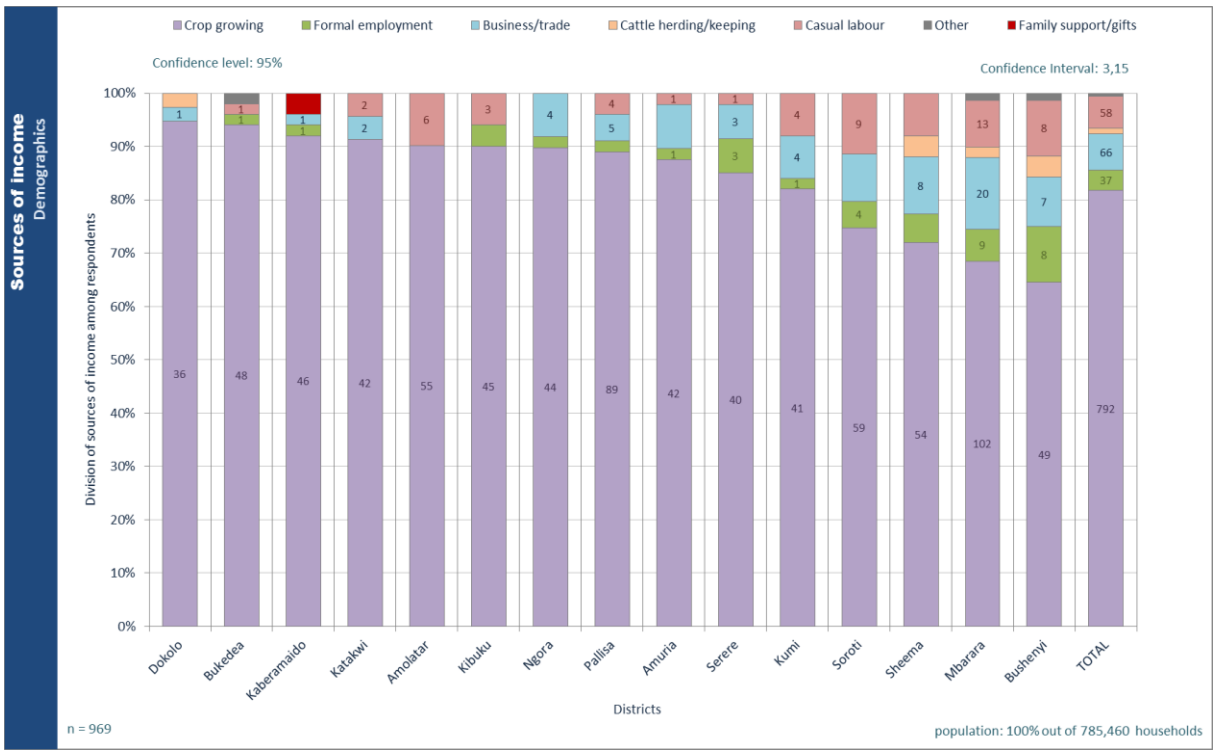


Figure 16 Distribution of sources of income among respondents within districts



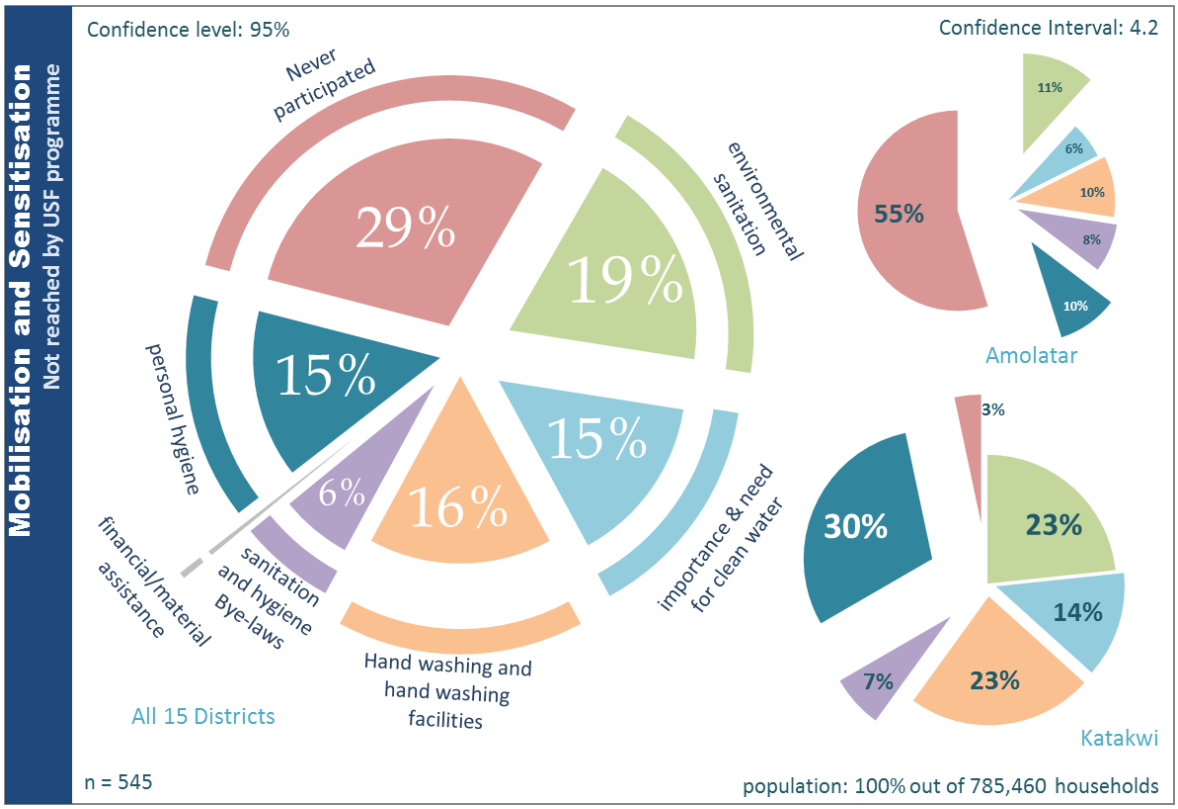
4.2 Findings in villages not covered by USF

This section provides an overview of sanitation and hygiene orientated findings in villages within the districts designated by the USF programme that have not yet been reached by the programme. These villages generally have not yet seen any implementation of USF objectives.

Participation in sensitisation and mobilisation

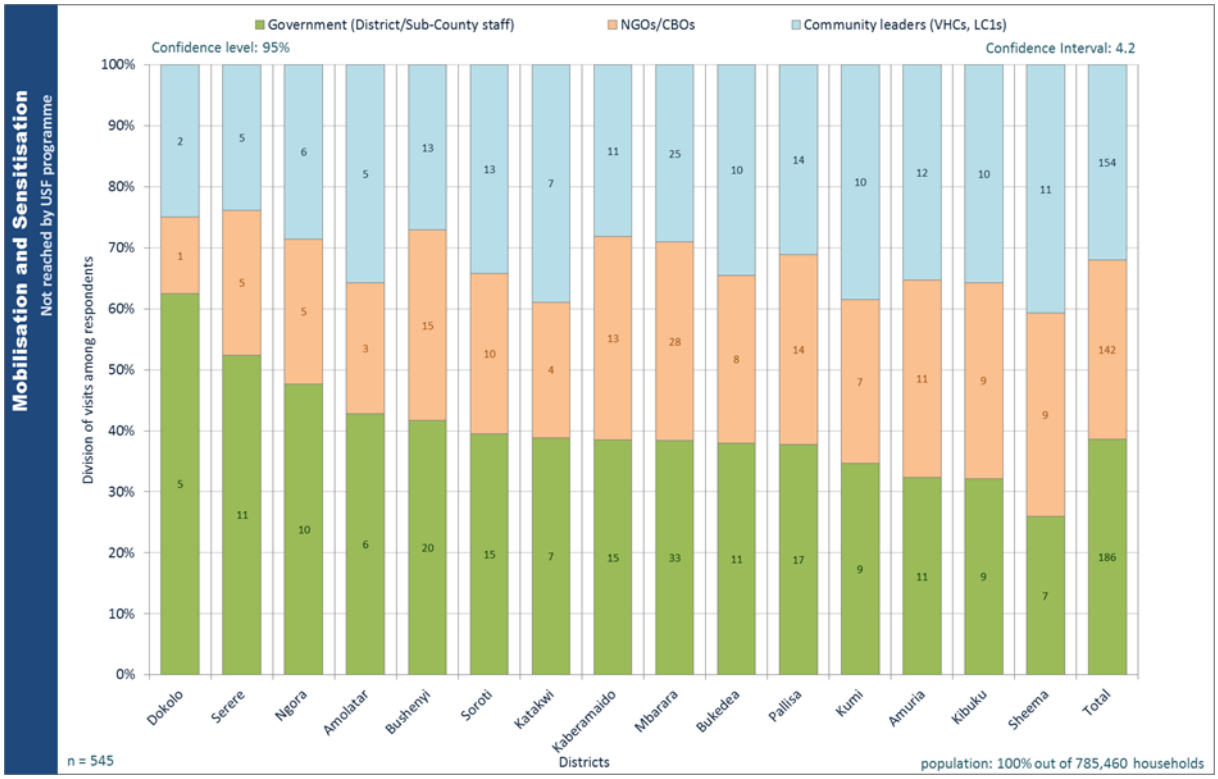
All districts have received mobilisation or sensitisation visits regarding different aspects relating to sanitation and hygiene. Visits about financial and material assistance seem to be least in number (less than 1%). Environmental sanitation is the topic most discussed during these visits with 19% over all 15 districts. A few (29%) of the respondents in all 15 USF districts indicated never to have participated in sensitisation and mobilization focused on sanitation and hygiene. In Amolatar the highest percentage of the respondents indicated not to have participated in sensitisation and mobilisation focused on sanitation and hygiene (55%). Katakwi has the highest percentage of households visited about personal hygiene (30%) and the lowest percentage of not participating (3%). For an overview on mobilisation or sensitisation visits and their topics refer to Figure 17.

Figure 17 Distribution of sensitisation and mobilisation topic respondents were visited for in different districts (not USF)



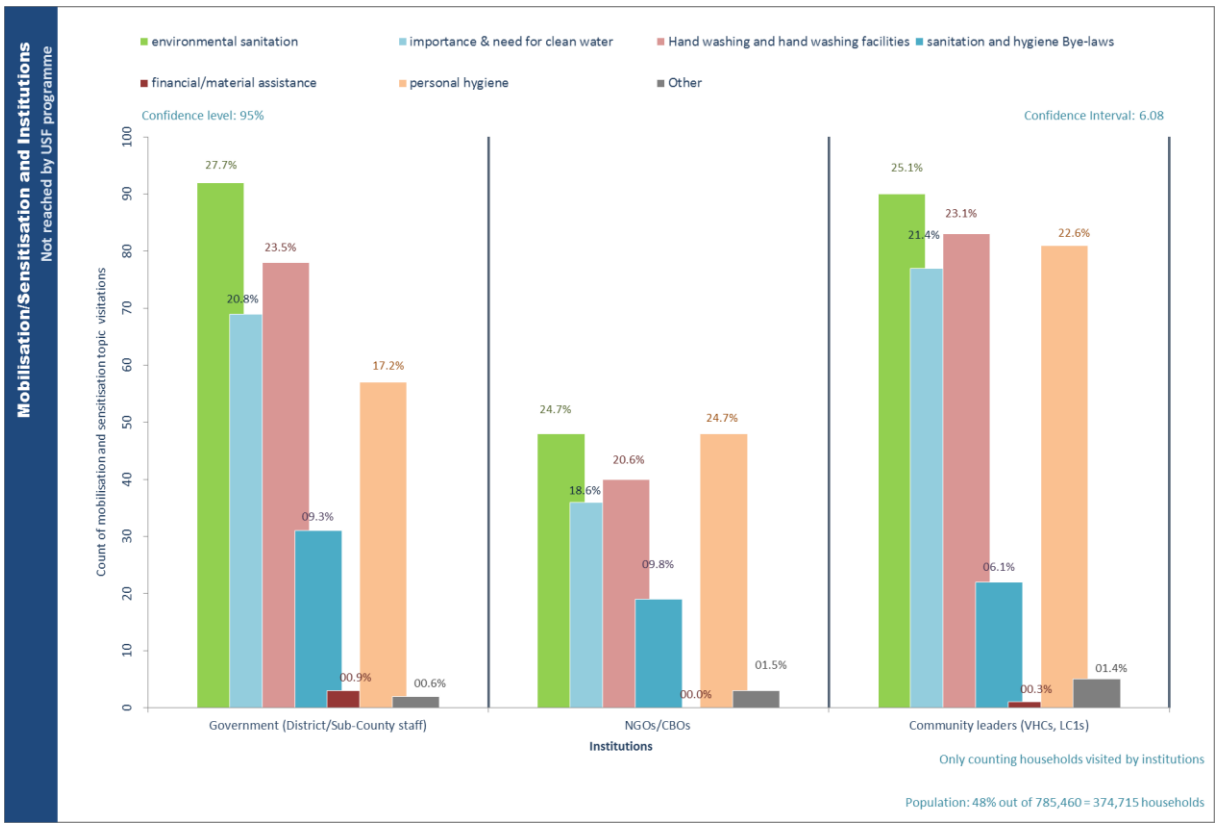
All of the USF districts have been visited by Government (38%), NGO/CBO (30%) and community leaders (32%). Dokolo has the highest percentage of households visited by District and Sub-County staff (63%). For an overview of the distribution of the visits refer to Figure 18.

Figure 18 Distribution of instances respondents were visited by for mobilisation and sensitisation in different districts (not USF)



All parties conducting the mobilisation and sensitisation visits seem to show similar trends in topics covered. The exception Personal hygiene seems to be favoured by both NGO/CBO's (24.7%) and community leaders (22.6%). Neither parties seem to focus on financial and material assistance. For an overview on the parties involved in mobilisation and sensitisation and the topics covered please refer to Figure 19. The percentages shown in Figure 19 are based on the part of the population visited by either Government, NGO/CBO's or Community leaders for sensitisation or mobilisation focussed on sanitation and hygiene (48% of total population), and thus influencing the confidence interval (from 4.2 to 6.8).

Figure 19 Parties involved with mobilisation and sensitisation and covered topics (not USF)



Before the USF programme, the most common sources of information on hygiene and sanitation considered by the communities were the local councillors at village level, NGOs i.e. WEDA, LWF, the parish chiefs, village health teams, local FM radio stations such as Etop and Continental, newspapers, some health workers, community development workers and churches. Some health assistants were not seen active in communities due to facilitation challenges.

The respondents in the FGDs explained that communities are sensitized and encouraged to construct and use latrines, install hand-Washing Facilities/tippy taps, and other sanitary facilities such as drying rack, drying lines, rubbish pits, practice personal hygiene, keep the safe water chain and to have clean compound.

FDG

FDG's (Focus Group Discussions) were conducted without making distinction between villages noticing USF intervention and villages without USF intervention. Therefore comments in this chapter that are derived from FDG's will mostly be retrospective in nature, giving a hint to the situation before USF intervention. If a comment is derived from an FDG it will always be mentioned

Common knowledge

Importance of latrines is largely attributed to management of faeces (32%) and cleanliness in general (24%). Dignity (7%) and accordance to law (2%) are least mentioned as important aspects of a latrine. For an overview on the views on latrine importance refer to Figure 20.

Communities commented that the most important function (s) of the latrines are:

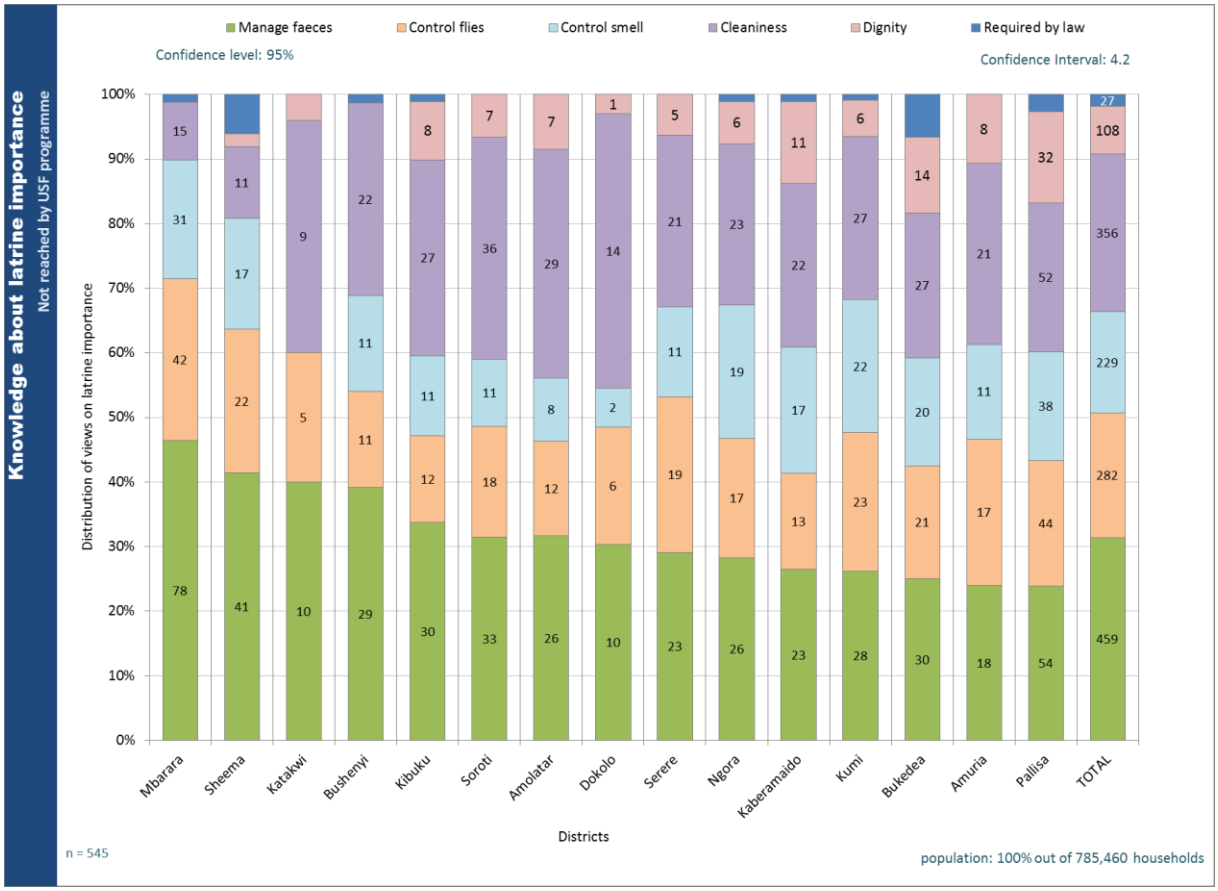
- Proper faeces disposal
- To reduce flies
- To make the home clean
- Help to prevent faecal related diseases i.e. diarrhoea, dysentery, cholera

- To prevent children from defecating anywhere apart from the toilet
- To make visitors feel comfortable

In the Akibui Focus Group Discussion (FDG) in Kumi district commented that if a home does not have a latrine, that home will not receive visitors and will always be embarrassed. It is likely that this view is widespread.

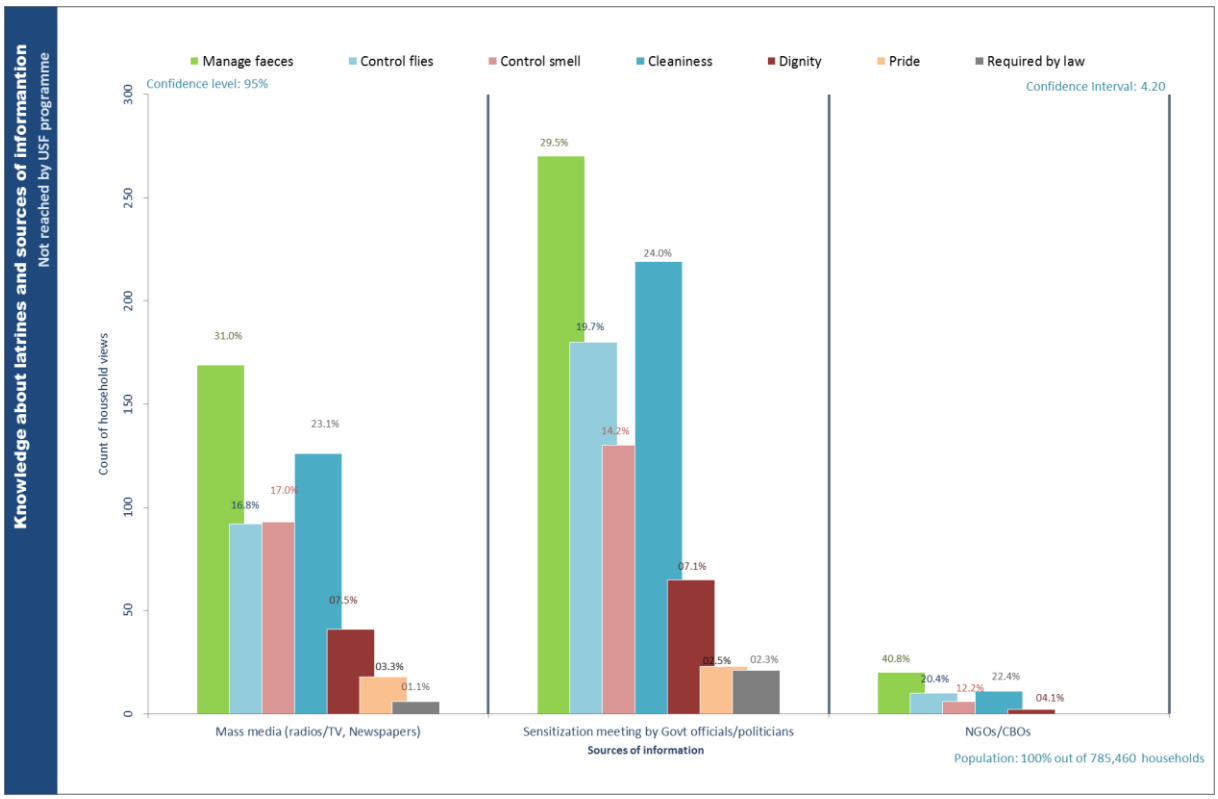
In all the FGDs it was commented that open defecation may make one get in contact with faeces i.e. stepping in faeces would make their feet or hands itchy. Latrines help them keep the faeces away. Figure 20 shows the distribution of views on latrine importance in different districts.

Figure 20 Distribution of views on latrine importance in different districts (not USF)



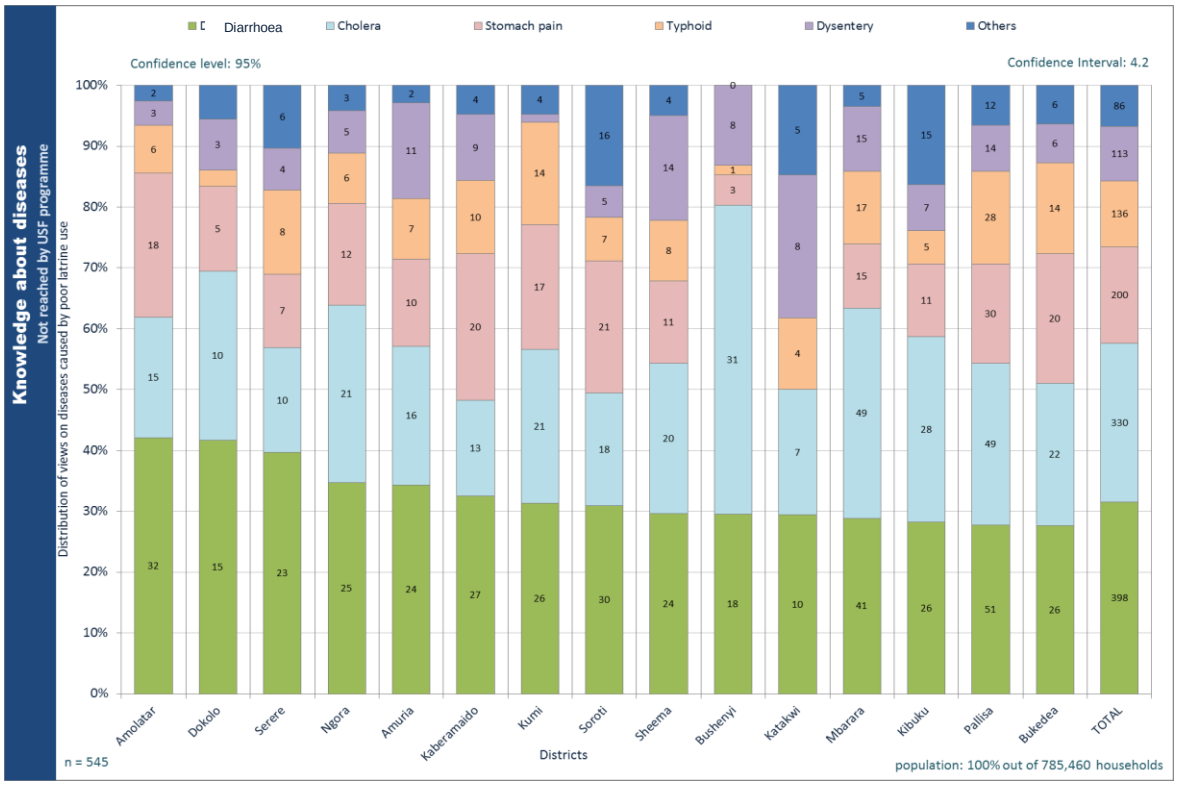
Different sources of information do not seem to yield different views on latrine importance as can be seen in Figure 21.

Figure 21 Sources of information and views on latrine importance (not USF)



For an overview on knowledge about diseases resulting from poor latrine use refer to Figure 22.

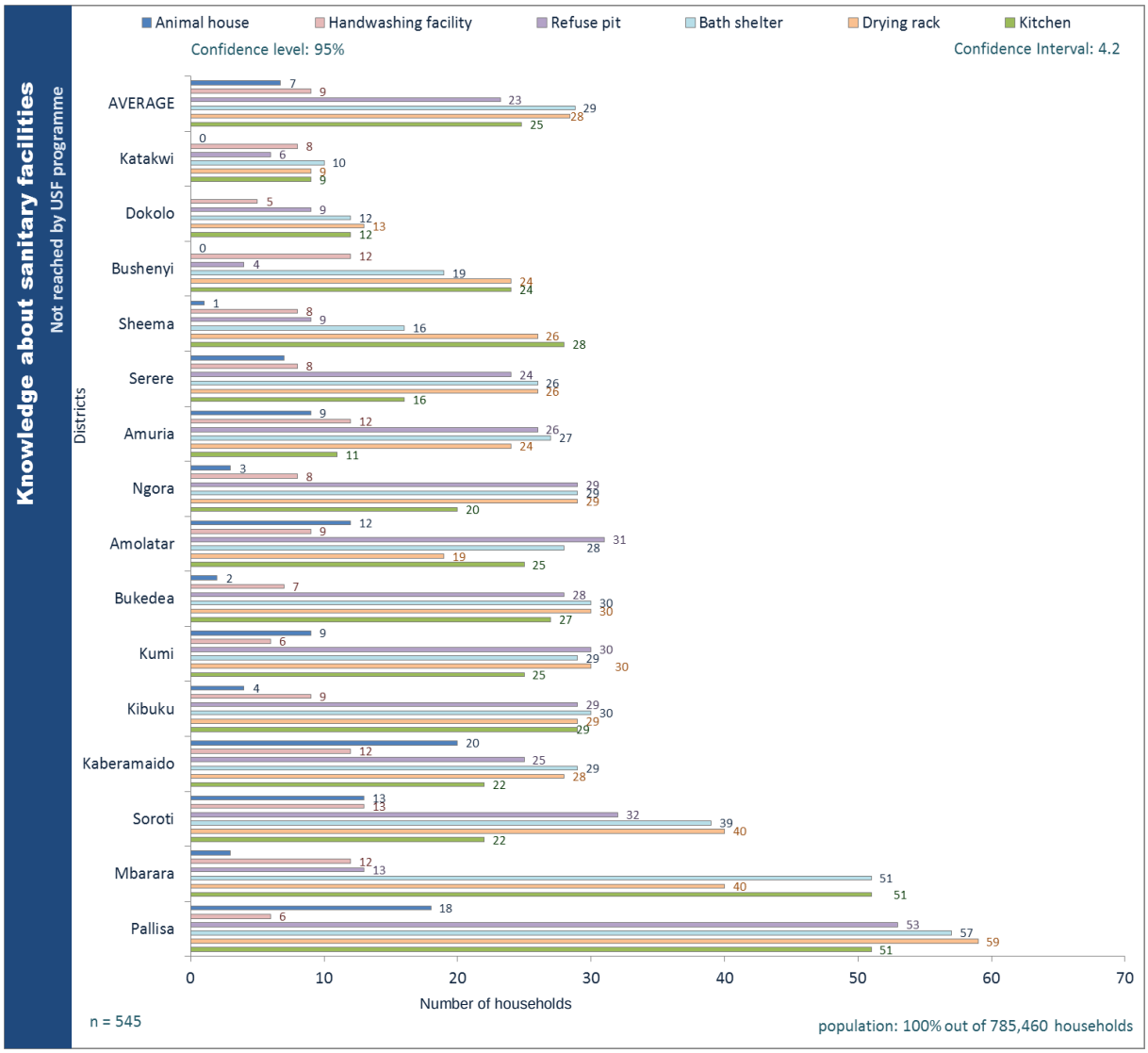
Figure 22 Distribution of views on diseases caused by poor latrine use in different districts (not USF)



Respondents commented that diseases such as diarrhoea, cholera, worms, hepatitis E, eye diseases and dysentery arise from poor sanitation and hygiene practices. A few community members, especially the women seemed to not have adequate knowledge on the sanitation related diseases. They mentioned malaria, stomach-ache, cough and flue as common diseases that arose from poor hygiene practices but could not explain or understand the cause of the diseases.

For important sanitary facilities characterising a responsible household, a hand washing facility was not often named. It can be considered the most undervalued sanitary facility in some districts and in other only second to an animal house. For an overview on the importance of sanitary facilities in a responsible household refer to Figure 23.

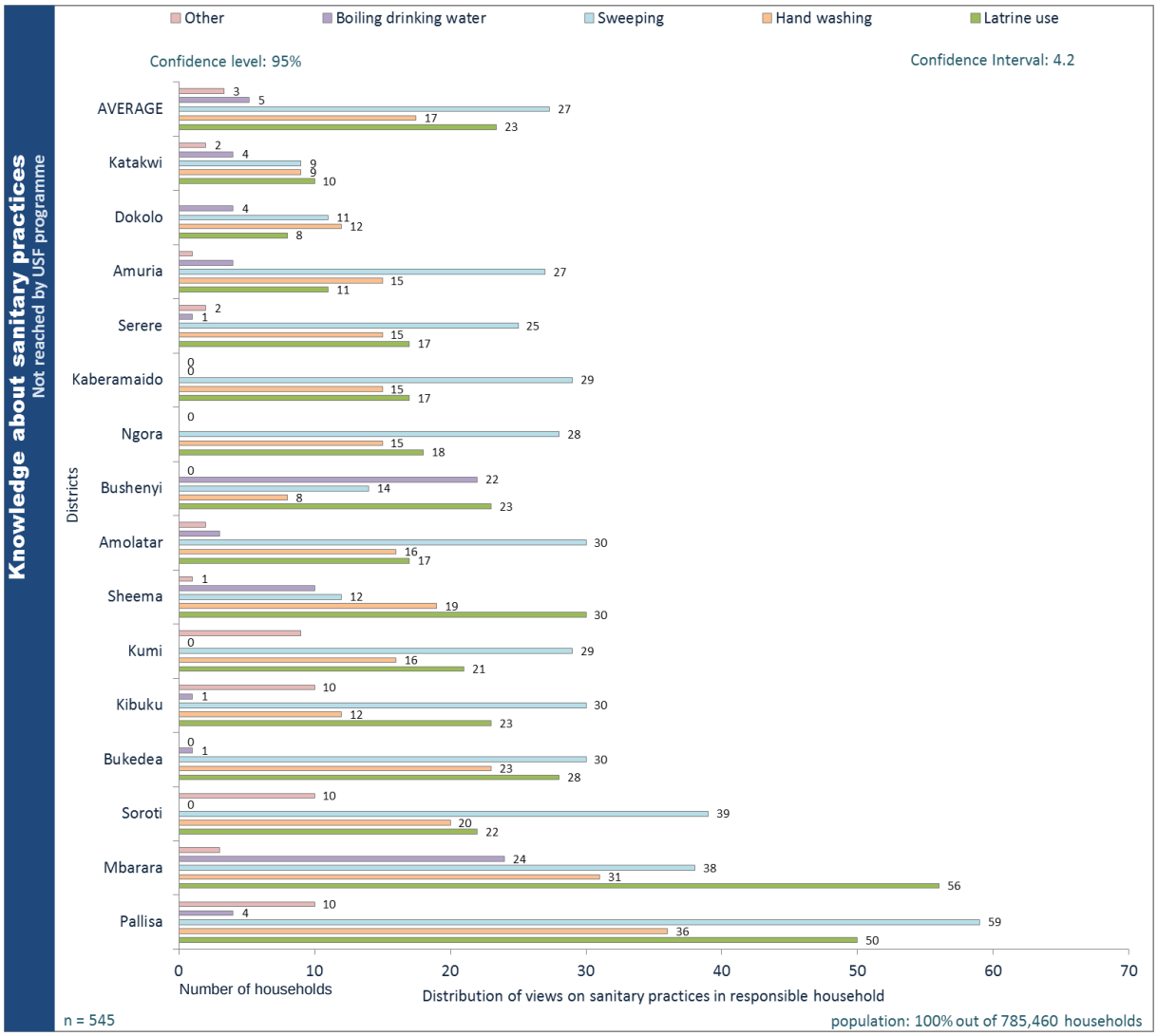
Figure 23 Distribution of views on sanitary facilities present in a responsible household in different districts (not USF)



The people in the FGDs responded that there was no difference in effects from a poorly used latrine and lack of a latrine in home. It was commented that flies from a poorly used latrine are no different from flies from a home without a latrine because they both carry faeces which cause diseases.

While hand washing facilities might not have been named often as important sanitary facilities, hand washing itself was in many districts named as an important sanitary practice, though still it is undervalued if compared with latrine use and sweeping. For an overview on important sanitary practices in responsible households refer to Figure 24.

Figure 24 Distribution of views on what sanitary practices represent a responsible household in different districts (not USF)



Current sanitation status

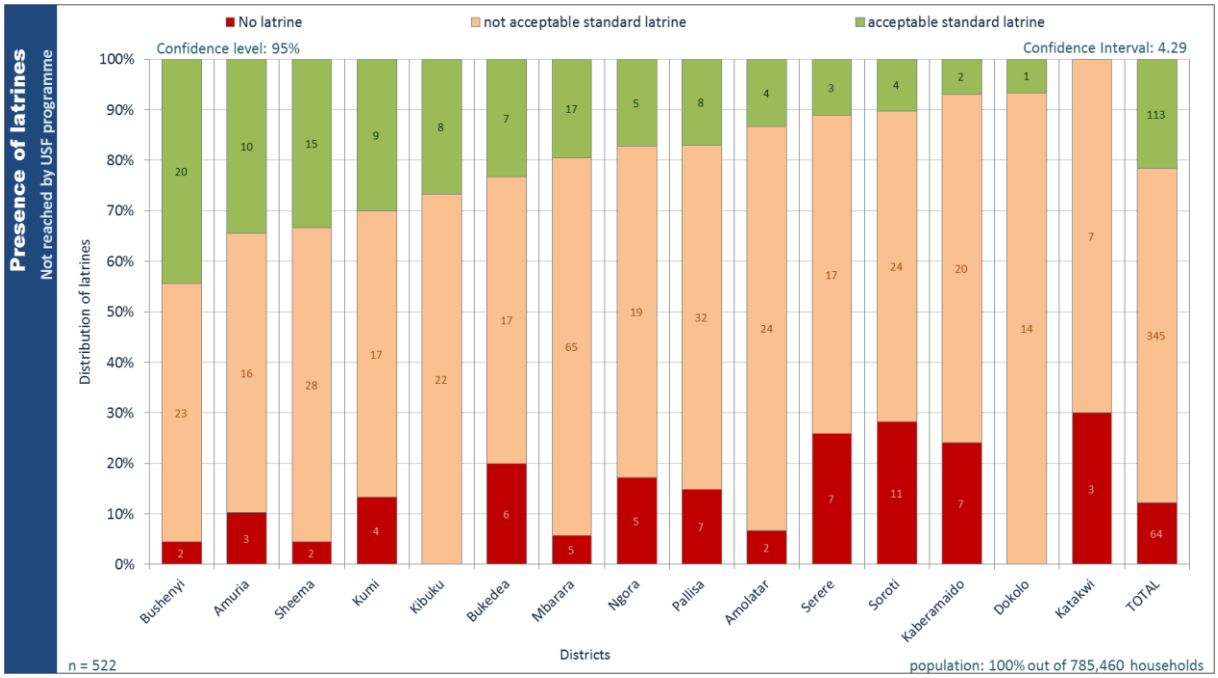
Most households generally seem to have a latrine, with about 12% on overall average not having a latrine. Of the remaining 88 % with latrines, 66% could be considered as less than acceptable standard latrine, leaving only 22% with at least an acceptable standard latrine. Katakwi was the only district where no latrines of an acceptable standard were found. For an overview of the presence of latrines according to standards refer to Figure 25. For an overview of the presence of latrines according to latrine types refer to Figure 26. For a clear comparison between "Benchmark" and "Pro-

Definition of an acceptable standard latrine for the purpose of the study

an acceptable/standard pit latrine is a pit, ideally not less than 3 feet deep if it is in use (Public Health (Drainage and Sanitation) Rules Sec. 67 (12) with a slab fitted with a squat hole through which users defecate into the pit and a superstructure, sufficient to ensure privacy and provide protection from the weather. It must be possible to clean the slab. The slab could be traditional that is of smoothened earth on logs or plastic or could be of concrete.

gress" one can refer to Figure 52 to clearly see the difference between latrine presence in areas with USF intervention and areas without USF intervention. Even in a short period of time that areas have been exposed to USF intervention (Progress), they show improvement in latrine presence and quality when compared to areas without USF intervention (Benchmark).

Figure 25 Presence of latrines at households in different districts (not USF)

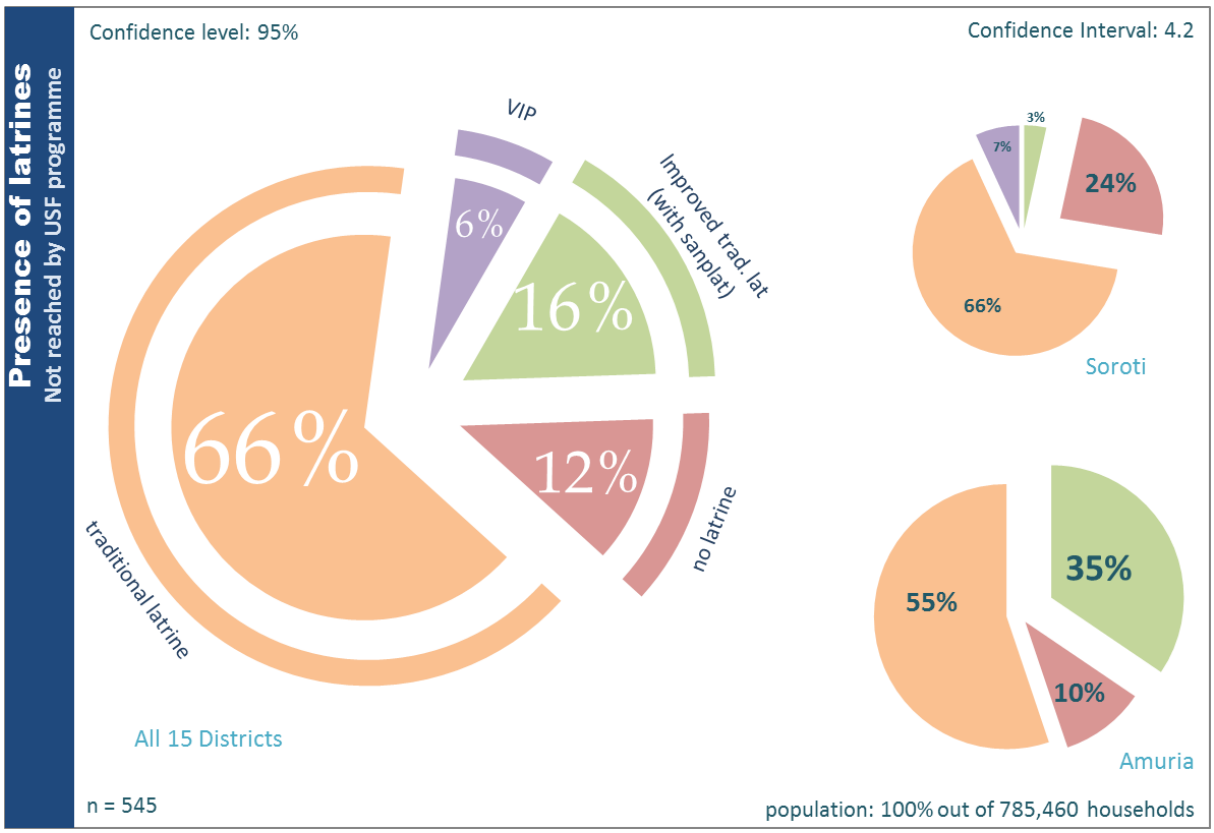


The FGDs especially in the North and Eastern districts revealed that before the USF programme started in their communities, there was a lot of open defecation practiced in the environment. Community members did not have latrines and would go to the bushes, gardens or even along the road sides. Communities near water bodies i.e. in Pallisa, Serere, and Kibuku would defecate in the lakes and rivers especially among the fisher communities. The cat method where the individuals would dig a hole, defecate and cover the faeces in the ground was a common practice.

At that time some households had latrines but most of the latrines were not on standard i.e. had no shutters, some were incomplete, without roof or door. Others were on the verge of collapsing and again others were full and could not be used anymore. There were a few members who had latrines that were on standard especially in the Western Districts.

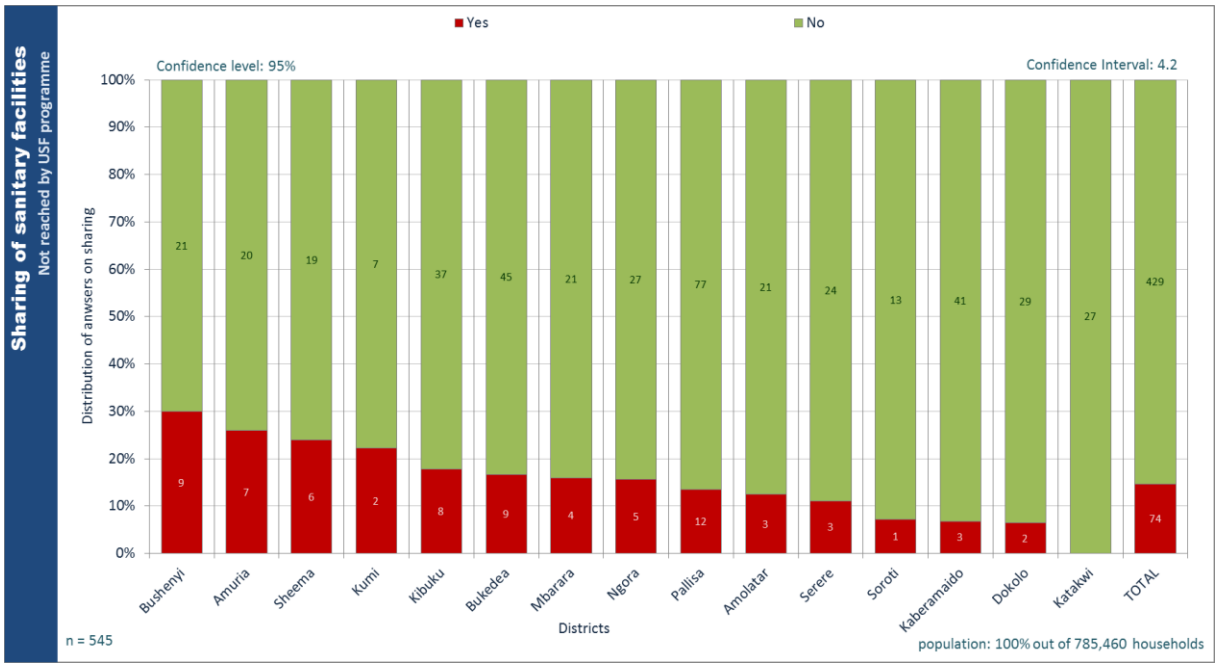
The most common latrine encountered was the traditional latrine accounting for 66% of the households visited in the 15 districts. The highest percentage of improved traditional latrines was encountered in Amuria (35%). The highest percentage of latrine absence was noted in Soroti (24%).

Figure 26 Presence of latrine types in different districts (not USF)



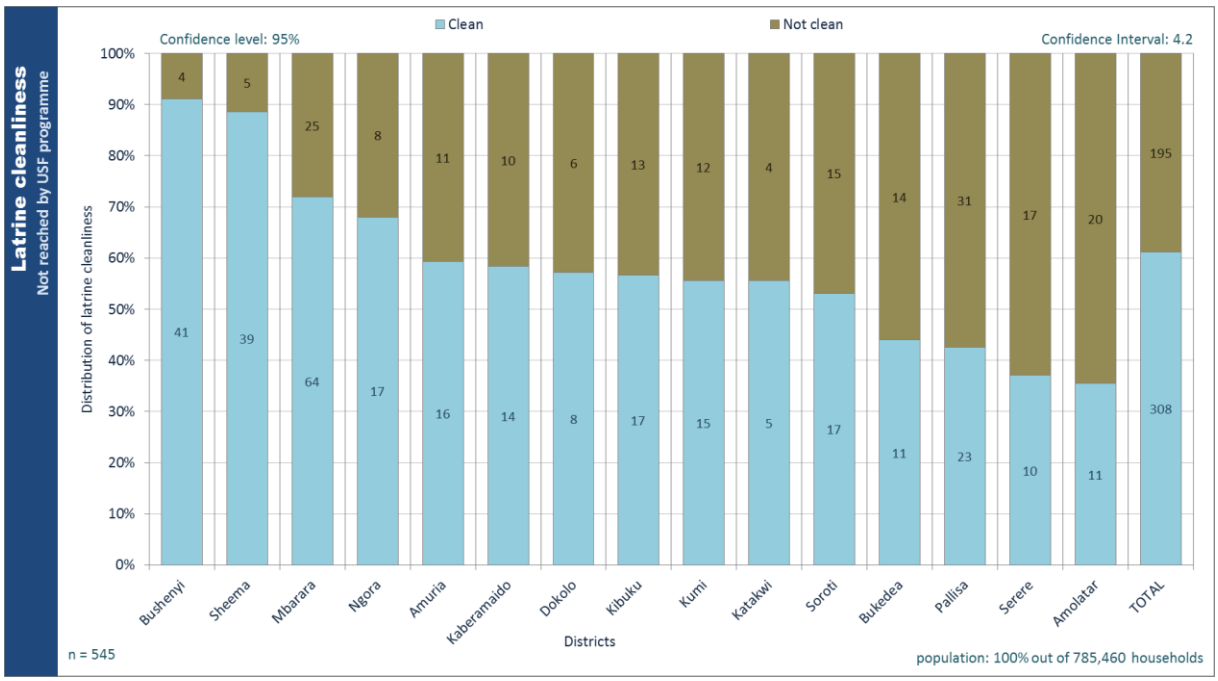
Not many household seem to share their sanitary facilities. About 14% of all households interviewed over all 15 USF districts seemed to share their latrine with different households. In Katakwi no households were encountered that share their latrine. In Bushenyi the highest percentage of latrine sharing was encountered (30%). For an overview on latrine sharing in different districts refer to Figure 27.

Figure 27 Sharing of sanitary facilities in different districts (not USF)



Overall latrines inspected in the USF district during the survey at 62% were considered clean. Cleanliness of latrines greatly varied among different districts, with Bushenyi seeming the cleanest (91%). For an overview on the cleanliness of latrines refer to Figure 28.

Figure 28 Distribution of latrine cleanliness in different districts (not USF)

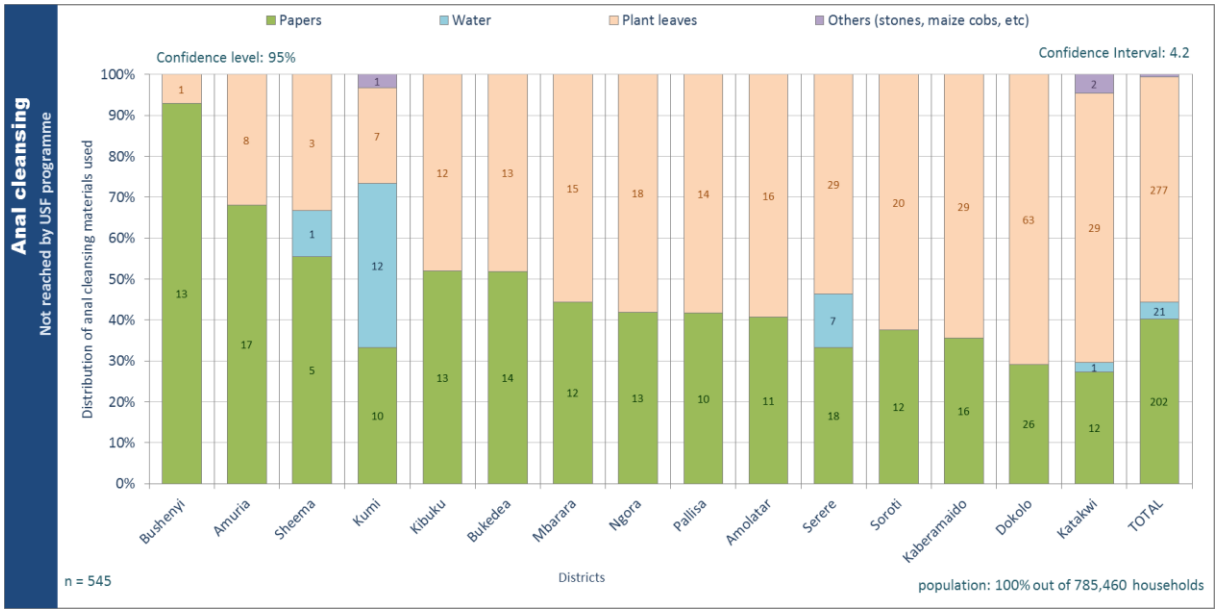


The Focus Group Discussions showed people were knowledgeable on why a latrine should be kept clean. FGD respondents commented that dirty latrines encourage open defecation. They therefore added that latrines are kept clean for many reasons which include:

- To motivate users to use it and control open defecation
- To prevent bad smell in homes
- To avoid flies from the latrines to contaminate the food.
- For comfortable use and motivate users to use it.
- To control diseases especially diarrhoea, cholera, dysentery etc.

In all districts people use paper for anal cleansing (30%), though in most cases in lesser extent than plant leaves or other attributes. For an overview of anal cleansing materials used refer to Figure 29.

Figure 29 Distribution of anal cleansing materials used in different districts (not USF)



It was established that most community members use papers such as old newspapers and any other papers, and soft, wide enough leaves as anal cleansing materials. However it was also noted that some members of especially the Muslim community use water while a few individuals use hard soil particles. The FGDs added that very few households use toilet papers because of lack of affordability by the majority.

Hand washing

According to the answers of the household survey almost everybody (just under 100%) knows the need to wash their hands at some point However while people may know when to wash their hands, absence of hand washing facilities and no evidence of the use of hand washing facilities indicates a distinction between theory and practice. Overall 78% of the households interviewed did not have a hand washing facility near the latrine. For an overview on knowledge, presence of and use of hand washing facilities please refer to Figure 30, Figure 31 and Figure 32 respectively.

Figure 30 Distribution of hand washing practices in different districts (not USF)

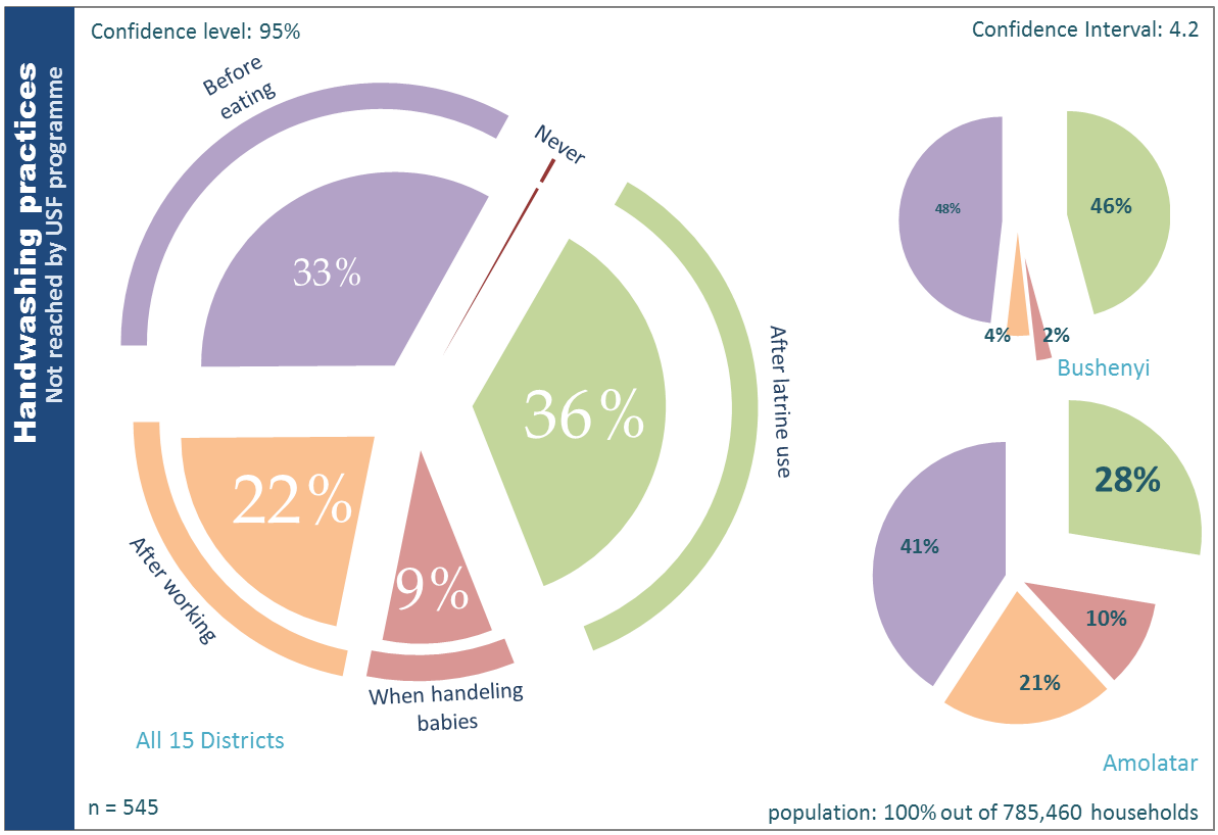
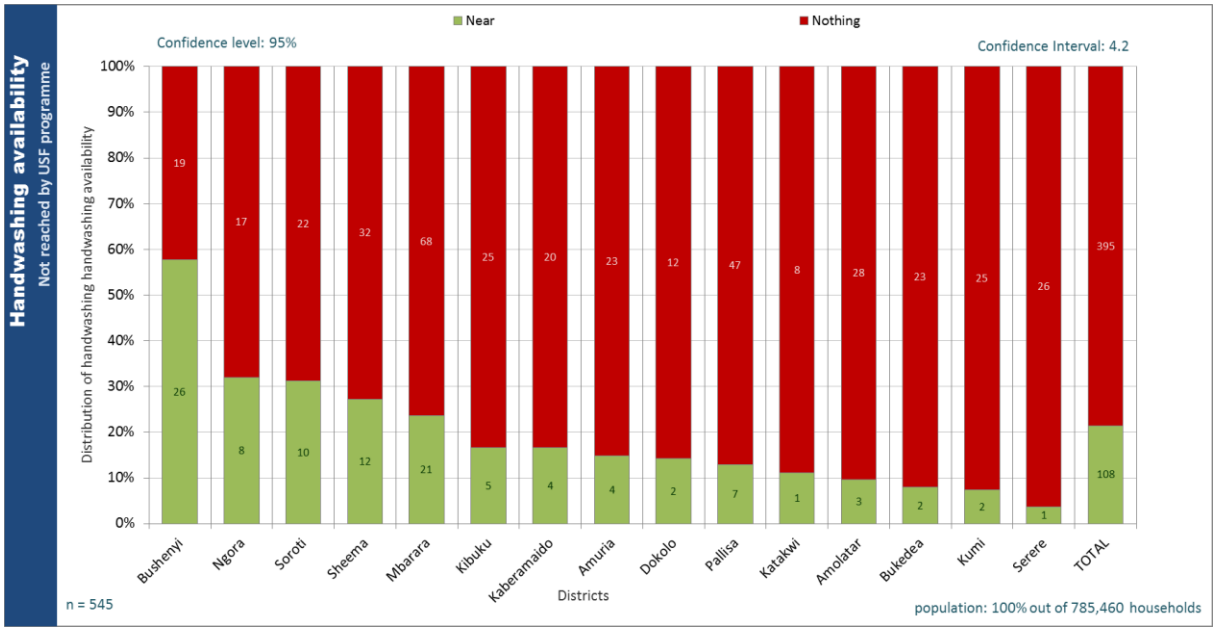


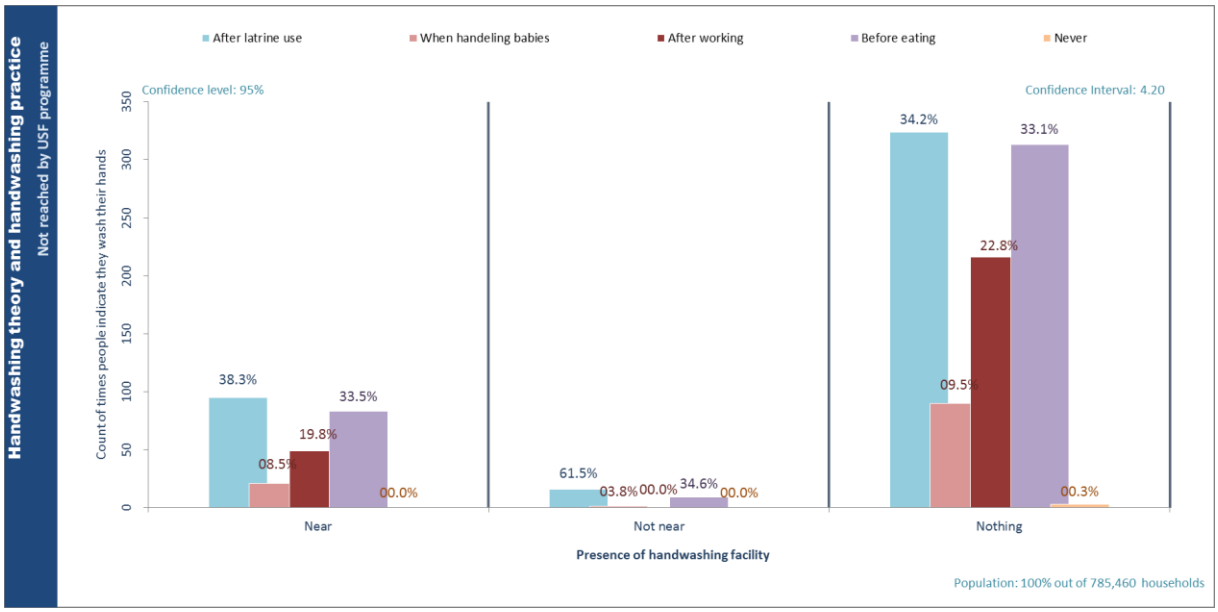
Figure 31 Distribution of availability of hand washing facilities near latrines in different districts (not USF)



Focus group discussions established that hand washing facilities are normally to be placed near the latrines. It was noted however that only few households had the facilities at their la-

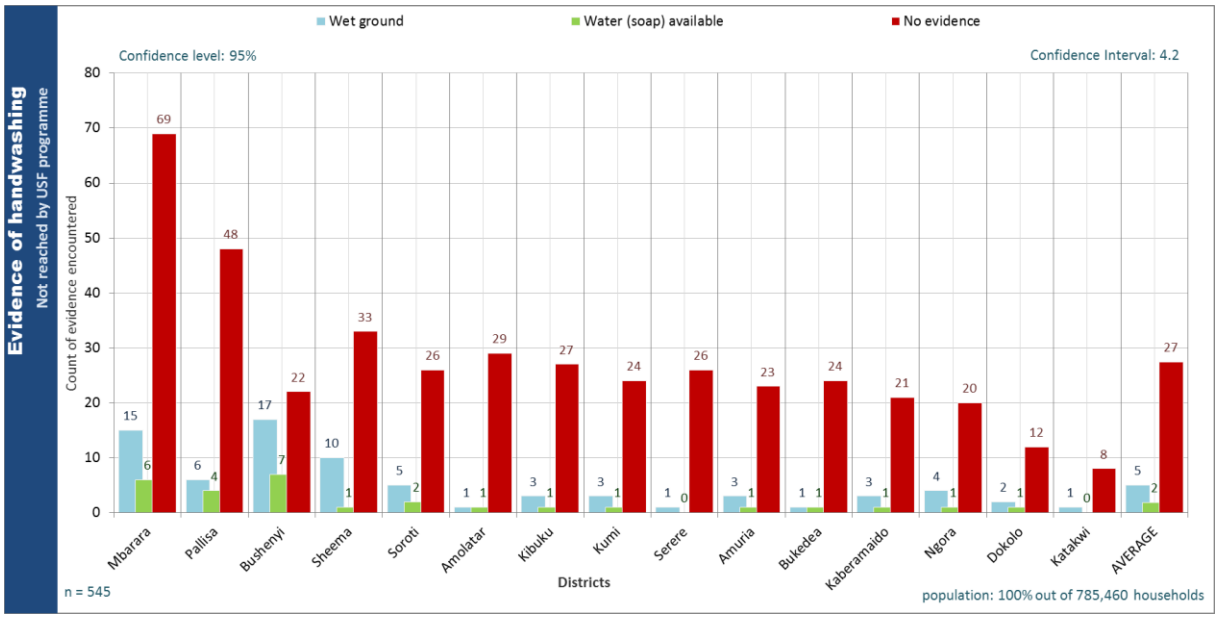
trines. As can be seen in Figure 32, knowledge about when to wash your hands does not relate to actual presence of a hand washing facility.

Figure 32 Hand washing practices and presence of hand washing facilities (not USF)



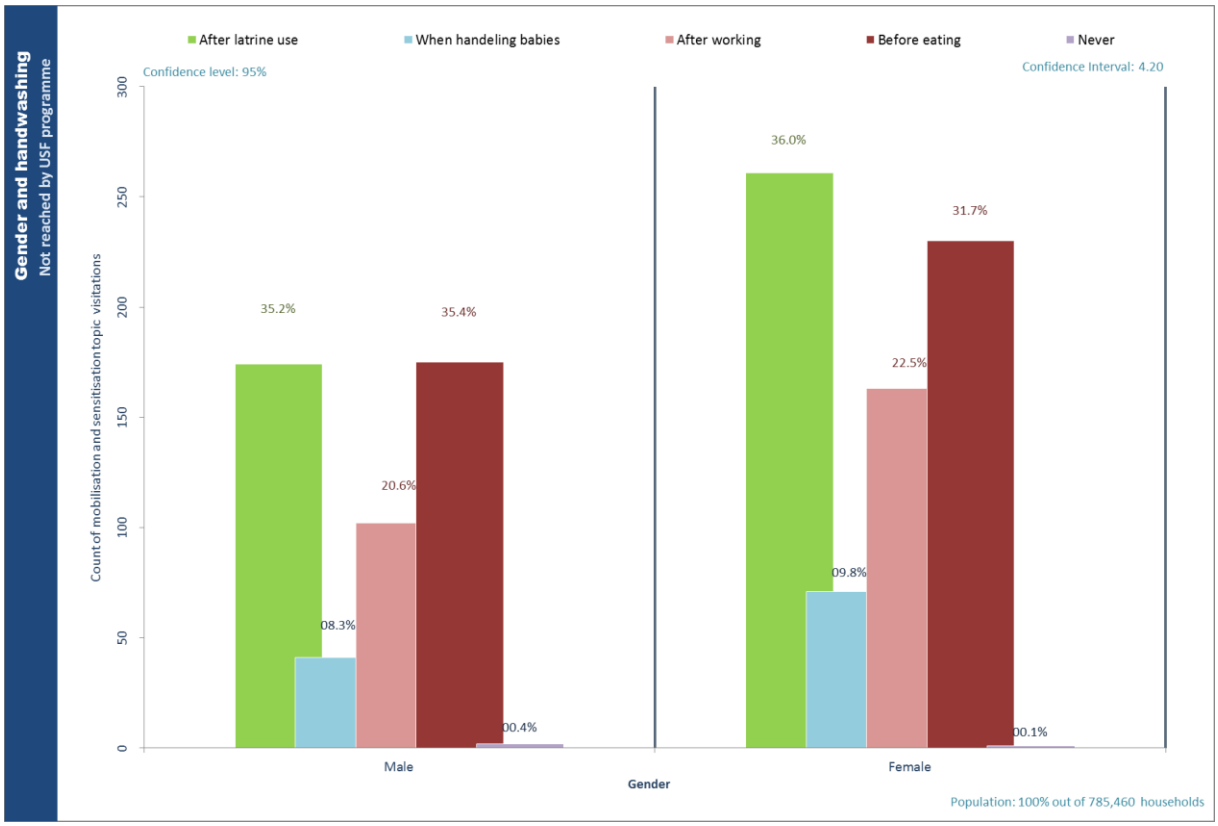
The respondents who did not have tippy taps commented that though they do not have them installed due to destruction by animals and vandalism by malicious people, especially in Akibui village in Kumi district, they do wash their hands through the pour system especially when they are going to eat food.

Figure 33 Distribution of evidence of hand washing encountered in different districts (not USF)



Functionality of the Hand Washing Facility is a shared responsibility for all family members. Men buy the jerry cans and the soap, women and children ensure that the jerry can has water and soap is available. However, this setup is still a challenge in most communities. There seem to be no distinct differences in knowing when to wash your hands when differentiating based on gender, see Figure 34.

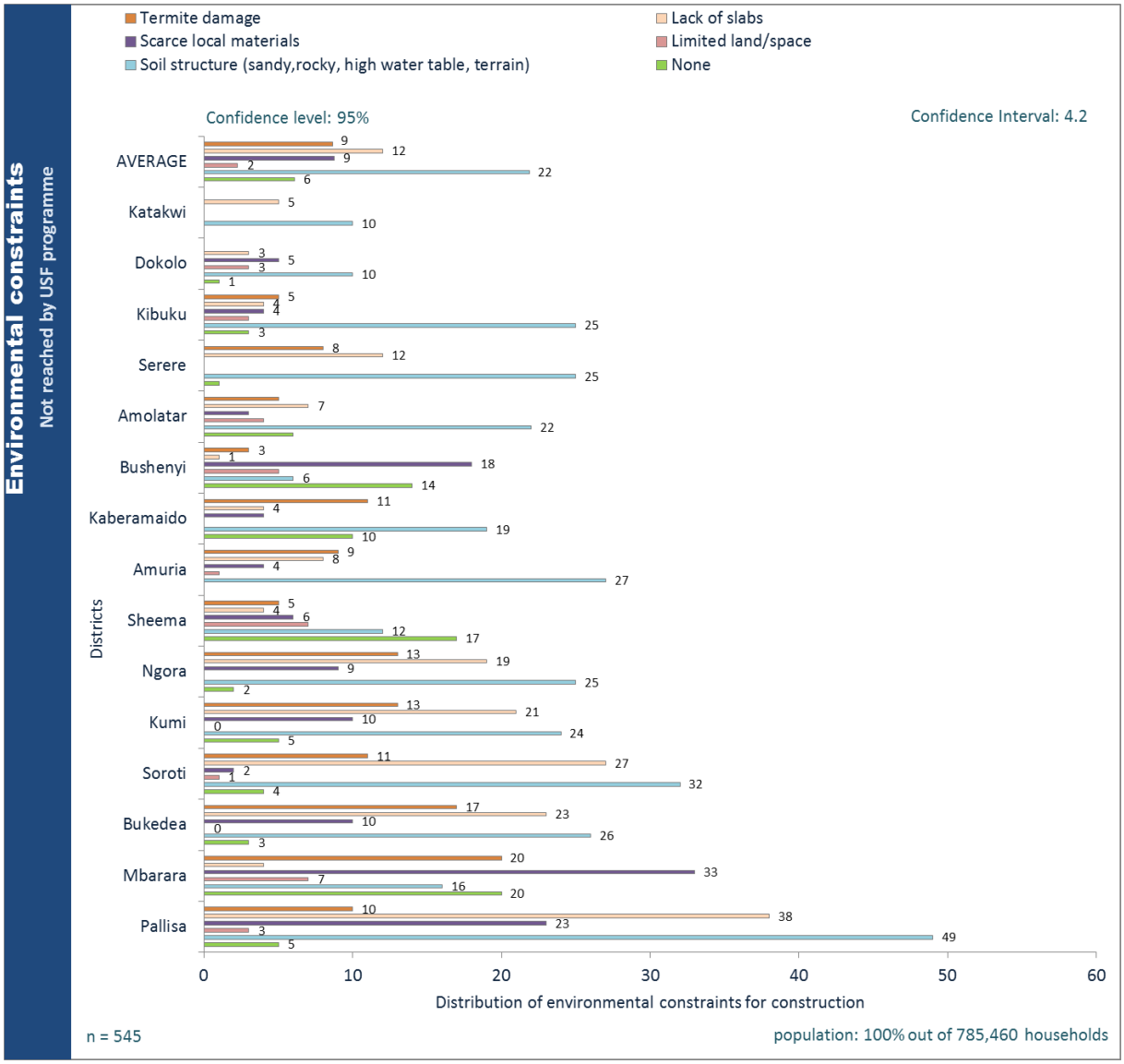
Figure 34 Hand washing knowledge and gender (not USF)



Latrine construction and related factors

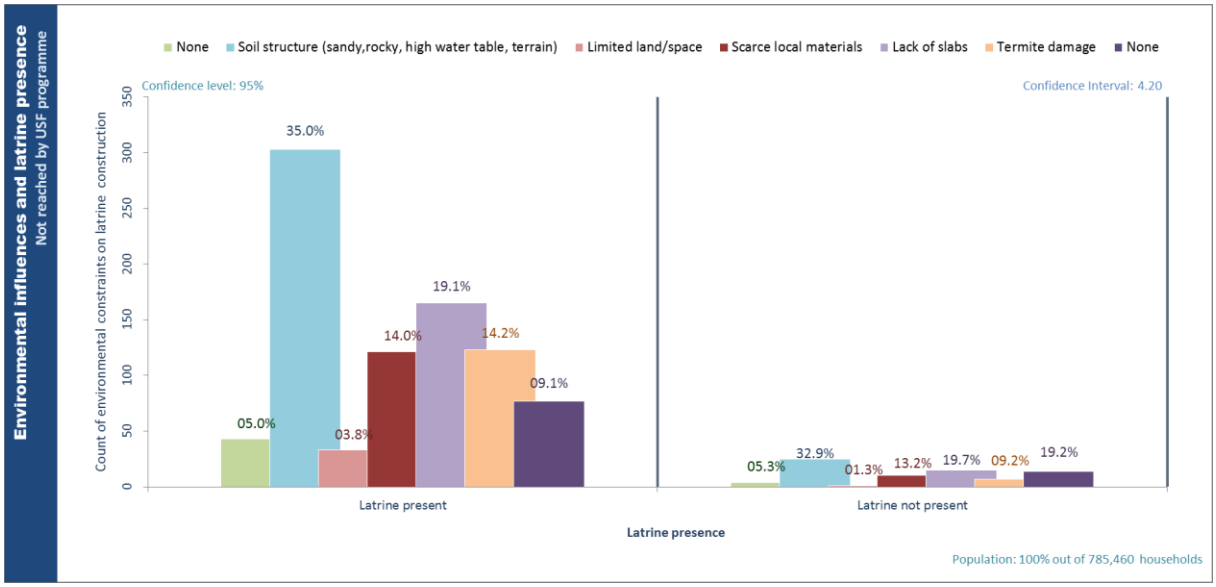
Respondents in Sheema indicated to have the least environmental constraints on construction. The biggest environmental constraint overall seems to be the soil structure. Limited space was only scarcely named as an environmental constraint. For an overview on environmental constraints in the different districts please refer to Figure 35.

Figure 35 Distribution of environmental constraints for construction in different districts (not USF)



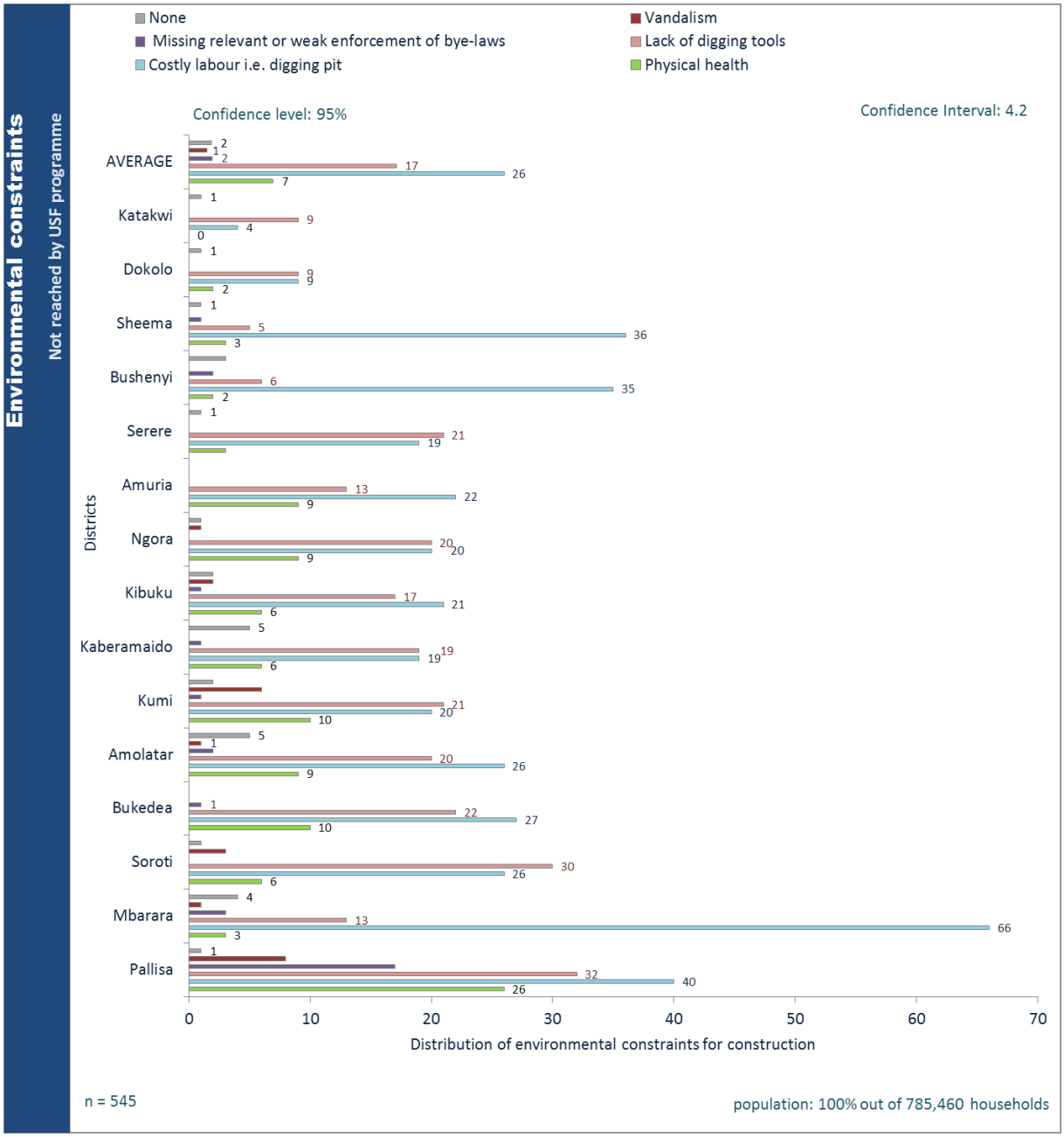
Environmental constraints on latrine construction do not seem to have a noticeable negative effect on actual presence of latrines. With latrines present only about 9% of the households commented on having no environmental constraints. Without latrines present however about 19% of the households commented on having no environmental constraints, as can be seen in Figure 36.

Figure 36 Latrine presence in relation to environmental constraints (not USF)



Apart from environmental constraints, the biggest limiting factor in latrine construction seems to be costly labour, followed by a lack of digging tools. For an overview on limiting factors other than environmental constraints, refer to Figure 37.

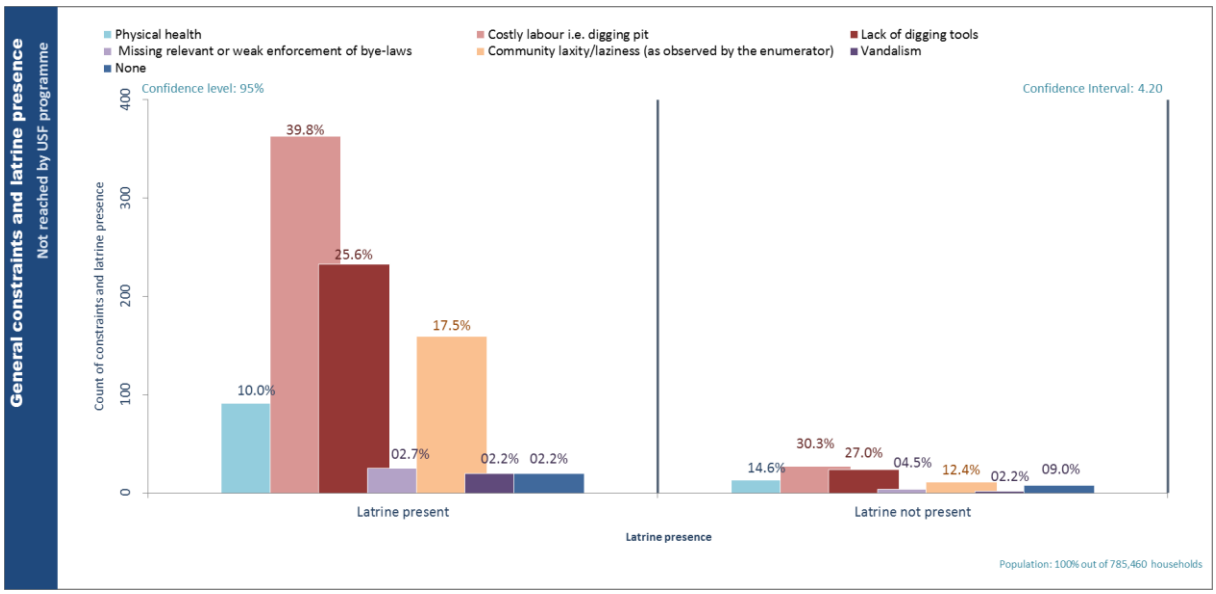
Figure 37 Distribution of other constraints limiting latrine construction in different districts (not USF)



The reasons forwarded in FDG's for not having latrines included child headed families, widows and elderly i.e. above 70 years old, rocky soils, floods, negative community attitude, single/not married, laxity and negligence.

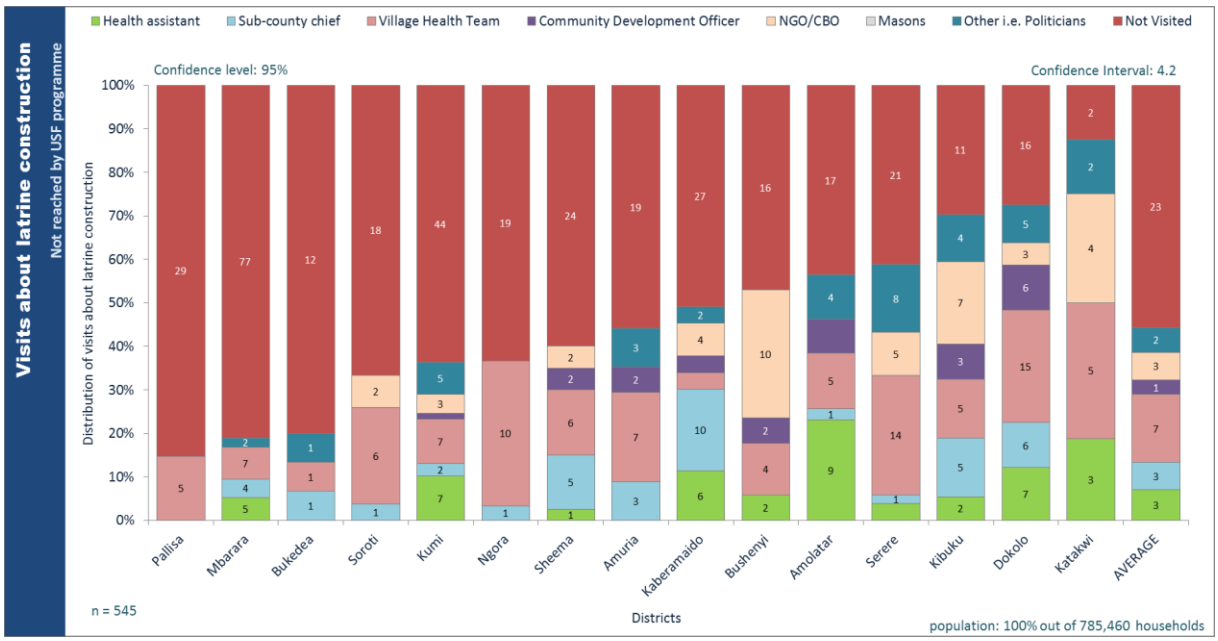
General constraints on latrine construction also do not seem to have a noticeable negative effect on actual presence of latrines. With latrines present only 2% of the households commented on having no constraints. Without latrines present however, 9% of the households commented on having no constraints, as can be seen in Figure 38.

Figure 38 Latrine presence in relation to general constraints to latrine construction (not USF)



The majority of the households (56%) have not been visited to talk about latrine construction. The households were most visited by the village health teams (16%). For an overview on visits about latrine construction refer to Figure 39.

Figure 39 Distribution of visits about latrine construction in different districts (not USF)



According to the FDG's Health Assistants, VHTs and Local Council leaders support communities on latrine construction. Even though some communities have masons trained by the districts, Ministry of water and Environment or USF programme, community members rarely seek for mason's support and expertise because they cannot afford to pay for the services.

Masons charge 15,000/= to 20,000/= for a slab and 12,000/= to 16,000/= per day of labour. This view of unaffordable masons is supported by the data displayed in Figure 39.

Operation and maintenance of sanitary facilities

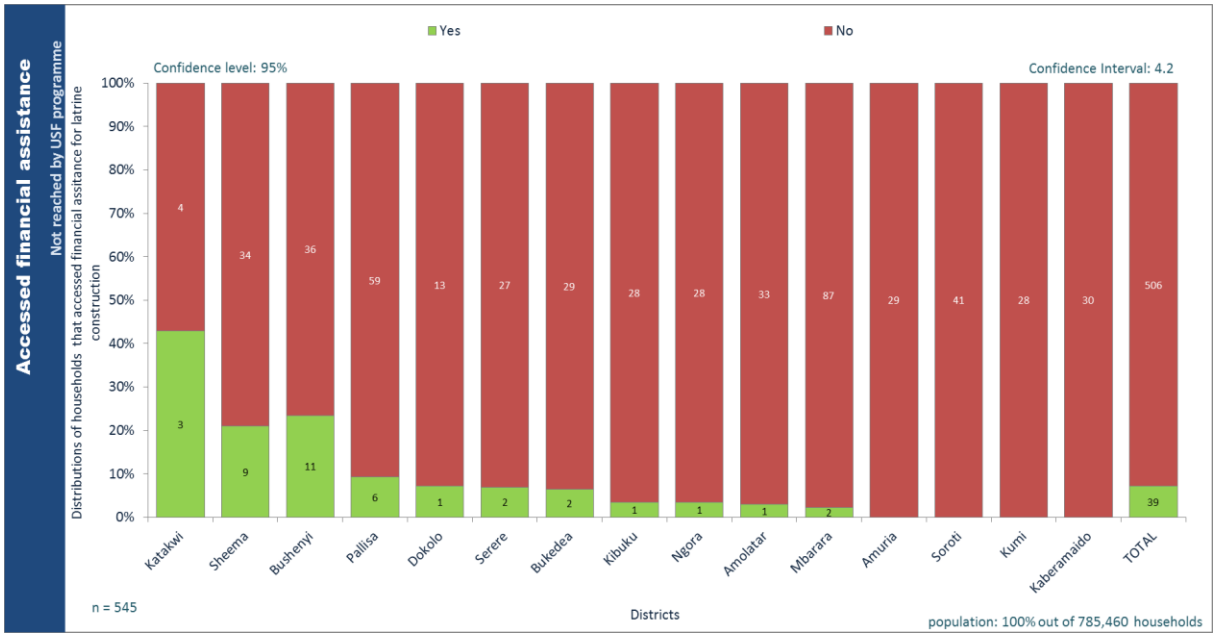
Maintenance of sanitary facilities especially latrines is done by regular smoking, mopping the floor (in case of cement slab), spraying with ashes to keep flies away, replacement of damaged grass and repairing of damaged walls. Some households however do not care to maintain the latrines and consequently those latrines are always dirty.

Regarding the labour needed for cleaning the latrines, it can be noted that women and children are mainly responsible for cleaning the latrine. In some cases men would help out if they considered the responsibility shared by men and women.

Access to financing

Only a small percentage of respondents at 7% have accessed financial assistance for the construction of sanitary facilities. In Amuria, Soroti, Kumi and Kaberamaido none of the respondents have accessed financial assistance for the construction of sanitary facilities. For an overview on the accessed financial assistance refer to Figure 40.

Figure 40 Distribution of financial assistance accessed in different districts (not USF)



Most communities at 93% have not accessed sanitation financial support from either Government, NGOs or any other partner to construct household latrines. Household members meet all the costs of construction of their latrines. However, it was established that some communities, especially in the Eastern and Northern regions accessed San Plats at lower costs, having subsidised by RUWASA and UNICEF, respectively.

4.3 Findings in villages covered by USF

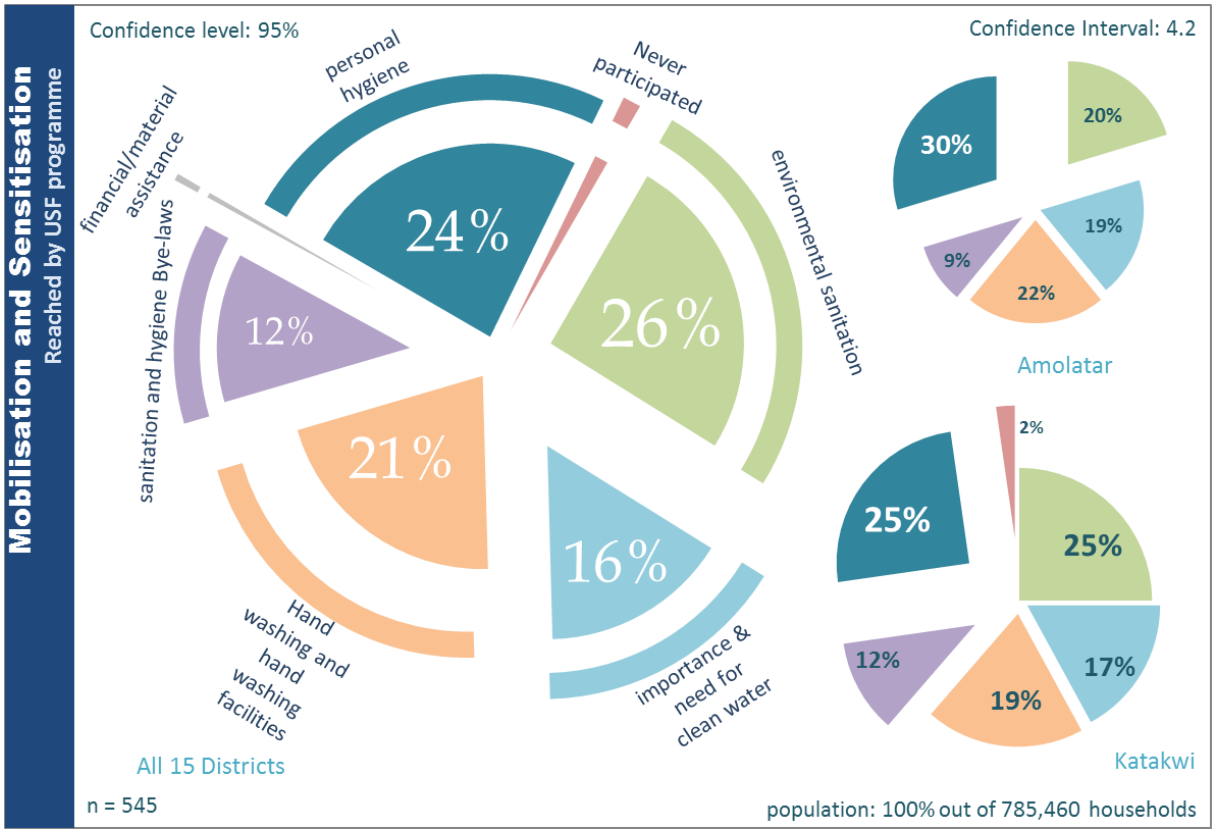
This section provides an overview of sanitation and hygiene orientated findings in villages within the districts designated by the USF programme and having been reached by the pro-

gramme. These villages generally have seen different forms of implementation of USF objectives.

Participation in sensitisation and mobilisation

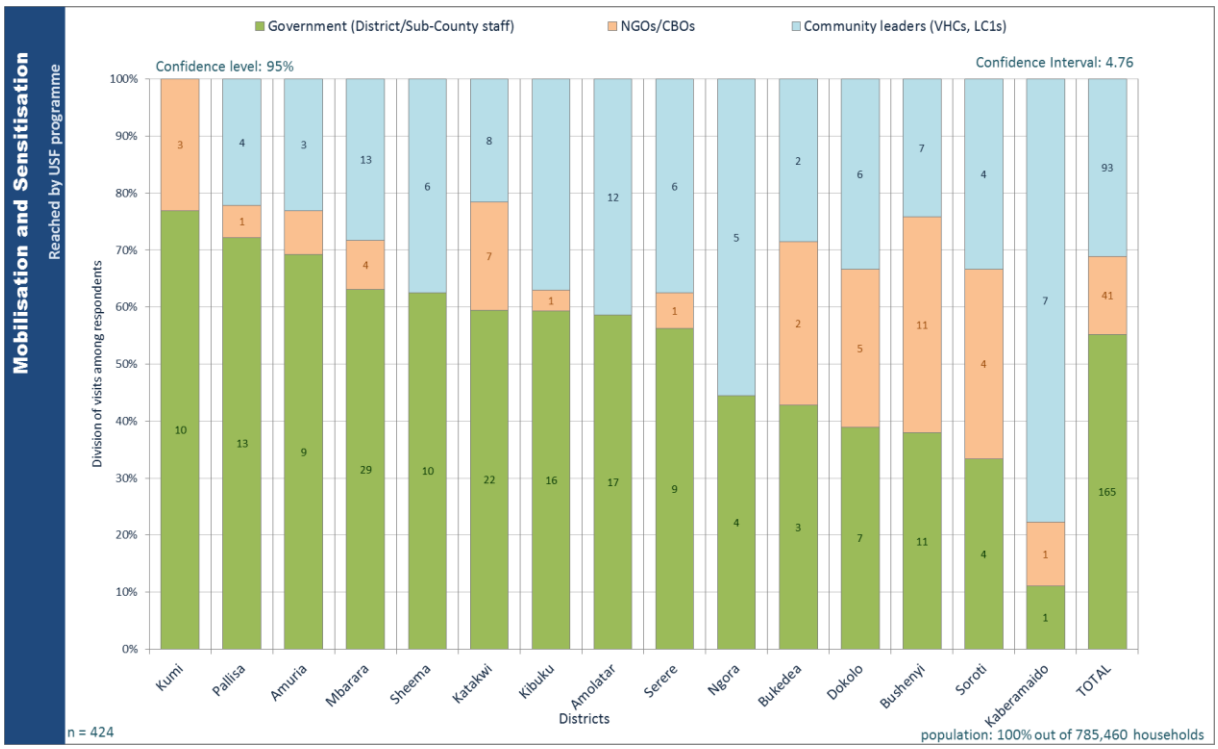
In the villages with USF intervention, communities are mostly mobilised and sensitised on environmental sanitation and personal hygiene Where 29% of the households in areas without USF intervention had not participated in mobilisation or sensitisation (Figure 17, page 26), only about 1% never participated in areas with USF intervention. This change is especially noticeable in Amolatar, where 55% of the respondents never participated in areas without USF intervention. In areas with USF intervention in Amolatar all respondents have participated in some form of mobilisation or sensitisation focused on sanitation and hygiene. Katakwi seems to be consistent in both not USF and USF areas, not showing significant changes.

Figure 41 Distribution of sensitisation and mobilisation topics respondents were visited for in different districts (USF)



There is more Government support at about 55% to community mobilisation and sensitisation in the USF areas. Kaberamaido shows the lowest indication of government involvement (12%), while in "not USF" areas this is higher (38%, Figure 17, page 26). For the distribution of visits in different districts by different parties refer to Figure 42.

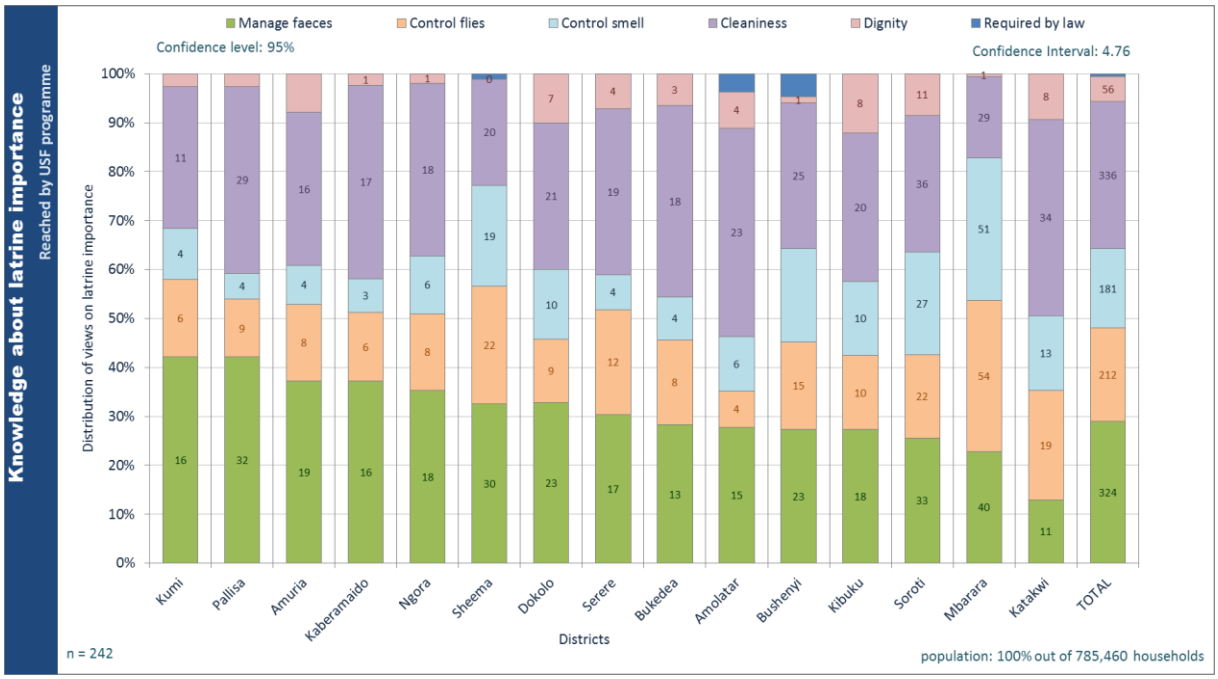
Figure 42 Distribution of instances respondents were visited by for mobilisation and sensitisation in different districts (USF)



Common knowledge

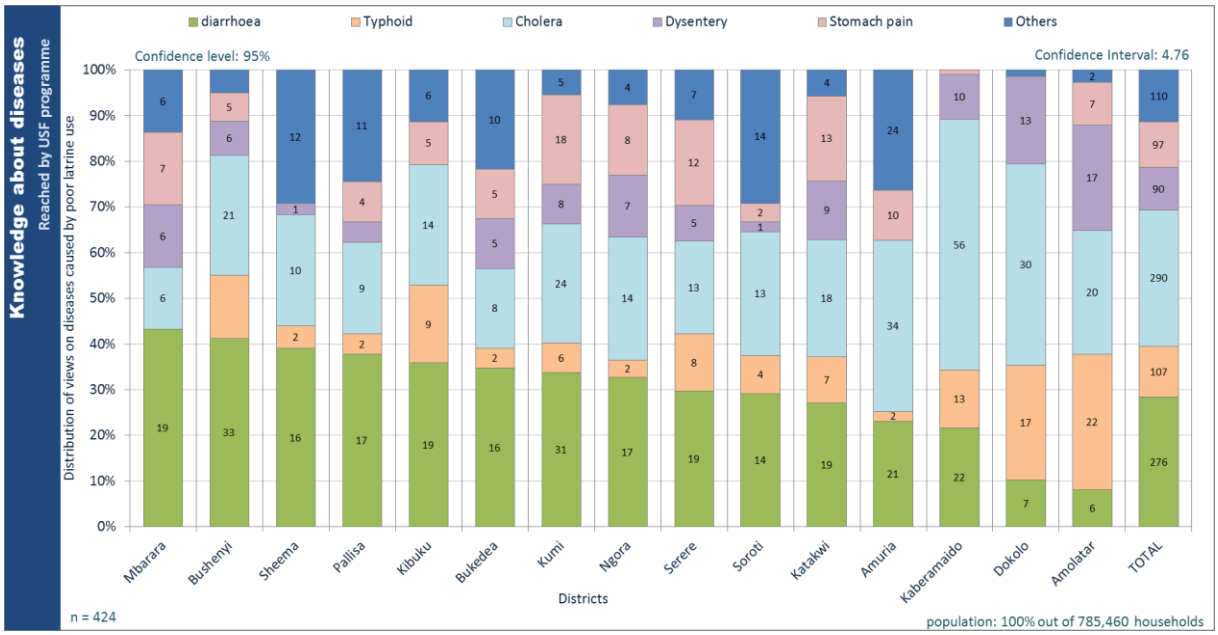
In both USF and not USF communities there is awareness of the importance of latrine use. The main reasons given by respondents as to why latrine use is important include managing faeces (29%) and maintaining cleanliness (30%). Figure 43 indicates the views expressed by the respondents on the importance of latrines.

Figure 43 Distribution of views on latrine importance in different districts (USF)



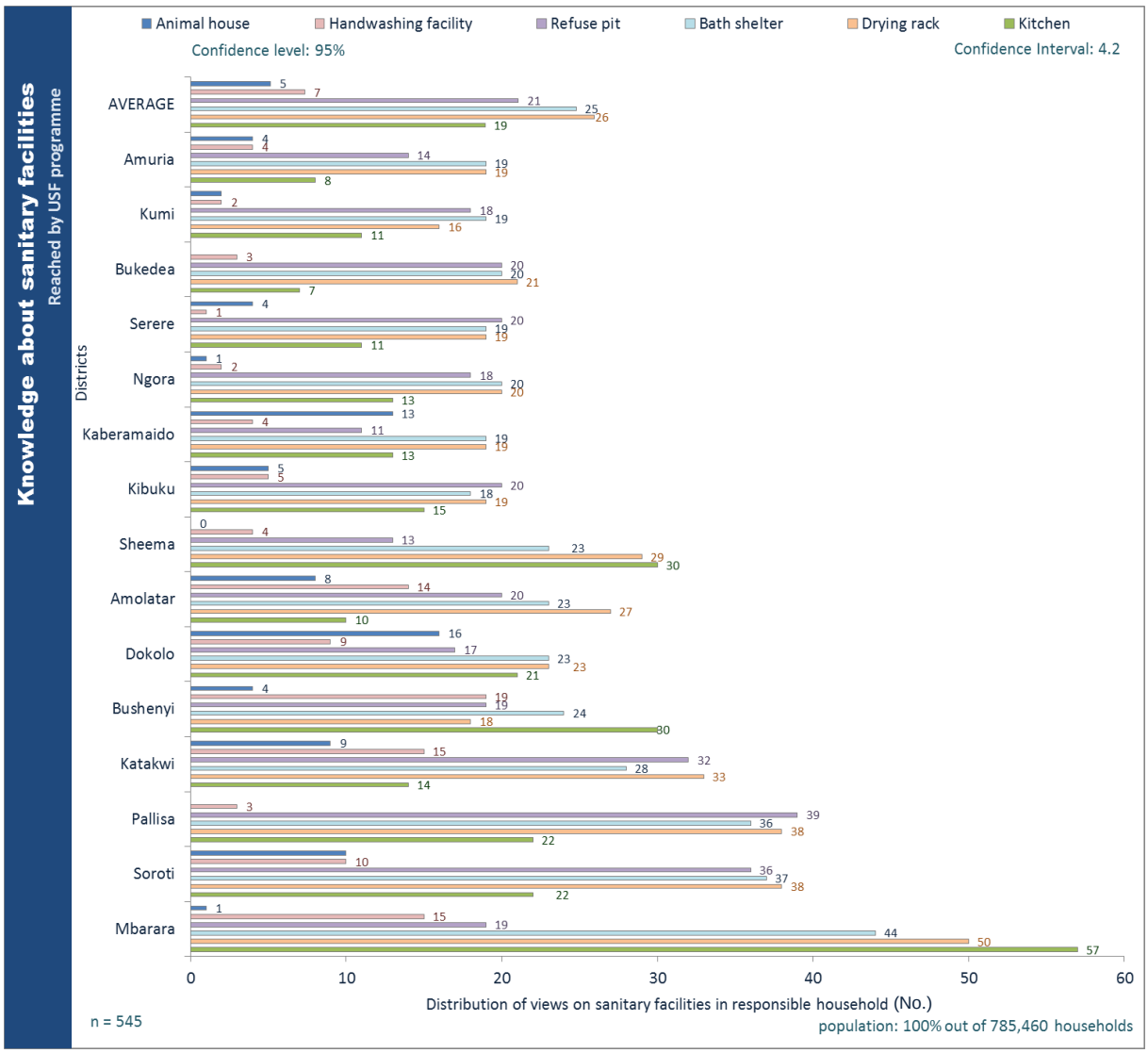
Communities are aware of the various diseases that can arise from poor latrine use with diarrhoea (28%) and cholera (29%) as the most common diseases. Figure 44 summarises the respondents' views on diseases caused by poor latrine use.

Figure 44 Distribution of views on diseases caused by poor latrine use in different districts (USF)



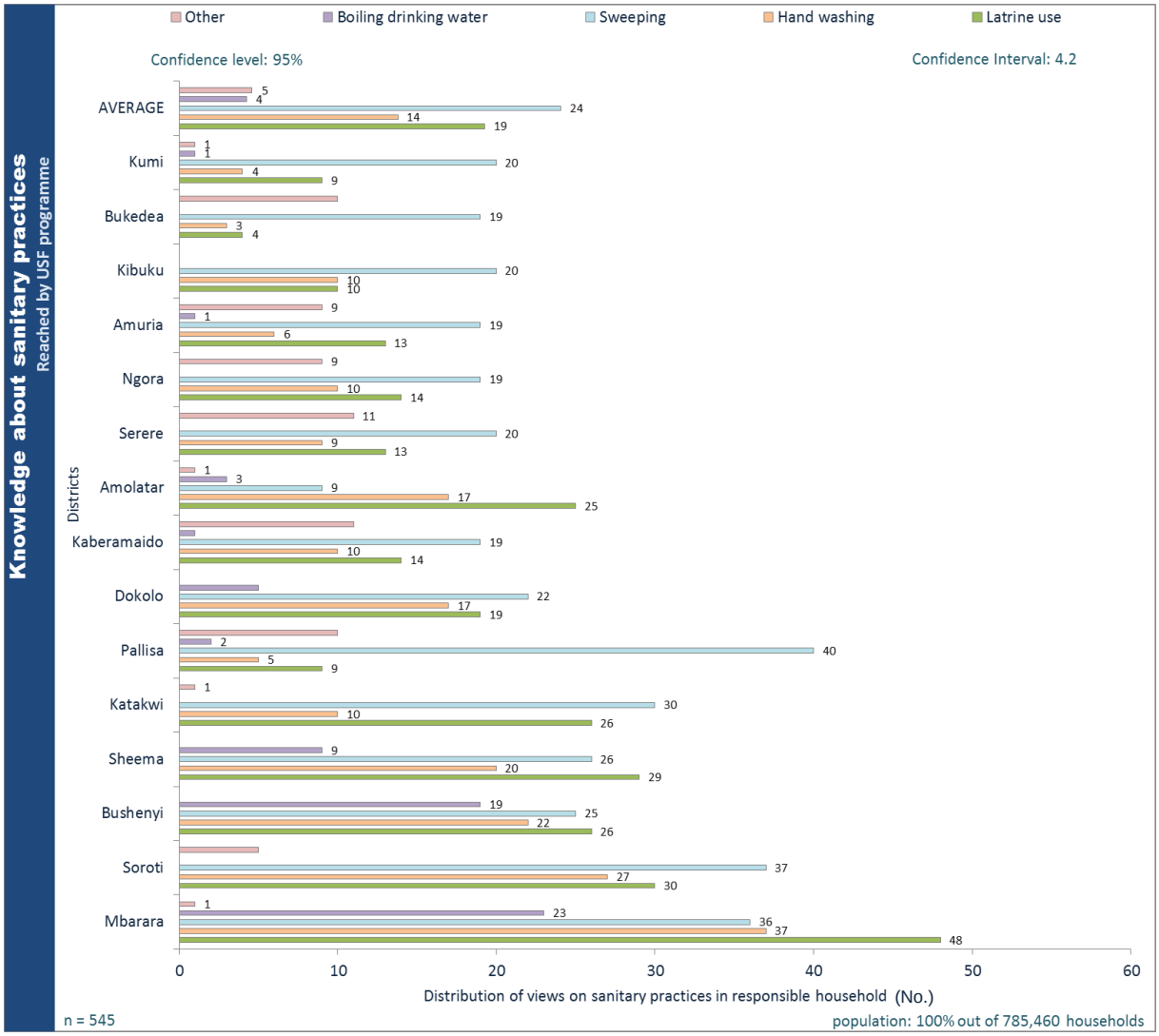
Drying racks, bath shelters and refuse pits were the most constructed sanitary facilities unlike hand washing facilities and animal houses. Responses from the FGDs about other sanitary facilities indicated that communities find it easier to construct bath shelters and drying racks because they use locally available materials. Figure 45 presents the views of the respondents on other important sanitation facilities.

Figure 45 Distribution of views on sanitary facilities present in a responsible household in different districts (USF)



Sweeping the house and compound is the most common sanitary practice encountered especially in districts of Pallisa, Bukedea, Kibuku and Kumi while latrine use was another common practice especially in Amolatar and Katakwi. Figure 46 gives an overview on the respondents' views on important sanitary practices in the different districts. Trends in views on both sanitary practices and sanitary facilities are similar in both USF covered and not USF villages.

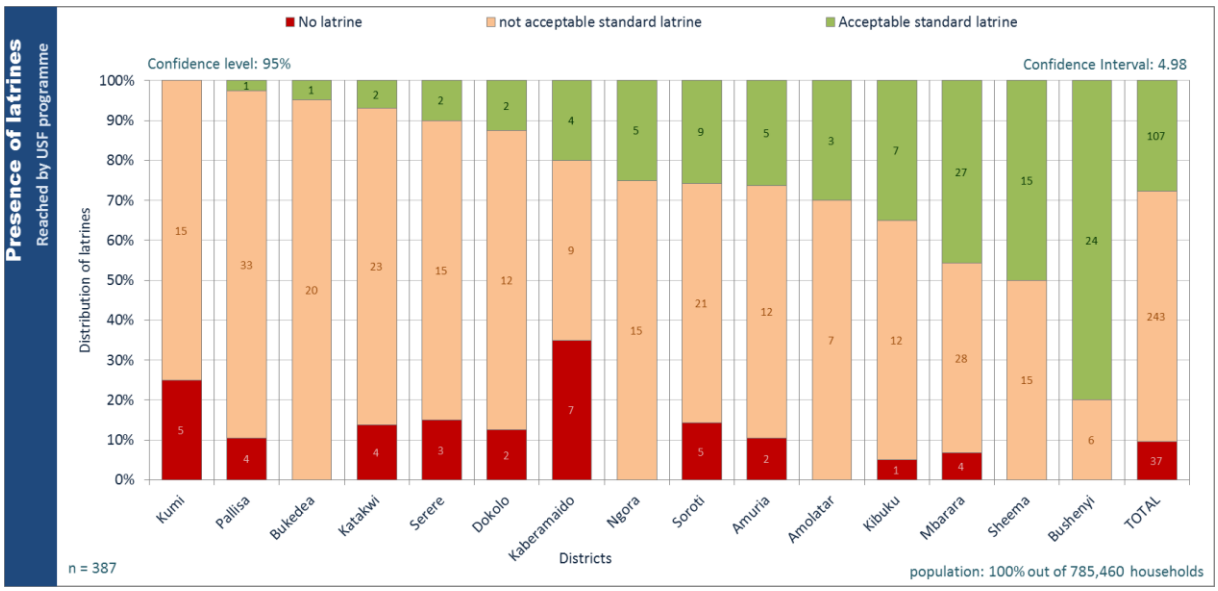
Figure 46 Distribution of views on what sanitary practices represent a responsible household in different districts (USF)



Current sanitation status

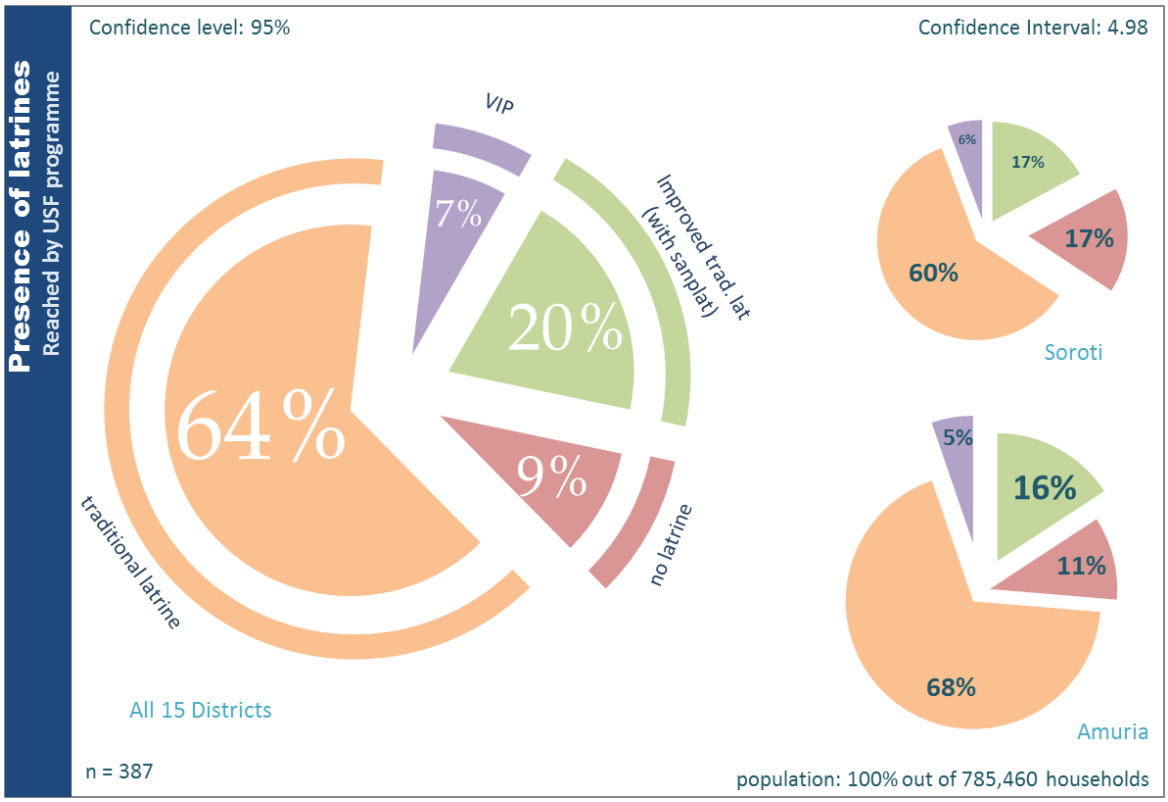
Although communities have latrines, most in both USF and non USF villages do not meet the required standard of latrine at a range from 20% in Bushenyi to 97% in Bukedea district. Latrines that meet required standards were mainly in Bushenyi and Sheema districts. Of all 15 districts included in the programme, none has achieved a coverage of 100% latrines that meet the required standard. For a definition on an acceptable standard latrine please refer to page ix. For an overview on latrines meeting the required standard in USF intervention areas please refer to Figure 47. There seems to be no direct relation between presence of acceptable standard latrines and intervention from USF. While some districts show higher percentages of acceptable standard latrines in villages with USF intervention, the overall percentages in villages with USF intervention and without are about the same (Figure 25, page34)

Figure 47 Presence of latrines at households in different districts (USF)



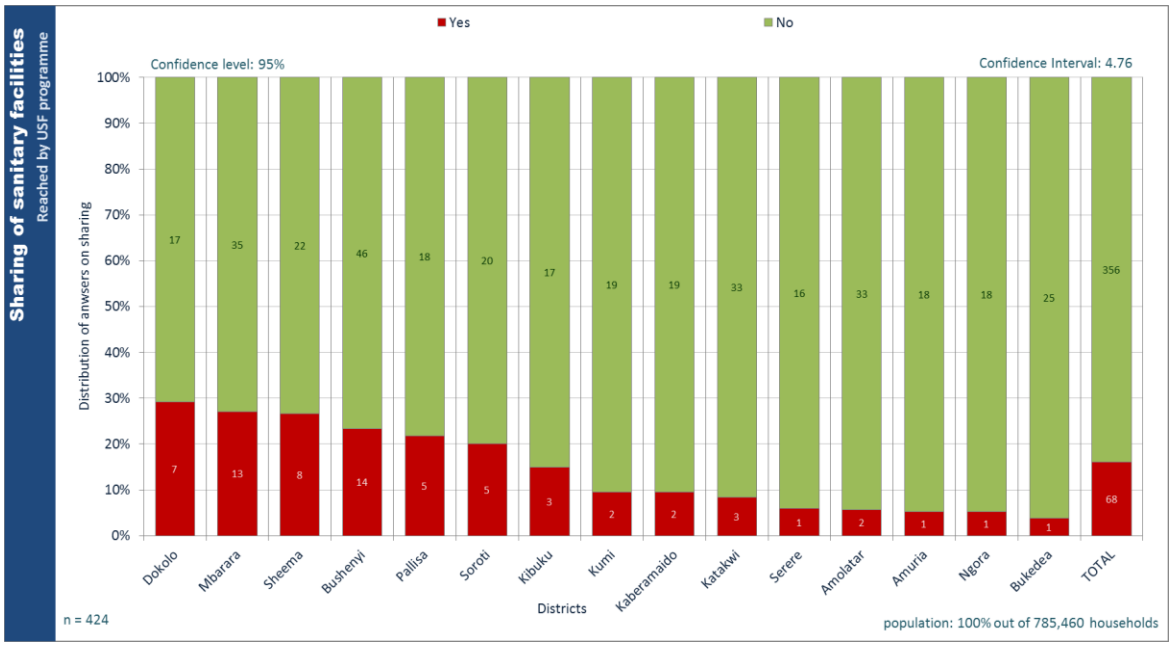
The most common type of latrine in communities was the traditional latrine (64%, with mud and wattle, earth slab with logs, grass thatched roof and a few with firm shutters). Most of them did not have squat hole covers and brooms. It should be noted that traditional latrines were mostly found in the Northern and Eastern districts while improved traditional latrines and latrines with a San Plat were observed in the Western districts. For an overview of latrine types encountered please refer to Figure 48.

Figure 48 Presence of latrine types in different districts (USF)



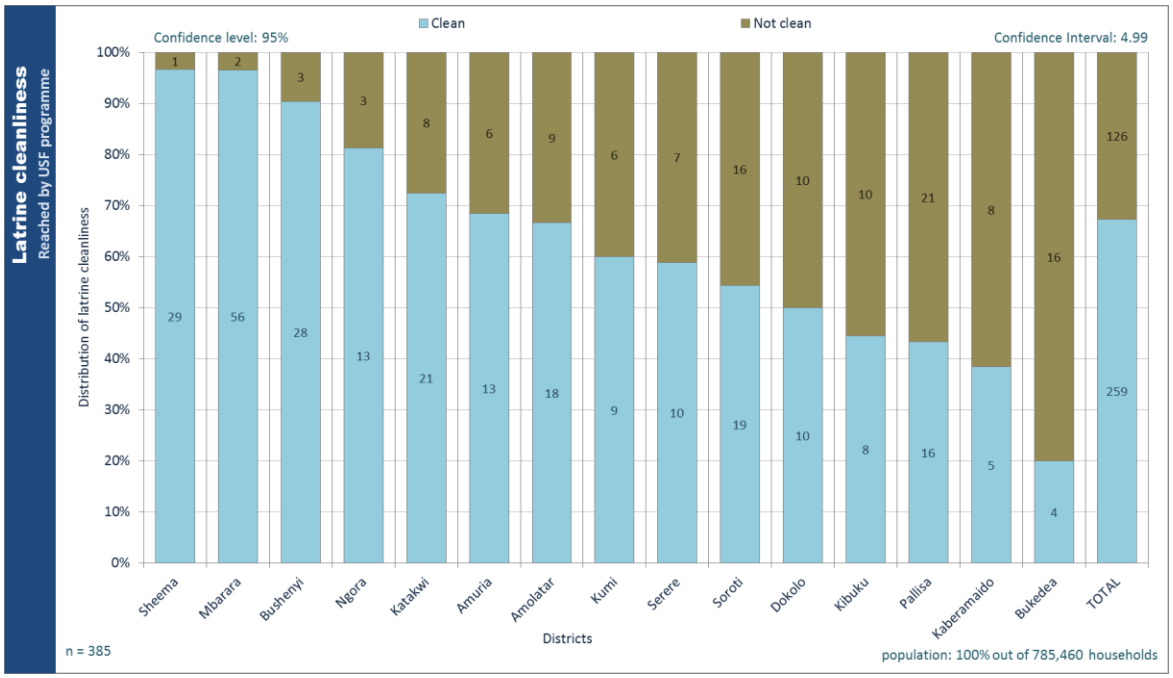
Few households at 16% in the USF villages share latrines and this was noticed especially in the Northern and Eastern districts. Figure 49 clearly shows that only a small fraction of the people in the programme area share sanitation facilities, though this doesn't differ much from villages without USF intervention within the programme area (14%).

Figure 49 Sharing of sanitary facilities in different districts (USF)



Cleanliness of latrines was mainly in the Western Districts with Sheema as the highest at 97% while Bukedea district was observed to have the highest number of unclean sanitary facilities at 80%. Overall 67% of the latrines visited during the survey were considered clean. Figure 50 shows the level of cleanliness of latrines in the 15 districts.

Figure 50 Distribution of latrine cleanliness in different districts (USF)

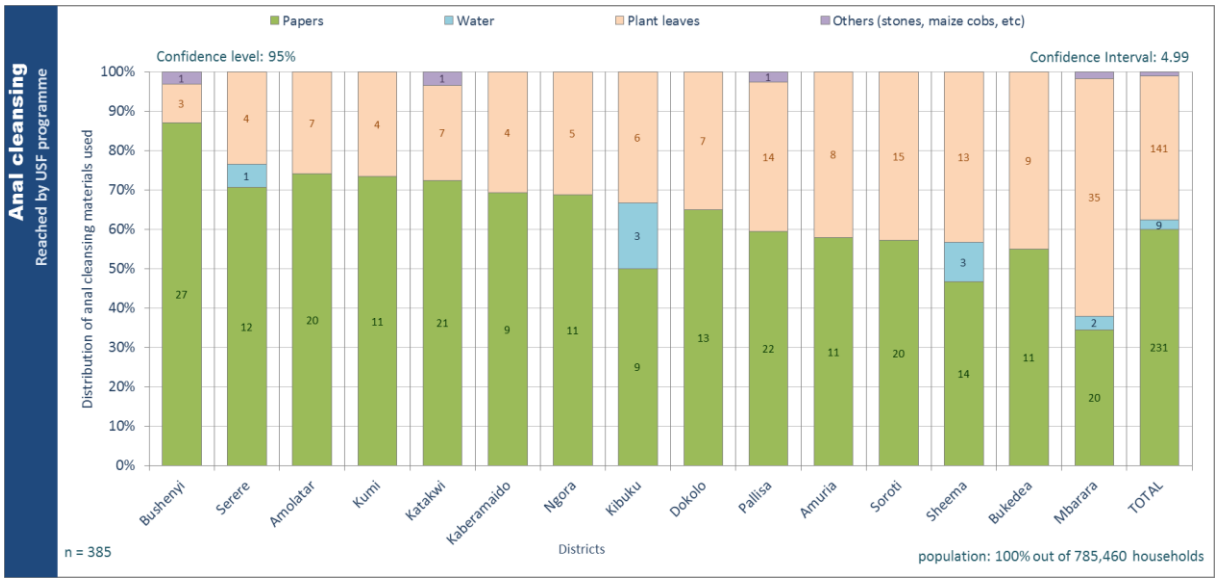


The most common cleansing materials used in communities where USF intervention had taken place were papers (60%).

Earth floors and squat holes are difficult to keep clean especially when they are accidentally fouled. Figure 51 indicates clearly that use of papers and leaves is practiced in all the districts (36%).

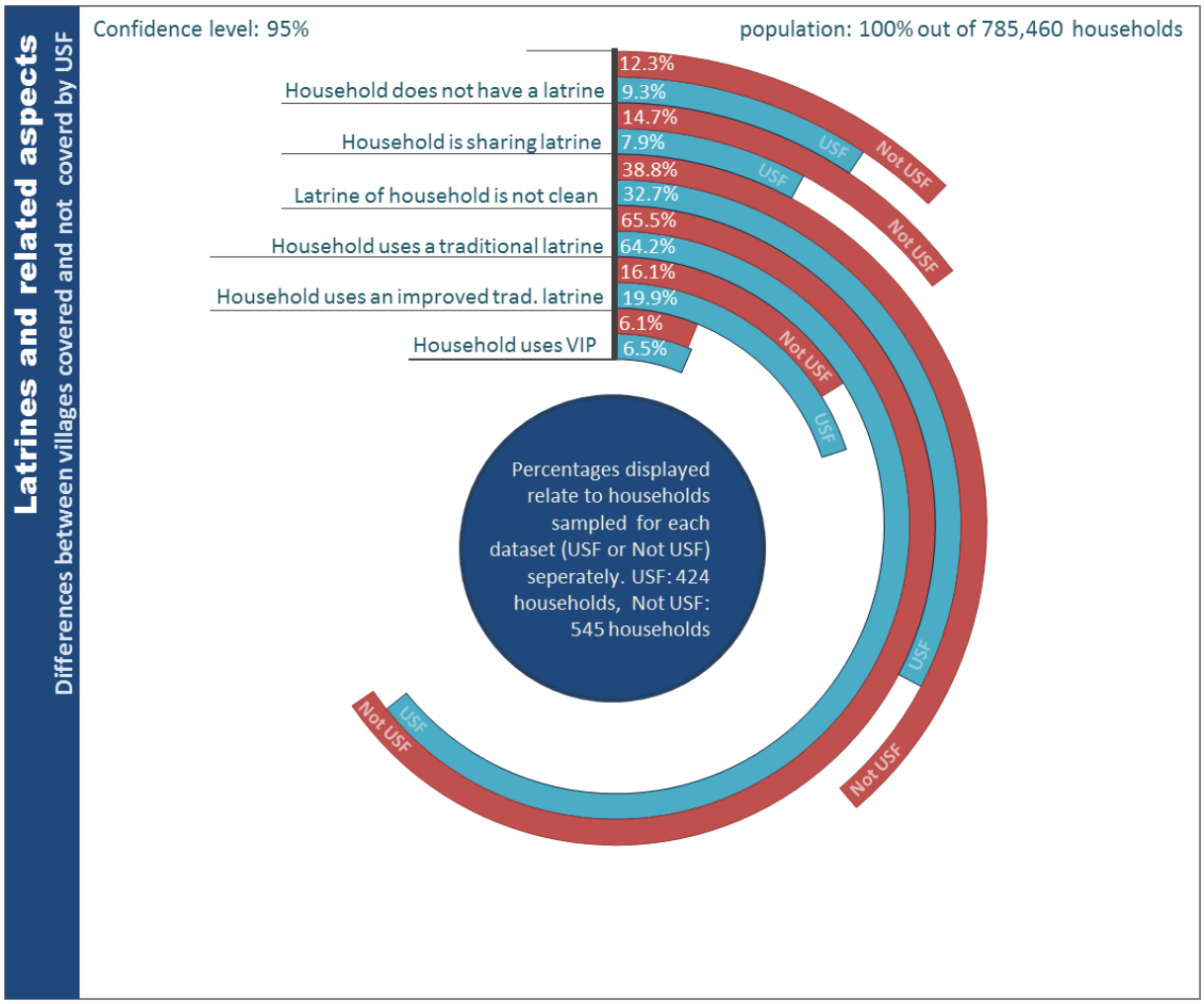
In villages without USF intervention generally leaves are used for anal cleansing (55%, Figure 29 page37), in villages with USF intervention however paper is the most used anal cleansing material.

Figure 51 Distribution of anal cleansing materials used in different districts (USF)



In areas with USF intervention overall there is a lower percentage of latrine absence, less households are sharing a latrine, more latrines are clean, more people use an improved traditional latrine and more people use VIPs, when compared to areas without USF intervention. For an overview refer to Figure 52.

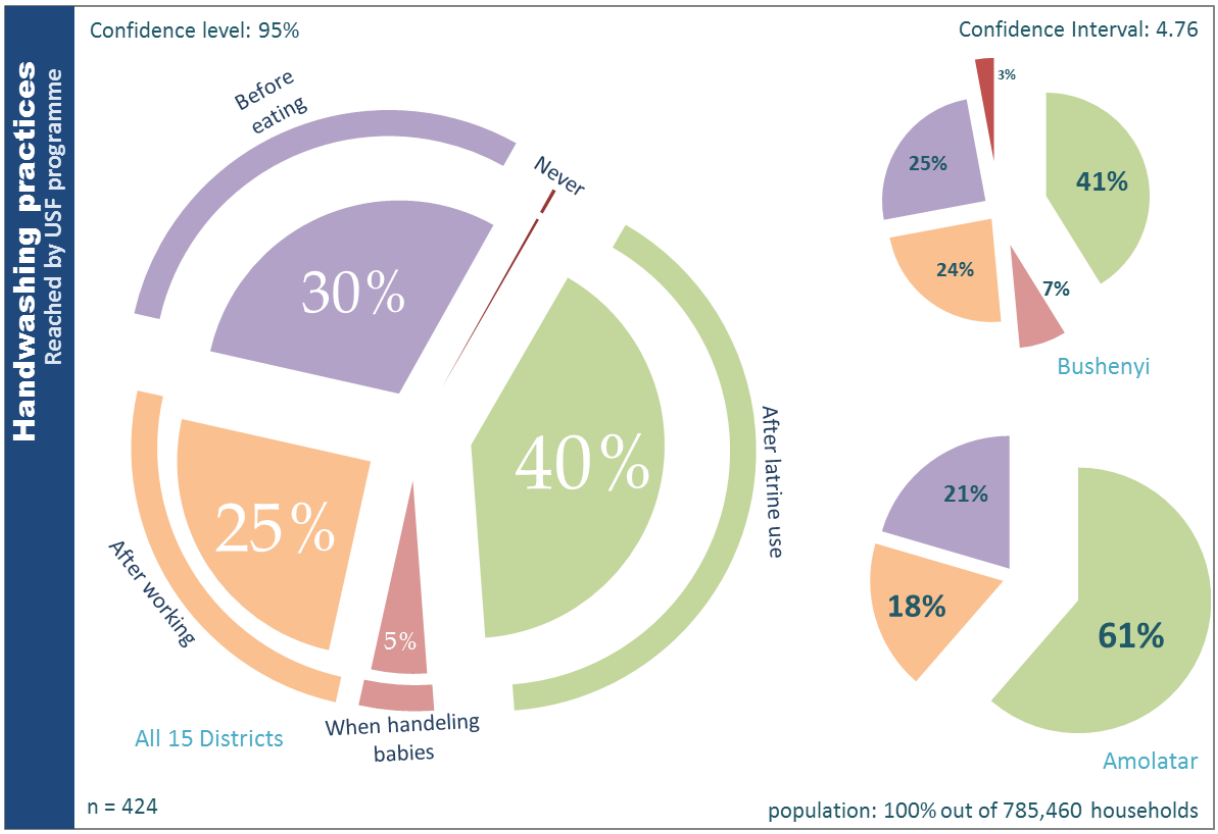
Figure 52 Overview on latrines in areas with USF intervention and without



Hand washing

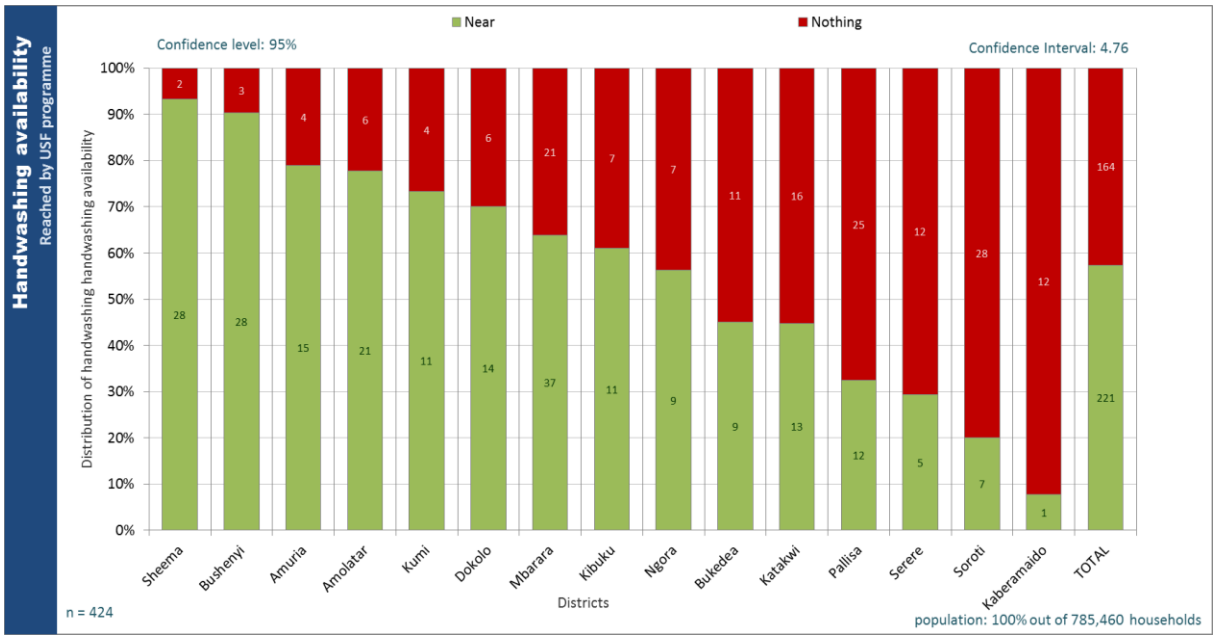
Most people in the USF intervention areas indicated to wash hands after latrine use. Only a vast minority at less than 1% stated they did not wash their hands at all For an overview on people view as critical moments to wash hands refer to Figure 53.

Figure 53 Distribution of hand washing practices in different districts (USF)



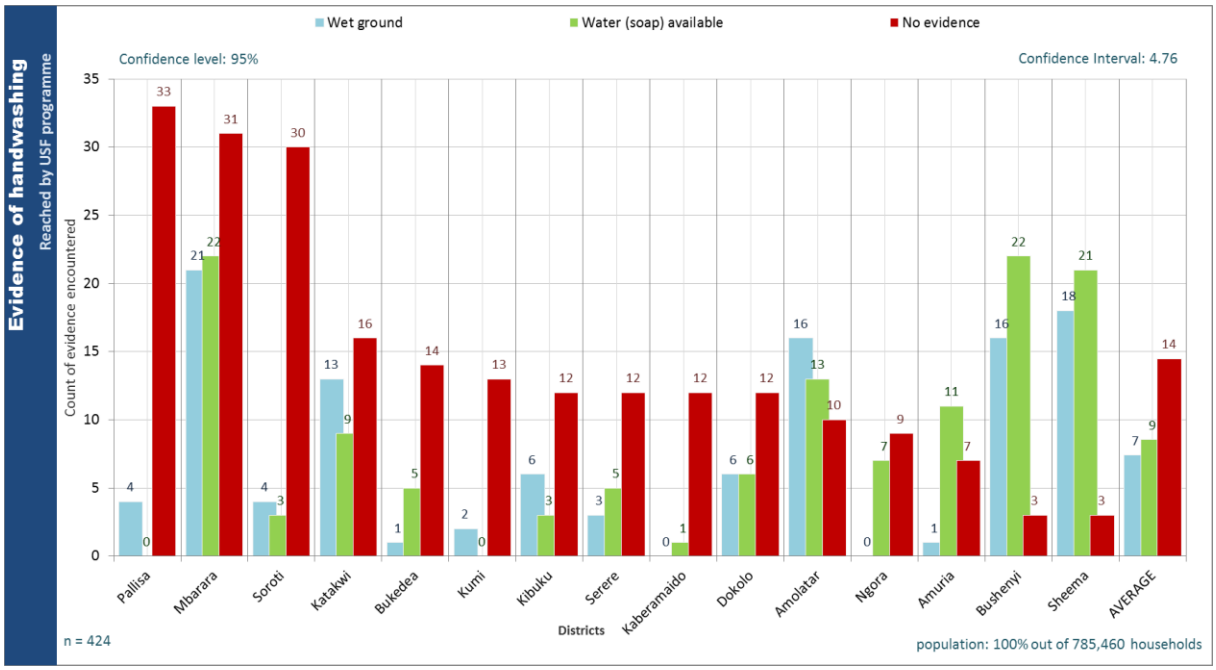
Hand washing facility coverage in USF intervention areas shows improvement (57%) when compared with areas without USF intervention (22%). Figure 54 displays the availability of hand washing facilities in the different programme districts.

Figure 54 Distribution of available had washing facilities near latrines in different districts (USF)



Evidence of hand washing was observed mostly in the three Western districts and Amolatar in the North. In the other districts the hand washing facilities often did not show indication of use. The cases of evidence of hand washing encountered are still more in areas with USF intervention, than in areas without USF intervention (Figure 33 page39). Figure 55 shows the availability of the evidence of the use of the hand washing facilities in the different districts.

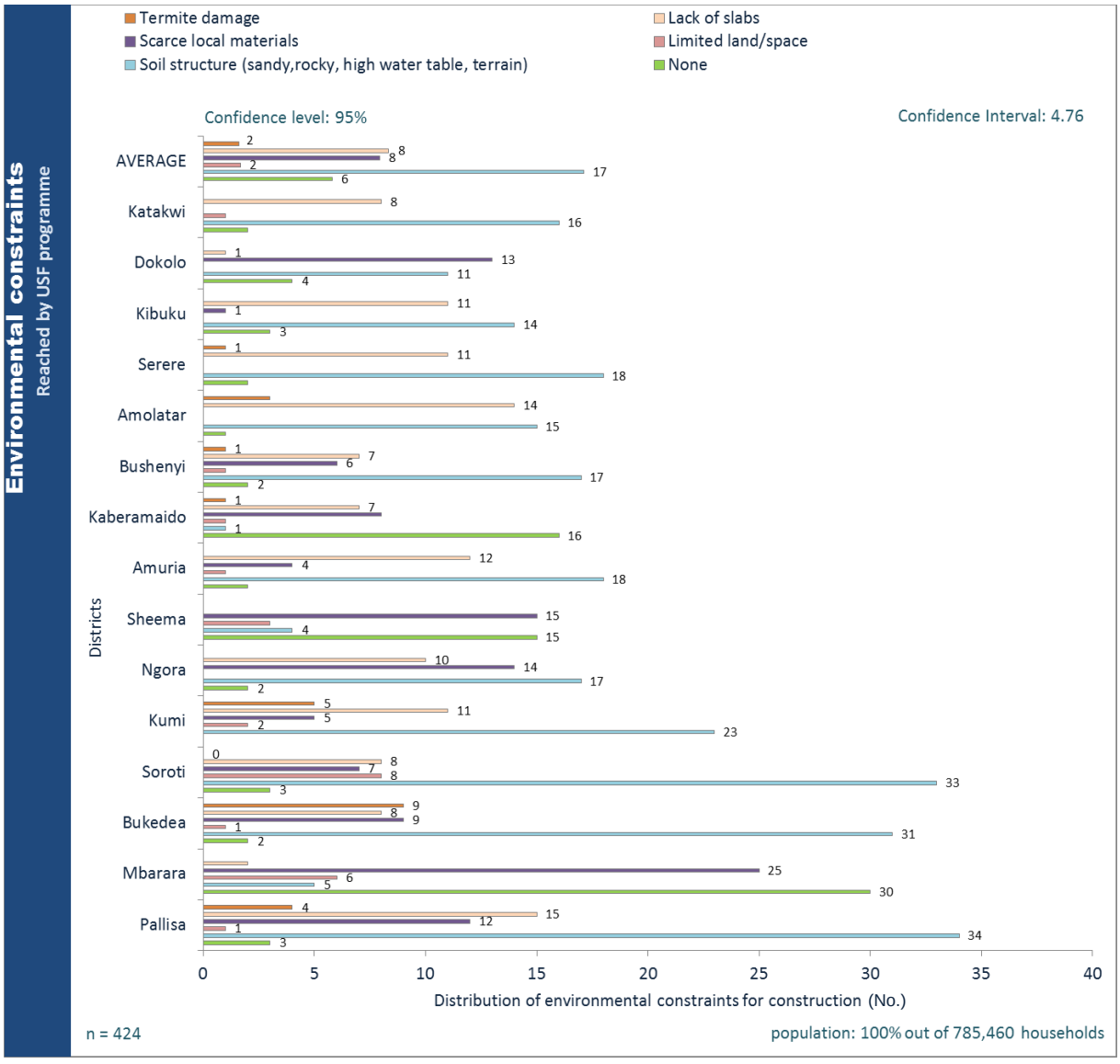
Figure 55 Distribution of evidence of hand washing encountered in different districts (USF)



Latrine construction and related factors

All districts especially in the North and East faced environmental constraints to latrine construction specifically with the soil structures which are sandy, rocky or water logged. Western districts had few environmental constraints but were faced with the challenges of lack of local materials. Both USF and non USF areas face the same challenges especially with the soil textures and labour costs for pit digging (**Figure 35**). For an overview of environmental constraints to latrine construction faced in areas with USF intervention refer to Figure 56.

Figure 56 Distribution of environmental constraints for construction in different districts (USF)



The study established that latrine construction was constrained especially by costly labour for pit digging mainly in Amolatar and in the Western districts. Lack of digging tools was another major constraint especially in Bukedea and Kaberamaido. Figure 57 presents an overview of the general constraints to latrine construction which communities encounter in the different districts in USF intervention areas.

Figure 57 Distribution of other constraints limiting latrine construction in different districts (USF)

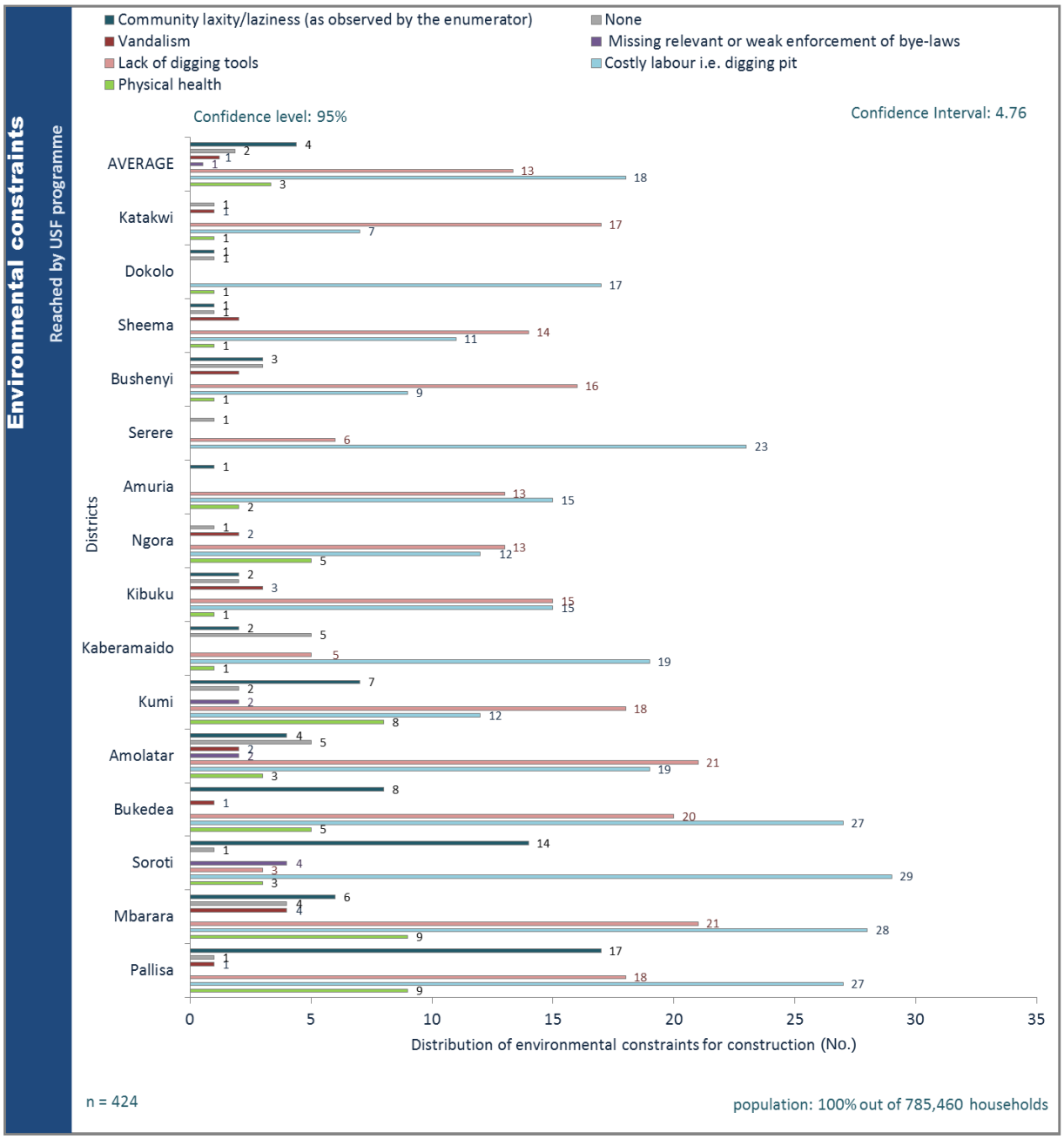
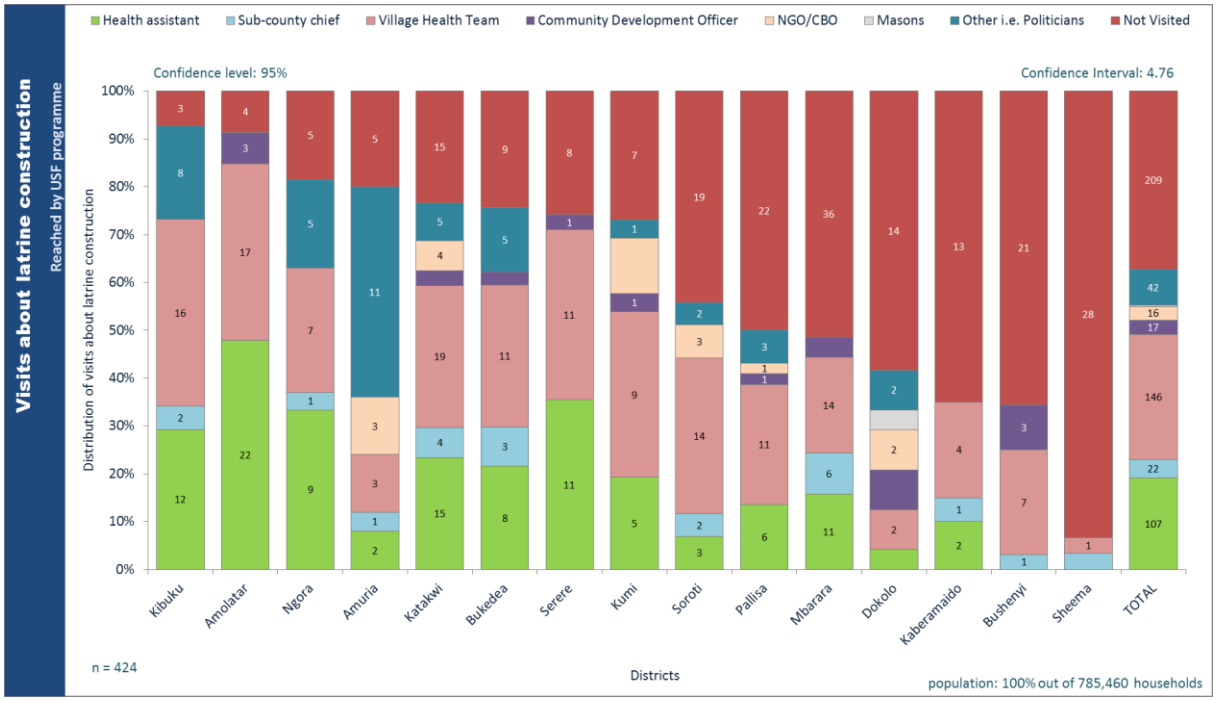


Figure 58 shows the distribution of visits by different agents about latrine construction in different districts.

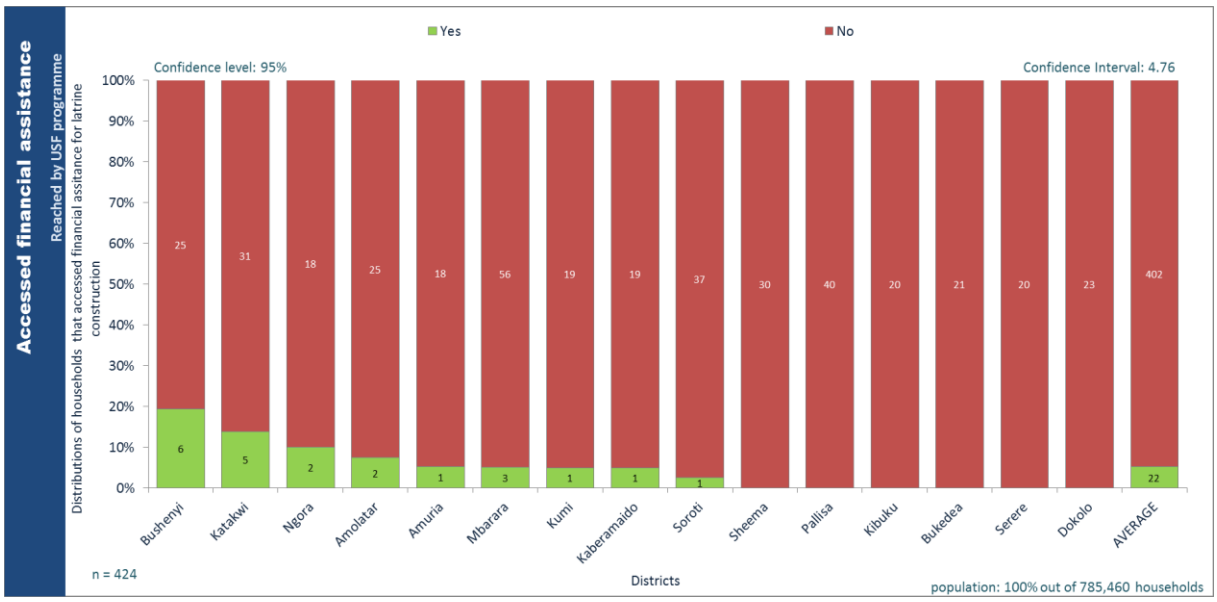
Figure 58 Distribution of visits about latrine construction in different districts (USF)



Access to financing

As shown in Figure 59 also in the areas with USF intervention financial assistance is rarely accessed.

Figure 59 Distribution of financial assistance accessed in different districts (USF)



5. Findings at institutional level

This section provides findings at institutional levels. Institutional levels include National, District and Sub-county levels. Institutional findings at national and district levels have not been disaggregated into USF and none USF. This is because at this stage it was intended to get general views about the management and progress of the USF programme.

5.1 National level: Program Coordination Mechanism and Executing Agency

5.1.1 Funding for National sanitation and hygiene policies and strategies

As listed in Section 1, the Ugandan Government has implemented various sanitation and hygiene policies and strategies, and the Public Health Act. Due to limited funding for the subsector, implementation of these sanitation and hygiene policies have not been as adequate and effective as required especially at Local Government Level (CPP).

More so, sanitation and hygiene receives insufficient funding and is never a priority for funding by both implementers and the beneficiaries, not until there is an epidemic arising from a poor sanitation and hygiene condition (CPP). There were no direct budget lines to support sanitation and hygiene at central nor district levels, Sanitation and hygiene activities had therefore always been tagged on to the Primary Health Care (PHC) grant which districts still claimed was inadequate. The Ministry of Health disseminated guidelines on allocation of funds for Sanitation and hygiene activities to districts from the PHC grant but implementation of the guidelines seemed to vary from district to district given priority allocated to sanitation and hygiene.

The PCM also noted that the policies are fragmented, which makes implementation complex at all levels. It was observed that there was need to strengthen inter-sector collaboration to reduce the fragmentation

5.1.2 Technical advice and support on sanitation and hygiene improvement

Although the Ministry of Health (MoH) was constrained concerning funding especially for sanitation and hygiene before the commencement of the USF programme, the USF districts were supported in various activities which were geared towards sanitation and hygiene improvement in their districts. These activities include sanitation and hygiene work plan and budget preparations, Home Improvement Campaigns, sanitation and hygiene training, and sanitation and hygiene field verification orientation. The technical and advisory support was given to both USF districts and non-sub-grantee districts including but not limited to Adjumani, Moyo, Koboko, Ntoroko, Kasese, Kalungu, Masaka, Rakai, Lwengo, Yumbe and Bukomansimbi to enable them improve sanitation and hygiene levels. MoH facilitated the technical advisory staff to support the districts using the limited funds.

The challenge remaining was late preparation and submission of progress reports to MoH. The technical advisory staff from MoH also noted that districts were more interested in funds than identification of their capacity gaps during the support visits.

USF districts were regularly monitored and the PCM provided financial advisory services on utilisation and management of the USF by the USF districts.

The study established that there was no specific budget line for sanitation and hygiene for the Ministry of Health, unlike in the Ministry of Water and Environment budget. However, some

local governments prioritise, plan and budget for sanitation and hygiene under the PHC, up to 5%. The MoFPED advises MoH to prioritise sanitation and hygiene during the budgeting process, give guidance and provision on reporting formats. The MoH should also guide and support districts on guideline implementation and sanitation and hygiene allocation under the PHC.

Districts are also guided on implementation of sanitation and hygiene activities by the NSWG and its members i.e. Ministry of Water and Environment, and Development Partners. EHD is the secretariat to NSWG and mandated for sanitation and hygiene.

5.1.3 Technical advice and support from GSF/WSCC Advisory Committee upon commencement of USF implementation

The Water Supply & Sanitation Collaborative Council (WSSCC) organised the USF inaugural meeting with the PCM and the EA in which the objectives, the principles for the USF were elaborated. During the workshop, experiences and challenges from other countries implementing the Sanitation Fund were shared with the USF implementers and managers. Orientation of the USF managers and implementers was also done by the WSSCC to ensure efficient and effective handling of the funds.

During the USF Inaugural meeting in Soroti in 2010, the WSSCC was very instrumental mentoring the EA and the PCM about the USF management and utilisation. The WSSCC oriented the EA on the USF objectives, expected outputs, approaches, guiding principles and capacity built the EA on the USF implementation strategies.

The WSSCC guided the EA on development of communication strategy for the USF support and has provided tremendous support in monitoring and supervision of the program in the country through field visits and electronic correspondences.

The WSSCC supported the EA during the launch of the USF programme which was held in Kumi district in 2011. Other activities that have supported by the WSSCC include mentoring on USF progress report preparation, team building, and organisation of retreat workshops to review and improve performance.

On behalf of the Government, the MFPED received financial support to Sanitation and hygiene and was guided on the development of the financing agreement and operation modalities of the USF programme.

5.1.4 Role of Development Partners/NGOs in the Sanitation and Hygiene sector

A number of NGOs and other Development Partners have funded implementation of sanitation and hygiene activities in districts such as home improvement campaigns, sanitation and hygiene training, sanitation and hygiene week activities. Many NGOs and other implementing agencies have materially supported sanitation and hygiene through provision of latrine construction tools i.e. wheel barrows, pick axes, spades, and hand-washing facilities, whereas others have been very instrumental in supporting School Sanitation and hygiene, especially UNICEF. Some have supplemented districts budgets to support the sanitation and hygiene component.

Both national and international NGOs and other Development Partners have been very active in the sanitation and hygiene sub-sector and have supported districts all through the country in implementation of improved sanitation and hygiene activities before and after the USF programme. Some of the NGOs and Development Partners that have been very instrumental in

sanitation and hygiene activities include WEDA, Water Aid- Uganda, UNICEF, WSP-WB, PLAN, Water for People, World Bank, HEWASA, Church of Uganda-TEDO, LWF and ASB, which operate mainly in Western and Eastern Uganda. The MoH/EHD encourages more NGOs and other organisations such as JICA, GIZ, and National Water and Sewerage Corporation (NWSC) to show interest and support sanitation and hygiene improvement in the country.

NGOs are also encouraged to apply for work under the USF activities especially in the USF districts. Additionally they are encouraged to prepare work plans, budgets and progress reports for activities implemented. Both the NGOs and Sub-grantee districts have been advised to clearly indicate their achievements under the USF programme in their progress reports.

The USF Executing Agency (EA) noted that NGOs and Organisations mostly report to the NSWG but do not submit reports to the MoH/EHD. To follow up the EA recommended that the NGOs and Organisations should provide their progress reports and work plans to the MoH/EHD as the sanitation and hygiene policy making body for improved coordination.

Additionally the EA recommended that NGOs provide physical accountability of their outputs, share their work plans, budgets and progress reports with their partners/districts where they operate. Collective monitoring of sanitation and hygiene activities by both the NGOs and the Government/District Local Government for quality outputs and value for money was also recommended.

5.1.5 Strategies to achieve ODF status

The PCM through the EA receives annual work plans from the USF districts and analyses the targets for the each sub-grantee and how these can be realistically achieved. The PCM and the Executing Agency organise review meeting for the USF districts to discuss progress of activities, share challenges and experiences. Capacities of implementers in the USF districts are also built through trainings and support supervision especially by the Executing Agency.

The EA designated a USF desk within the MoH/EHD, assigned specific USF programme staff who are Senior Officers from the MoH/EHD, to form the USF technical team. This team carries out activities geared towards the achievement of the USF targets for the coming five years. The desk officers work under the supervision of the technical assistants and are assigned specific districts. The Monitoring and Evaluation Specialist on the team together with other technical staff on the team conduct the main task of monitoring and evaluation of implementation and progress of the USF activities in the USF districts.

The EHD conducted training on CLTS for all EHD staff, the USF districts and the NGOs in order to enable them understand the concepts and process towards the achievement of the ODF status. The political leaders and communities in the USF districts were also sensitised to get them on board and enable them support the USF programme willingly.

Inter-District Meetings, retreats, and capacity building training sessions for USF districts have been organised by the EA. These meetings discuss the USF implementation approach, share experiences and challenges, mentor and provide technical support to districts in the areas of planning, budgeting and reporting and help them set realistic annual targets i.e. total number of villages for ODF status per a year. The EHD builds the USF districts' capacity in management and utilisation of the USF to ensure value for money, it reviews their work plans and carries out team building.

Districts are encouraged to prepare their work plans and budgets for their USF activities and submit them to the centre for review in line with the log frame, and for approval.

The EA and the PCM collectively conduct field verification visits to monitor USF programme implementation in districts to verify progress reports, identify gaps and form strategies to address them. Internal auditing of outputs is also done by the MoH/EHD Internal Audit department to ensure value for money. It was also noted the EHD/MoH is also guided by the Long Term Institutional Arrangement (LITEA) framework to enable achievement of the USF targets.

USF districts have also been trained on development of the Management Information System to enable them document and capture all information and keep track of their progress. However, this is still a challenge at both National and District levels.

The PCM/NSWG office oversees implementation of the USF programme in the USF districts, receives work plans and reports and promotes synergies for all on-going activities in USF districts.

5.1.6 Management and Utilization of USF

There are structures in place such as the Programme Coordinating Mechanism (PCM), the National Sanitation Working Group, the Executing Agency, the Country Monitoring Unit and the auditing systems at both the Ministry of Health and Auditor General's Office monitor the utilisation of the USF through various mechanisms i.e. field visits, support supervisions where bank balances and gaps are established, and analysing quarterly and annual progress reports, to ensure effective management and utilisation of the USF.

Although it was noted that most of the components under USF programme were effective, some challenges were experienced from the procurement system. This lead to delays and untimely implementation of USF programme activities. Team work and transparency at both national and sub-grantee levels for the programme are core values that should be enhanced to enable effective management of the Fund.

The Ministry of Finance Planning and Economic Development (MoFPED) receives funds on behalf the Uganda Government. The MoFPED then sends the funds to individual sub – grantees' general account. The funds are then approved by the respective sub-grantee CAOs and CFOs on request by the programme implementers. The DHO and the DHI, as USF implementers, are expected to prepare work plans and budgets, submit them for approval and also request for funds against these work plans.

The CAO is expected to make timely releases for the funds against approved work plans and budgets and it is at this level where the District technocrats i.e. CAO's office and the Political leadership are expected to monitor and follow up USF programme implementation. The District Internal Auditors are also expected to monitor and audit the USF programme activities, and verify expenditures at the sub-grantee/district level.

The PCM provides an oversight role in the utilisation and management of the USF. The PCM receives quarterly reports from the USF districts to analyse USF activity progress, challenges and any other concerns. The PCM depends on the government auditing system to provide guidance, though the system has some challenges. The CPM-UNICEF plays the monitoring role and audits the outputs to ensure that the USF are utilised and managed according to its purpose.

Management of the USF, MFPED expects USF districts to manage the funds as governed by the constitution on public finances, the Accountability Act and use the funds according to implementation guidelines as provided by MoH.

The MFPED expects USF districts to prepare and submit work plans and reports following the output budgeting tool to reflect work done/achievements vies-a-vies work plan. However, it was noted that the extent to which MoH and the USF districts use the tool is not adequate, especially during reporting.

5.1.7 Comments on USF guiding principles

From the KIIs, it can be concluded that the USF principles are realistic and are being implemented along government sanitation and hygiene policies, plans and procedures. However, the principle of on Demand Driven approach for improved sanitation and hygiene is still a challenge, because it has been noted that it is mainly the poor communities that have low sanitation and hygiene levels and experience the consequences of poor sanitation and hygiene. These poor communities do not have resources to demand for improved sanitation and hygiene services.

Regarding to pooling of funds, WSP-WB supplements the USF programme activities such as training of masons. The Ministry of Water and Environment promotes sustainability of the USF programme outputs through replication in other areas. However, it was noted that the USF programme is silent on gender and on aspects such as the inclusion of people with disabilities.

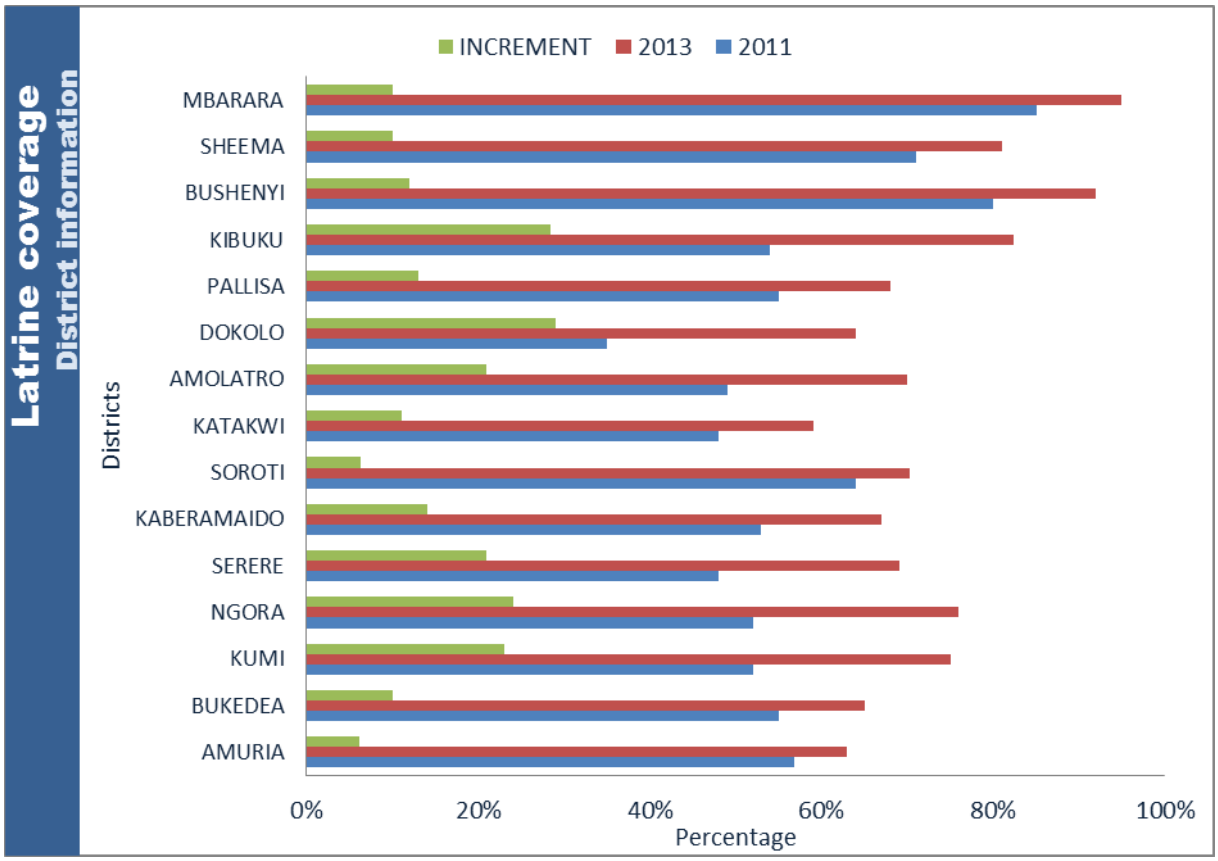
5.2 Local Government: District level

5.2.1 Sanitation and Hygiene situation

The Chief Administrative Officers, the Local Council Chairpersons, and Secretaries of Health, the District Health Officer and the District Health Inspectors of the 15 USF districts commented that before the USF programme started in their districts in 2011/2012, the sanitation and hygiene situation was appalling especially in the Northern and Eastern USF districts.

The districts presented their records on latrine coverage for 2011, 2012 and 2013 the analysis of which showed that there was progress as indicated in figure 60.

Figure 60 District latrine coverage based on district figures



It can be deduced from the graph that there was an increase in latrine construction ranging from 5% in Amuria to 28% in Kibuku in the period 2011 to 2013. In addition the graph indicated that Mbarara had the highest at 92% while Katakwi had the lowest at 58% at the time of the study based on the district data.

In the Northern and Eastern districts, latrine coverage was as low as 42%; which means that most people did not have latrines and were defecating indiscriminately i.e. in bushes, water bodies, gardens and along the road. Figure 60 summarises the latrine coverage by district based on district data.

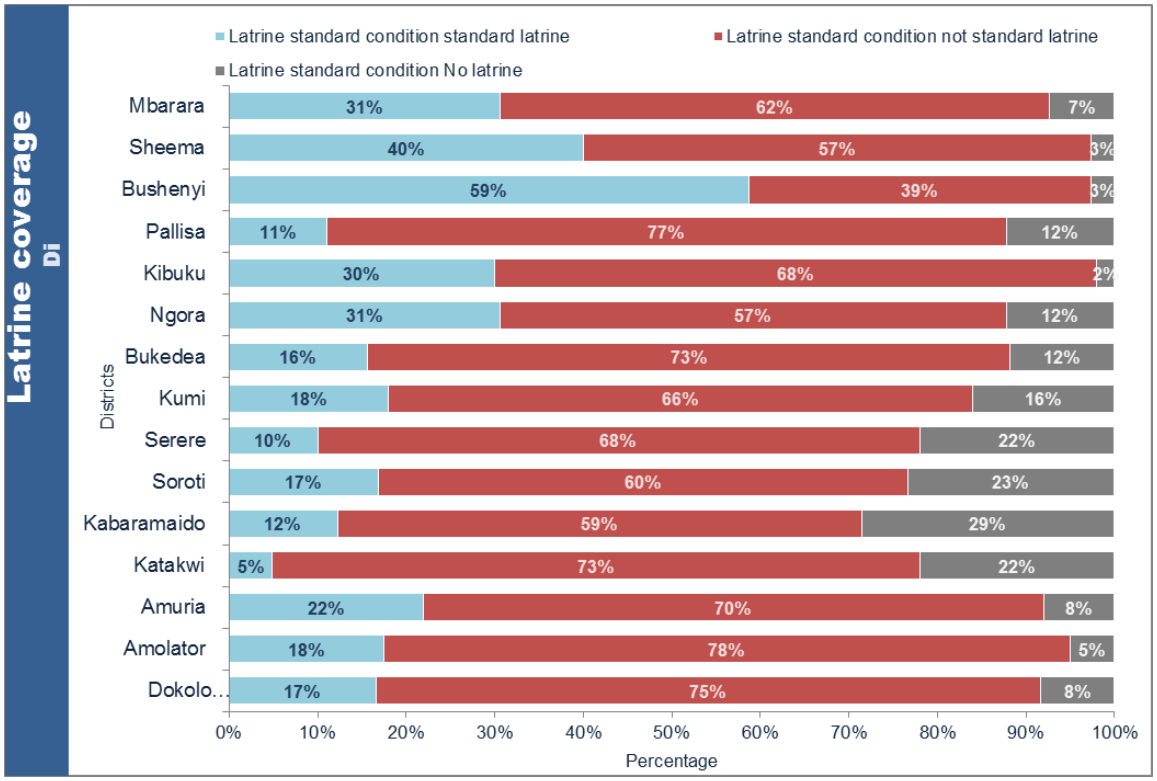
Table 7 Sanitation ladder

Improved Sanitation and Hygiene Ladder
Lower risk (safe practices)
• (10) High volume flush with HWF
• (9) Pour-flush and hand washing facilities
• (8) Eco-san with HWF
• (7) Improved latrine (slab, vent pipe) with HWF
• (6) Traditional Pit latrine (TPL) with HWF
• (5) Traditional Pit latrine (TPL) without HWF
• (4) Flying toilets (defecation in plastic bags) common in urban informal settlements
• (3) Cat method/trench
• (2) Defecation in the open/open defecation (indiscriminate)
• (1) Defecation(young child) in the compound
High Risk (unsafe practices)

In relation to the sanitation ladder, the study established that before the commencement of the USF programme, the North and Eastern districts were at the lowest steps (1, 2, and 3) of the ladder as can be seen in figures 25 and 31. After the introduction of USF programme the same districts are making progress and are grappling to reach step 5 and 6 as can be seen in figure 47 on presence of latrines and figure 54 on availability of HWF.

Since the current status of the latrines could not be established from the district data, the data from the household survey was analysed along with the district data. The analysis showed that the latrines that met the required standard ranged from 5% in Katakwi to 59% in Bushenyi. The latrines that were not on standard ranged from 39% in Bushenyi to 78% in Amolatar. The field findings indicated that overall the quality of the latrines was poor, i.e. without shutters, no pit covers, some had short and small superstructure, and many were incomplete, without roofs, poorly maintained and lacked hand washing facilities. Figure 61 presents the presence and status of latrines in the different districts. To compare with data collected during the field exercise of the study please refer to Figure 25 (Benchmarks) and Figure 47 (Progress).

Figure 61 latrine types in 15 districts based on survey data



5.2.2 Selection criteria for villages for the programme

In all the 15 USF districts, selection criteria for pilot villages for the USF programme was dependent on level of sanitation coverage for the sub-county or village to be selected, i.e. below 30% to 40% in Northern and Eastern region and below 50% in the Western region.

Areas which had supportive and cooperative leaders at all Local Council levels were also selected for the programme. The criteria considered availability of health extension staff and accessibility of the areas for easy monitoring and roll out to other areas.

In some districts like Katakwi, the criteria also considered areas which had NGOs and CBOs active in the sub-county and in other districts such as Serere. Additionally they considered areas which had soils that would accommodate the ordinary pit latrine as they await technical support on latrine construction in problematic areas i.e. water logged.

The Districts commended the criteria because it targeted low sanitation coverage areas and areas which needed intensification of hygiene and sanitation activities given their low level. However, it was also recommended that the programme be rolled to all parts of the districts for general improvement.

5.2.3 Comments about the USF guiding principles

The analysis established that all the 15 USF districts respected, appreciated and were implementing the USF programme following the principles for the success the program in their respective districts.

The District leaders commented that there was involvement of all district leadership at all levels in the district to the sub-county, both technical and political in the USF programme activities for the purposes of transparency and physical accountability. It was noted that quarterly joint meetings and monitoring field visits with all stakeholders was done through the District Water and Sanitation Committee meetings. This was done to discuss progress, challenges and ensure value for money through quality result achievements.

It was also recommended that more advocacy and sensitization especially to the political leadership about the objectives, the USF principles and other aspects of the programme was required in order to avoid misunderstanding of implementation methodologies.

5.2.4 Role of District leaders in management of the USF programme

The study established that the office of the Chief Administrative Officer receives and authorizes release of the funds to the Health Department account managed by the District Health Officer. The office is responsible for ensuring full accountability of the released funds and timely reporting on progress. CAO's office does joint monitoring of the USF programme activities together with other technocrats and political leadership through the District Water and Sanitation Coordination Committee to ensure value for money and quality service.

Local Council V Office: The District Local Council V through the Chairman L.C.V and the Councillors, oversees implementation and management of the USF programme activities through joint quarterly meetings and field visits to programme areas. The council is responsible for passing bye-laws and sanitation and hygiene ordinances. The office in conjunction with other Lower Local Government leaders mobilizes communities to embrace the USF programme and support implement in their communities.

The DHO and the USF-Focal Point Person prepare work plans and budgets for the USF programme and submit them for approval to the District Council and funding from CAO's office. The DHO/DHI/USF-FP implements the work plan with assistance of extension workers at lower local levels. The DHO/DHI is also responsible for preparing progress reports and timely submits them. The DHI's office implements the work plan with the extension staff i.e. the Health Assistants, Community Development Workers and the Village Health Teams. The DHO supervises and monitors the activities implemented by the health inspectorate staff in the communities.

5.2.5 Availability of Health Staff for the programme

All USF districts had Health Staff who included the District Health Officer, District Health Inspector, Health Educators, Health Assistants and Village Health Teams. The main body of staff was also supplemented with staff from line departments such as the Community Development Workers and Environment Health Officers. At the beginning of the USF programme the staff available in most districts however, were not adequate to manage the programme hence most districts recruited more Health Assistants and Health Inspectors. In some districts like Amuria, volunteers were to be recruited to supplement the efforts of the Health teams in the communities.

5.2.6 Availability of masons

The study found out that some districts had masons who were scattered all through the villages/sub-counties especially in the USF pilot areas. Some of the masons were trained by the District under the USF programme and others were trained by the Directorate of Water Development- Ministry of Water and Environment under Amaizi Marungi Water and Sanitation Project in South-Western Uganda. However, no district had an accurate record of the total number of masons available in the district. Table 8 shows the availability of trained masons in different districts.

Table 8 availability of masons

District	No. Of Masons trained	Trained by
Amuria	Not established	-
Bukedea	36 (2 per sub-county)	District
Kumi	21 (3 from 7 sub-counties)	District
Ngora	Not established	-
Serere	16	District
Amolatar	Not established	-
Kaberamaido	Not established	-
Katakwi	7	District
Kibuku	Not trained	-
Soroti	66	District and MWE
Dokolo	6	District
Pallisa	Not trained	-
Mbarara	Not established	-
Bushenyi	40	MWE
Sheema	Not trained	-

Although many of the masons had been trained, they rarely support communities on latrine construction especially in areas with problematic soils due to non-affordable mason services by the communities. Secondly, it was noted that more masons needed to be trained on latrine technology options and be encouraged to support communities.

It was recommended that the USF programme and the District conducts an intensive training for the masons and equip them with tools and business skills. In addition, the District Health Office should set unit costs for construction activities and items in such a way that masons do not overcharge communities.

5.2.7 Strategies and Sustainability mechanisms for ODF villages

The study noted that most USF districts conducted sanitation and hygiene promotion activities such as community mobilization and sensitization, community trainings, home visits and home improvement campaigns, radio programmes. Although these activities were not specifically targeting ODF status, they enabled most districts improve their sanitation levels. Determining the ODF status of the villages in the different districts was not part of the TOR for this study. It

is therefore recommended that a separated and in-depth study of the CLTS activities and status of ODF in respect of different districts should be undertaken.

5.3 Lower Local Government: Sub-county level

5.3.1 Community Mobilisation and sensitization

The analysis established that the Health Assistants, Community Development Officers,L.C.1 and Parish Chiefs mobilized and conducted sensitization on hygiene and sanitation before the commencement of the USF programme.

Strategies used to mobilize, sensitize and train communities included home to home visits, village competitions and community meetings, demonstrations to enable communities acquire practical skills, community gathering such as at burial functions, in churches, use of VHTs especially during out-reach activities, drama, poems and posters on hygiene behaviours.

The most effective strategies to mobilize and sensitize communities that were identified during the discussion were:

- Home to home visits are effective because it is one to one discussion and enables observation of sanitation and hygiene situation in homes.
- Home improvement campaigns, competitions and rewarding systems en-courage other communities to improve their sanitation and hygiene levels.
- Community meetings are effective because they bring together very many people and establish a bigger coverage.
- Use of Village Health Teams is very effective at the community level because they are in touch with the community and are spread out in the whole sub-county.
- Demonstrations of standard sanitary facilities enable communities to acquire practical skills.

The identified strategies were implemented in both USF and non USF sub-counties which led to improvement in Sanitation and hygiene levels in both communities.

According to the findings, total costs for community mobilization and sensitization ranged between 200,000/= to 2,000,000/= per a quarter due to limited district funds. However, districts integrated sanitation components in other activities such Water activities. It is also a policy for most development programmes such as NAADS, CIDI, LWF, WEDA, for all beneficiaries to install sanitary facilities in their homes before they benefit from the programme.

5.3.2 Sanitary facility construction

Type of latrines constructed: the type of latrine most constructed in communities are traditional pit latrine with mud and wattle walls, earth slab over the pit and grass thatched roof. However most of them do not have squat hole covers and shutters. It was observed that some community members have VIP latrines while others have ECOSAN toilets especially in Western districts.

As noted by the district leaders, most of the latrines constructed were below the required standard. According to the analysis, standard latrines were at 24 % in mostly Bushenyi, Mbarara, Kumi; 227 households with standard latrines, 12 %; 108 households without latrines in

mostly Bukedea, Katakwi, Pallisa and Soroti , and the majority at 64 %; 559 households with latrines not on standard in mostly in Kaberamaido, Soroti, Bukedea and Katakwi.

5.3.3 Technical support to communities on sanitary facility construction

It was established that it was the Health Assistants, VHTs and the Local Council leaders who supported communities on latrine construction. Although most communities had masons some of whom were trained by either the district under USF programme, Ministry of Water and Environment, community members rarely sought mason's support and expertise because they could not afford to pay for the services. For instance masons charge 15,000/= to 20,000/= for a slab, charge 12,000/= to 16,000/= per a day for labour. In this respect, it was recommended that more masons be trained and equipped with tools to enable them provide support services to communities at affordable cost.

5.3.4 Operation and maintenance of sanitary facilities

Maintenance of sanitary facilities especially latrines was done by regular smoking, mopping the floor in case of a cement slab the cement slab, spray with ash to keep away flies, replace damaged grass and repair damaged walls. Some households however, did not care to maintain their latrines and they were always very dirty.

When looking at labour for cleaning the latrines, it was noted that women and children were responsible for cleaning the latrine. Some men however, take the responsibility to clean the latrines because they consider it the responsibility for both women and men.

Functionality of the Hand Washing Facility was a shared responsibility for all family members in that the men buy the jerry-cans and the soap, while the women and children ensured that the jerry-cans had water and soap. However, this was a still a challenge in most communities.

5.3.5 Access to sanitation financing

In most of the USF districts, it was discovered most communities have not accessed sanitation financial support from either, Government, NGOs or any other partner to construct household latrines. Few at 7% mentioned having received financial support to construct household latrines. Household members meet all the costs of construction of their latrines. It was also established that some communities especially in the East and North regions accessed san plats at lower costs some years ago, having been subsidized by RUWASA and UNICEF respectively.

5.3.6 Other Sanitation initiatives and innovations

- Donation of funds known as "bol chap" from village savings to people without latrines especially the vulnerable groups to enable them construct latrines in Dokolo district.
- Drama groups and campaigns as source of motivation.
- Existence of groups which use their savings to promote sanitation through rewards to the winners i.e. clothes, chairs, promoted hygiene among its members in Ngora district.
- Team work among district leadership
- Construction of pit latrines using sack with sand/soil used in water logged areas in Rwatama village, Pakwir Parish, Ngariam Sub-County, Katakwi District.

6. Conclusions and recommendations

6.1 Conclusions

The household survey sample size was sufficient to ensure that the findings are representative with a 95% confidence level and a confidence interval between 3.15 and 4.76. The FGDs and KIIs provided a further insight in the answers provided by the respondents.

The majority of the respondents were female, Christian, between 36-48 year old, married and spouse to the head of the household. The household size was 8 people on average with Kibuku having the highest number of household members at 11, whereas Sheema had the least, at 5 people per home.

With regard to income, Bushenyi had the highest percentage of respondents at about 16% with a high income, derived from formal employment. Bushenyi respondents were also having the highest percentage of people with tertiary education, whereas Kumi respondents were least educated, with 80% having only primary education. Kibuku had the highest percentage of respondents at about 75% with the lowest level of income, from mainly crop growing. It was established the majority of the respondents were owners of their homes at between 90% and 100%. For an overview of the relation between income and latrine presence refer to Table 9 and Table 10.

Table 9 relation income and latrine presence (No USF intervention)

No USF intervention	No Latrine	Not acceptable standard	Acceptable standard
High income	3%	67%	30%
Middle income	12%	58%	30%
Low income	10%	70%	20%
Absolute poverty	22%	62%	16%

Table 10 Relation between income and latrine presence (USF intervention)

USF Intervention	No Latrine	Not acceptable standard	Acceptable standard
High income	13%	33%	53%
Middle income	1%	49%	50%
Low income	9%	71%	20%
Absolute poverty	21%	63%	16%

All districts have received mobilisation or sensitisation visits on different aspects relating to sanitation and hygiene. A few community members especially the women do not have adequate knowledge on the sanitation related diseases.

According to findings derived from FGDs, there still is a lot of open defecation where USF is not operating, especially in the Northern and Eastern districts. Many community members go to the bushes, gardens or even along the road sides. Communities near water bodies i.e. in Pallisa, Serere, and Kibuku defecate in the lakes and rivers especially among the fishing communities.

Most households have some form of latrine, with about 12.3% on average not having any latrine at all. Of the 86 % with latrines, 66% could be considered as a latrine below acceptable standards, leaving only 20% of all households having an acceptable standard latrine. About 15% of all households over all 15 districts share their latrine with different households.

Cleanliness of latrines greatly varies among different districts, with Bushenyi having the cleanest latrines. Therefore there seems to be a direct relationship between level of education and wealth, and clean latrines.

It was established that community members use papers and leaves as anal cleansing materials. Some members especially the Muslims use water while a few individuals use hard soil particles. Very few households use toilet papers because of lack of affordability by the majority.

According to the answers of the household survey almost everybody knows that it is important to wash their hands at some point. However, while people may know when to wash their hands, absence of hand washing facilities and not having evidence of the use of hand washing facilities indicates a distinction between theory and practice. A hand-washing facility can be considered the most undervalued sanitary facility in some districts.

The majority of the households (56%) have not been visited to talk about latrine construction.

Findings indicate that the least environmental constraints to latrine construction were experienced in Sheema district. The biggest environmental constraint overall seems to be the collapsing soils, shallow hard rock and high water tables. No availability of slabs, and costly labour were also mentioned as constraining in many districts. Limited space was hardly named as a constraint. Reasons mentioned for not having latrines included gender limitations in the household (families headed by a child, widow or elderly person), and environmental concerns.

Even though most communities have masons, either trained by district Ministry of water and Environment or USF programme, community members rarely seek mason's support and expertise because they cannot afford to pay for the services. Only 7% of respondents accessed financial assistance for the construction of sanitary facilities.

Maintenance of sanitary facilities especially latrines is done by regular smoking, mopping the floor (in case of cement slab), spraying with ashes to keep flies away, replacement of damaged grass and repairing of damaged walls. Women and children are mainly responsible for cleaning the latrine.

6.2 Recommendations

6.2.1 Community level

Knowledge and awareness on sanitation and hygiene

Little community mobilisation, training and sensitisation on improved sanitation and hygiene practices where encountered, especially in the non USF areas. Additionally teachers in primary school and village health teams seem to neglect hand washing as an important sanitary practice.

There is need to intensify community mobilisation, training and sensitisation on improved sanitation and hygiene practice especially in the non USF areas. Health Assistants should continuously monitor and follow communities to ensure continuity of improved behaviour.

There is a need for refresher training on sanitation and hygiene for teachers in Primary Schools and VHTs especially on hand washing.

Access to improved Sanitation facilities

Sanitary facilities constructed in the communities seem to be of a poor quality. Also schools seem to have poor or inadequate latrines for children and teachers. Often girls and boys use the same sanitary facilities at the schools.

There is need to improve on the quality of sanitary facilities constructed in the communities through the use of appropriate approaches such as sanitation marketing. There is need for continuous monitoring of latrine construction to ensure that communities construct desirable latrines and maintain them as well.

When looking at school sanitation and hygiene, most schools in the districts/programme areas have very poor i.e. inadequate latrines for the children and the teachers. Throughout the 15 programme districts, the consultant did not notice any organised efforts to address the appalling sanitation and hygiene situation in the schools and hence there is need to adapt strategies to address the problem.

Sanitary facility construction and related factors

FDGs showed that communities know little about the different latrine options available to them. It is recommended that communities should be sensitised on different latrine options that are suitable in the different soil conditions.

Little support was encountered concerning vulnerable groups. The USF guidelines should consider subsidies for vulnerable groups such as the persons with physical disabilities (PWDs) the elderly, and child-headed homes, as regards latrine construction i.e. provision of san plats, meet costs for pit excavation, in consistence with the Environmental Health Policy.

Sanitation improvement should consider general home improvement, so that a home is perceived in its holistic sense. Improvements should target dwelling houses, outer buildings, and domestic refuse management, personal and general cleanliness in addition to construction of house-hold latrines.

Access to Financing

To address the challenge of sanitation support to latrine construction, it is recommended that the USF programme consider hardware activities i.e. public latrine construction, slabs and san plat subsidies etc. in addition to software activities in line with the three pillars of ISH.

6.2.2 Institutional level

Funding for National sanitation policies and strategies

Visiting the USF districts, the consultant found that many find it difficult to effectively utilize the funds granted. All the 15 USF districts benefiting from the USF programme should ensure effective utilisation and management of the funds to ensure achievement of the programme objectives.

Technical advice and support on sanitation and hygiene improvement

Ministry of Health has a responsibility to support all districts (both USF and non USF) in the country so that there is general improvement in the sanitation situation in the country. Work/materials developed under the USF should be used in other areas to achieve a greater coverage.

Role of Development Partners/NGOs in the Sanitation and Hygiene sector

NGOs seldom share their progress reports and work plans with district representatives and the MoH/EHD/Executing agency. It is recommended that NGOs should provide their progress reports and work plans to the MoH/EHD/Executing Agency for coordination and improved policy formation.

NGOs should be encouraged to apply for work under the USF activities especially in the USF districts, prepare work plans, budgets and progress reports for activities implemented. Both the NGOs and Sub-grantee districts should clearly indicate their achievements under the USF programme in their progress reports.

It is recommended that NGOs provide physical accountability of their outputs, share their work plans, budgets and progress reports with their partners/districts where they operate. Collective monitoring of sanitation and hygiene activities by both the NGOs and the Government/District Local Government for quality outputs and value for money is also recommended. The consultant noted that in some USF districts, there were no NGOs and Organisations/Agencies that were active in Sanitation and Hygiene activities. The Consultant urges MoH/EHD to encourage more NGOs to support the Sanitation sub-sectors especially at the district level by using appropriate strategies through UWASNET.

Management and Utilization of USF

Since the USF Programme districts are now receiving more funds for sanitation and hygiene improvement from the USF programme, there is need to enhance their capacity to manage and utilize these funds in order to meet the programme objectives. The capacity of sub-grantee staff receiving and implementing the USF should be regularly reinforced and monitored in order to enable them effectively and efficiently manage and utilise the USF.

There is need to intensify support supervision to the USF districts especially by the Executing Agency. The EA team should allocate more time to the USF districts during the supervisory visits to discuss progress and challenges during the program implementation. Additionally, the core team of EA should devote more time to programme activities to ensure more effective support supervision. -

The consultant recommends that the USF programme reviews its policy principle about the poor because it does not define the categories of the "poor" and does not support subsidies which the poor especially the vulnerable poor may need to enable them to access improved sanitation facilities. Vulnerable poor may include the Aged people, the child headed families, the sick and the Disabled. It was also noted that it was the poor who always suffered the effects of poor sanitation and hygiene yet they lack resources to improve their sanitation and hygiene levels. The Environmental Health Policy has exceptions for the 'No subsidy' policy which the programme should take advantage of.

The USF should a have a deliberate strategy for to address the needs of the vulnerable groups. These include Elderly; Persons with physical disabilities (PWDs). Sanitation and hygiene education is a challenge of partnership and complementarily. It requires co-operation, co-ordination and networking between the public and private sectors, including NGOs, religious groups and individuals in reactivating the culture of collective responsibility and participation for improving sanitation and hygiene for the benefit of us all. USF should organise deliberate activities that enhance inter disciplinary and intersectional collaboration.

Voices of the people

Outside the scope of the Programme and therefore the survey, a number of comments were raised repeatedly; these are listed in this box.

- There is no focus on schools. The USF programme should therefore have a school sanitation component, and the availability of sanitary pads for girl children which was identified as a challenge should be an integral part of the school sanitation component.
- Little support was encountered concerning vulnerable groups. The USF guidelines should consider subsidies for vulnerable groups such as the persons with physical disabilities (PWDs) the elderly, and child-headed homes, as regards latrine construction i.e. provision of san plats, meet costs for pit excavation, in consistence with the Environmental Health Policy.
- Earth squat holes and earth slabs are difficult to clean when they are accidentally fouled because they cannot be washed. This why the programme should consider provision of subsidised San plats or concrete slabs, especially for the vulnerable groups. In addition, this will not only improve the living conditions of the vulnerable groups but will also to protect the environment through reduced cutting down of immature trees to construct earth latrine slabs.
- It is recommended that the USF programme considers hardware activities i.e. public latrine construction, slabs and SanPlat subsidies etc., in addition to software activities in line with the three pillars of ISH.