Uganda Sanitation for Health Activity (USHA)

Accelerating Achievement of Sustainable Household and Institutional Sanitation in seven Districts in Northern Uganda: Perspective from District Officials

Overview

Since July 2020, the USAID - Uganda Sanitation for Health Activity (USHA) has contributed to improving the water, sanitation, and hygiene (WASH) situation in 13 sub counties in the seven (7) districts of Agago, Gulu, Nwoya, Lamwo, Pader, Kitgum and Omoro in Northern Cluster (NC). On average USHA has supported two sub counties in Phase one per district, save for Gulu and Kitgum districts that had one sub county each. USHA implements community interventions targeting households and schools through technical assistance and small grants to local grantee partners (SORUDA, FOKAPAWA, ACORD, and GTI)[1] in close collaboration with District Local Government (DLG) officials mainly rom the departments of health, water, education, and community development. Table 1 below shows a summary of USHA's target sub counties of intervention by district.

Table 1: USHA's Supported Sub Counties by District in the NC

SN	NAME OF DISTRICT	NAME OF SUB COUNTY/SUB COUNTIES
1.	Omoro	Ongako, Lalogi
2.	Nwoya	Lungulu, Alero
3.	Gulu	Paicho
4.	Pader	Atanga, Ogom
5.	Agago	Arum, Omot
6.	Kitgum	Omiya Anyima
7.	Lamwo	Lokung, Padibe TC, Padibe West

About USHA

USHA is a five-year contract, February 2018 - January 2023, implemented by Tetra Tech in consortium with partners SNV USA, Sanitation Solutions Group, FSG, and BRAC.

The Activity works in 21 districts within three regions, implementing a series of contemporary and integrated WASH interventions at the district, community and household levels that lead to increased access to sustainable water and sanitation products and services.

Specifically, USHA aims to achieve three reinforcing outputs:

1. Increased household access to sanitation and water services;
2. Key hygiene behaviors at home, school, and health facilities adopted and expanded; and
3. Strengthened district water and sanitation governance for sustainable services.

This writeup summarizes district official's perspectives regarding USHA's interventions in phase one for 15 months from May 2020 to September 2021 as presented and discussed during a partners' review and learning meeting with grantees and DLGs that took place from 26th to 28th October 2021 in Gulu.

1. SORUDA-Soroti Rural Development Agency; FOKAPAWA-Forum for Kalong Parish Women's Association; ACORD-Agency for Cooperation in Research & Development; GTI-Grassroots Transformation Initiative-Uganda.

Summary of USHA interventions in Northern Uganda

To achieve project results in the supported seven districts, USHA together with stakeholders, implements sanitation and hygiene at community level using Community Led Total Sanitation (CLTS) at scale; promotes active private sector engagement; stimulates households to prioritize investment in sanitation; develops and executes a behavior change communication campaign; and strengthens District Sanitation and Hygiene planning and service delivery mechanisms. USHA employs the following market based sanitation (MBS) approaches reinforcing CLTS to achieve results and project targets: supports private sector involvement in the sanitation supply chain (e.g. training builders/mason to construct or upgrade toilets, enrolling stockists/hardware shops to sell sanitation products such as Safe Toilet-SATOs); enlist credit and finance providers (e.g. Village Savings and Loans Associations-VSLAs); develop latrine emptying and Fecal Sludge Management (FSM) services; provides governance support to DLGs to better plan, coordinate and convene District Water and Sanitation Coordination Committee (DWSCC) meetings; provides in-kind grants for the District Local Government (DLG) field support supervision and monitoring of WASH activities and constructs sanitation facilities in supported schools and health centres. Overall, the main purpose of USHA's interventions in the NC is to end Open Defecation (OD), achieve Open Defecation Free (ODF) villages and improve handwashing with soap (HWWS).

Achievements/impact

At the time of baseline by USHA, 19,416 households (HH) in the NC did not have toilets. By September 2021, 9,522 (49%) of the 19,416 HH had constructed a new toilet. During the same period, 10,988 HH invested in sanitation (new constructions and improvements to existing toilets) in the NC. Majority (74%) of the HHs invested in unimproved sanitation[2] and 1,442 HH (13%) in a basic sanitation[3] facility at endline (60 HHs already had a basic facility at baseline, while the remaining 1,382 HHs gained access for the first time). Of these 1,382 HHs, 1,006 (73%) were Open Defaecation (OD) at baseline, hence moved directly from OD to basic sanitation with the highest being in Kitgum with 12%. Amongst all districts, Pader had the highest percentage of conversion (~65%) from OD, while Lamwo had the lowest (33%). As of 30th Sep 2021, the percentage of households with no toilet in the NC area of intervention reduced from 50% to 27%. The table 2 below shows a breakdown per district.

Name of District	LATRINES AT BASELINE				
	Limited toilets	Basic toilets	Unimproved toilets	OD/no toilets	Total HHs
Agago	172	269	2,030	3,046	5,517
Gulu	119	186	2,031	3,342	5,678
Kitgum	148	155	1,852	2,196	5,420
Lamwo	153	281	1,564	3,422	4,351
Nwoya	185	75	3,040	2,845	6145
Omoro	568	405	4,128	2,481	7,582
Pader	342	185	1,440	2,083	4050
Total	**1,687**	**1,556**	**16,085**	**19,415**	38,743
Percentage of Baseline Total	**4%**	**4%**	**42%**	**50%**	

Name of District	LATRINES AT ENDLINE				
	Limited toilets	Basic toilets	Unimproved toilets	OD/no toilets	Total HHs
Agago	265	461	3,083	1,708	5,517
Gulu	272	307	3,394	1,705	5,678
Kitgum	295	618	2,606	1,901	5,420
Lamwo	213	511	2,519	1,108	4,351
Nwoya	278	146	4,194	1,527	6,145
Omoro	654	553	5,179	1,196	7,582
Pader	601	444	2,353	652	4,050
Total	**2,578**	**3,040**	**23,328**	**9,797**	38,743
Percentage of Endline Total	**7%**	**8%**	**60%**	**25%**	

2. flush or pour/flush toilets without a sewer connection or connected to a septic system; pit latrines without a washable slab/open pit; bucket latrines; or hanging toilets/latrines.

3. Defined according to the Joint Monitoring Programme (JMP) and the government of Uganda as of 2017, is a sanitation facility that hygienically separates human excreta from human contact, and that is not shared with other households. These may include flush or pour/flush facility connected to a piped sewer system or septic system; composting toilets; Pit latrines with washable (plastic, cement, porcelain, other) slab or squatting pan.

Regarding ODF status, out of 517 villages verified in the NC[4], 415 villages were declared as ODF representing 80.2% achievement for the Quarter 4 (July-September 2021) and 59.2% of the project target for the NC. The table 3 below summarizes the gains in the NC district post trigger.

Table 3: ODF Results in the Northern Cluster as at 20th Dec. 2021

Name of District	OD HHs at Baseline (HHs with No latrines)	OD HHs with access to a latrine/toilet Post-Triggering	Villages Verified ODF as at 20th Dec. 2021		
			Yes ODF	Not ODF	Total
Agago	3,046	1,421	55	28	83
Gulu	4,395	2,089	60	11	71
Kitgum	2,829	1,403	77	17	94
Lamwo	3,739	1,365	38	16	94
Nwoya	3,854	1,617	64	05	69
Omor	2,481	1,296	44	13	57
Pader	2,616	1,491	79	12	91
TOTAL:	**22,960**	**10,672**	**417**	**102**	**519**

Data Source: ONA. Note: The only difference with what was reported at the end of FY21 i.e. Sept. 2021 is 2 ODF villages. The total number of ODF villages reported at end of FY21 was 415.

For hand washing with Water and Soap (HWWS), the post trigger results using the Sanitation Committee Members (SCM) Tracker tools show that out of the 38,743 baselined HH in the NC, HWWS after toilet use improved from 3% to 24%.

Table 4: Hand washing post trigger gains in the Northern Cluster

Name of District	Total HHs baselined	HAND WASHING SERVICE AT BASELINE		HAND WASHING SERVICE post trigger using SCM TRACKER		
		Basic HWS	% Basic HWS	Total HHs baselined	Basic HWS	% Basic HWS
Agago	5517	62	1.12%	275	4,376	6.3%
Gulu	5678	129	2.27%	861	4,498	19.1%
Kitgum	4351	198	4.55%	1069	2,899	36.9%
Lamwo	5420	109	2.01%	1234	3,563	34.6%
Nwoya	6145	131	2.13%	670	2955	22.7%
Omoro	7582	219	2.89%	629	3,623	17.4%
Pader	4050	332	8.20%	1251	2966	42.2%
TOTAL	**38743**	**1,180**	**3.05%**	**5989**	**24,880**	**24.1%**

4. In Phase I in the Northern Cluster (NC), USHA and Partners triggered and followed up a total of 719 villages.

Perspectives from DLG officials

At the end of Phase one implemented from May 2020-September 2021, USHA together with the seven DLGs and four Grantees met to review performance and lay strategies to achieve more results in phase two (October 2021 – June 2022). Therefore, the information shared below is as presented by USHA's Focal Point Persons (FPPs) and informed by their perspective of implementation from each of the seven districts during the end of Phase I review meeting. Note that the coverage figures they presented captured any form of toilet/latrine and not necessarily as defined under the Sustainable Development Goal (SDG) Sanitation Ladder. The analysis and results focus more on sanitation in households and healthcare facilities (HCFs) and less on WASH in Schools.

According to the district officials, USHA's support has contributed to improved sanitation services in the 13 Sub Counties/Town Councils of the targeted seven districts in the NC, both in communities (719 villages) and 39 institutions (35 government aided primary schools and 4 Healthcare Facilities-HCFs[5]). For example, Lamwo Town Council in Lamwo District was reported to have the highest latrine coverage in the district of 77% at the end of September 2021 out of the 11 sub counties in the district. Lokung sub county, which had the lowest latrine coverage in Lamwo district at 41% before intervention, now stands at 69% and is continuing to improve. The Senior Environmental Officer (SEHO also the USHA Focal Point Person (FPP) for Lamwo District implored that "*With the extension of the project to Phase II, we are hopeful that the latrine and hand washing facility coverage in the Lamwo District will increase to 75% for the district and 95% for the sub counties where USHA operates*".

Photo 1: Follow up Mandona session in Ngomonyaa village-Pawor parish Lokung S/C in Lamwo District.

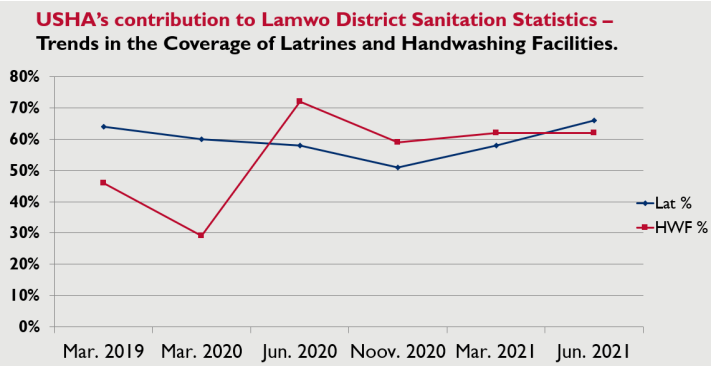
"Lokung Health Centre-HC III in Lamwo Town Council had no latrine and washroom for maternity. The only latrine block was shared with the Outpatient Department (OPD) staff on duty and other wards. Now a drainable latrine with attached washrooms and rainwater harvesting tank has been constructed and is being used by mothers coming for maternity services at the health facility". "Incinerators used to be only in health facilities across Lamwo District and a few schools in the refugee settlements. But with USHA's intervention, over five (5) new incinerators of good quality have been constructed ready for use in five (5) schools. *"USHA constructed the best WASH facilities for the districts. For example, the drainable latrines and washrooms in Lokung health centre III…., and the incinerators USHA constructed in schools are of best quality in the districts … better than even the incinerators in the health facilities" Said USHA's FPP for Lamwo district.* Table 4 below shows a snapshot of USHA's contribution to sanitation improvements in the NC districts, with some sub county and district specific data as reported by districts; while Figure 1 shows a snapshot of district sanitation coverage data as presented by Lamwo district for the period March 2019-June 2021.

Table 5: Snapshot on progress on latrine coverage in some selected. USHA supported sub counties and districts in the NC.

Name of District	Sub County of Operation	Latrine Coverage before USHA's Intervention	Latrine Coverage after USHA's Interventions
Kitgum	Omiya Anyima	40.2%	84.8%
Gulu	Paicho	41.1%	78.2%
Pader	Atanga	51%	94%
	Ogom	36%	86%
Lamwo	Lokung	41%	69%
Agago	District data	52.8%	58.6%
Nwoya	District data	67.0%	87.3%
Omoro	District data	-	78%

Source of Data: NC District Reports.

Fig. I: USHA's Contribution to latrine improvements in Lamwo district



Source of Data: Lamwo District Report.

5. USHA constructed sanitation facilities in Achol Pii and Patongo Health Centre-HC IIIs in Agago district; Omiya Anyima HC III in Kitgum district; and Lokung HC III in Lamwo district.

Reflections by the DLGs on overall USHA Project Performance during Phase I

DLGs recognize the fact that USHA's implementation is in line with district's priorities, National Development Plan III (NDP III) and the Sustainable Development Goals (SDGs). The DLGs also appreciate that the project entry meetings, both at the district and sub county level, acted as 'buy-in' for the District and Sub County leadership to embrace the sanitation interventions under USHA. Districts note that there is improved coordination of WASH partners in the seven districts and improved working relationship between USHA grantees and the DLGs. The DLG officials observed that Grantees work as a team with the districts and sub county authorities; and that there is great involvement of local government officials in implementation and monitoring of project activities. Teamwork and good working relations has also been made possible through participation in regular quarterly District Water and Sanitation Coordination Committee (DWSCC) meetings, and joint planning, implementation, and monitoring. USHA and Grantees made presentations and provided regular updates on progress of the project during the DWSCC meetings.

Photo of Mr. Okello Satedo's latrine, LC I Chairperson Ogili Village, Melong Parish, Omiya Anyima Sub County in Kitgum District, demonstrating behavioral change where he painted on the wall of his latrine a picture of a man washing hands to show users the right practice after using a latrine.

Another recognized strength of USHA is the integration of hardware (such as improved toilets in communities, schools, and healthcare facilities), software (behaviour promotions reinforcing CLTS, the capacity building of district stakeholders on WASH in Schools and CLTS and trainings on WASH policies and guidelines (and availing copies), which created awareness and bridged the knowledge gap on sector policies. There is also appreciation of USHA's timely response to the districts need for the provision of In-Kind Grants (IKG) to Environmental Health staff. The IKGs, among others included motorcycles, projectors, laptops, and water testing kits (one of the key action plans from the Institutional Strengthening Index-ISI plan) which has enhanced WASH service delivery in communities and schools. Above all, districts appreciate the availability of resources (human, transport/fuel, funds, etc.); and the availability of technical skills, knowledge, and experiences on the part of USHA team to support project implementation.

Photo 3: An Open Defecation (OD) Household at baseline that has moved to Basic Sanitation

The DLG staff and some political leader's capacity in WASH issues has been strengthened through attending, among others, Institutional Strengthening Index (ISI) self-assessment of WASH capacity, work planning sessions, WASH policies and guidelines dissemination, CLTS training, operation and maintenance trainings and institutional triggering meetings to embrace novel sanitation intervention under USHA. *"USHA staff are really specialists in the way they present themselves, their organization, and in doing their work……. The person that gave those titles to them surely gave the right tittles…. We have really benefited from their expertise; our capacity has improved, and I know we shall never move backwards but will continue moving forward even after USHA…." Said the SEHO/ USHA FPP for Lamwo district*

Photo 4: Peter Okot, former Local council III chairperson Paicho subcounty uses a handwashing facility. His household was OD at baseline but because to institutional triggering, he constructed a new toilet facility with a cement screeded floor hence exemplary leadership.

Drivers of Success

The district officials reported that the above achievements were realized as a result of: active community participation, involvement of different WASH stakeholders such as DLG staff including the District Health Inspectors (DHIs), District Health Officers (DHOs), District Water Officers (DWOs), health assistants (Has), Local Council ones (LCI's) chairpersons), and private sector actors (trained masons and participating hardware stores) at every stage and level of USHA interventions from the district, sub counties, parishes, and villages. For achievement ODF villages, districts attribute success to the functional community structures such as Sanitation Committees who support the Village Health Team (VHT) members to improve sanitation in each of the villages. DLG staff were also involved in enforcement of some rules and byelaws for sanitation improvements in the HH and were supported with ODF Tier 2 verifications. USHA also supported the adaptation of the grantees to Covid-19 situation ensuring continued implementation. Additionally, availability and orientation on new approaches such as market-based sanitation and CLTS with Quality to enhance technical knowledge, skills, and experience in WASH issues among the district officials, grantee staff, private sector, and USHA staff. The USHA provided in-kind grants (such as motorcycles and computers) supported all the seven districts to improve field supervision, monitoring and WASH data capturing and reporting.

Photo 5: ODF Tier 1 Verification, Ongako Sub County, Omoro District

Key concerns affecting achievement of improved sanitation in the NC

The attainment of 100% sanitation in USHA targeted districts of northern Uganda is affected by a number of factors: 1) migratory households especially during the farming season with most able bodied persons from

Photo 6: Pader DLG official and Atanga subcounty officials carry out monitoring prior DWSCC meeting in January 2021.

Nwoya, Pader and Agago districts shifting to far away farmland making it hard to talk to the household heads regarding the need for improved sanitation; 2) some households not adhering to latrine construction standards thus making sustainability to be questionable; 3) unsuitable/poor soil conditions that do not support pit latrine construction; 4) there was late engagement of DLG staff by some Grantees that slowed buy in, appreciation and participation in project activities in Phase one; 5) conflicting work schedules between DLG staffs and the grantee planned activities hence affecting provision of timely support to grantees; 6) lack of access to the USHA data base (ONA) by the DLG staff thus making tracking the grantee's progress difficult; 7) bad roads that hinder access to some communities 8) There are high expectations by the District staff, Sanitation Committee Members (SCM) and Village Health Teams (VHTs) during execution of USHA activities; 9) the trained political leadership have left office following the recently concluded elections which ushered in new political leaders and the transfer of Chief Administrative Officers (CAOs) has created gaps in awareness and support to USHA and 10) inadequate mechanisms of post ODF monitoring and sustainability.

Photo 7: A house in Paicho sub county flooded because of high water table problem in the area.

Recommendations

To achieve 100% sanitation in USHA operational districts of northern Uganda, the district officials propose the following recommendations:

A) Support the targeted districts establish WASH databases that can be updated regularly and USHA grantees to timely share household data with the districts so that this is used for tracking, follow up and decision making.

B) Have regular engagement and joint monitoring with the district/sub county staff, local leaders including politicians who can effectively reach out to household heads for sustainability of results.

C) The district health departments should increase enforcement of the Public Health Act among especially the unresponsive community members/ households and encouraging villages to come up with bye laws on sanitation.

D) USHA should train more masons to support households achieve ODF in villages by embracing Do It Yourself (DIY) for toilet construction.

E) Intensify follow up visits for the triggered villages to fast-track achievement of ODF

F) The villages found ODF should be certified after laying sustainability plans to enable the post ODF monitoring to avoid slippage; incorporate in the District Council a resolution for sustainability of the ODF villages using the available resources in the district.

G) Continue capacity strengthening of WASH technical staffs, selected political leaders and Village Health Teams-VHTs in the districts.

H) Continuous advocacy for prioritizing of sanitation and hygiene at district level especially during the annual planning and budgeting processes.

I) Integrate the sanitation committees into the usual cascade structures for health facilities; and the committees should report quarterly on their findings through the VHTs to the health assistants.

J) Integrate WASH within existing government programs for sustainability i.e., Integrated Community Case Management (ICCM)[6], Community Engagement Strategy (CES)[7], Parish Development Model (PDM), and Agricultural extension services, etc. The SCM model used by USHA and partners fits within all these approaches and programs.

Looking ahead

USHA Phase two in the NC intends to continue with the implementation in the exiting 719 Phase one villages but also reach an additional 150 villages in five out of the seven Districts making a total of 869 villages targeted to attain ODF status. The 417 villages that have attained ODF status in Phase one will be supported to sustain this achievement. The Grantees and DLGs will follow up the other remaining 302 villages to attain ODF status. The additional 150 villages phase two will be supported through CLTS implementation to also attain ODF status. Phase two implementation period is only 9 months from October 2021 to June 2022. The timeline is fixed with no extension expected meaning that the grantees will have to work very closely with DLGs from the beginning to ensure that the DLGs are on top to address the issues of sustainability.

The overall objectives of Phase two are:

- Support the balance of non-ODF villages in Phase one in seven districts to attain and maintain ODF
- Support the ODF Tier 2 verified villages in Phase two to maintain their ODF status and not to slip back to OD
- Support at least 30 new villages in each of the five districts to go through the entire process as laid out in the CLTS protocol.
- Promote increase in HWWS in all targeted villages.
- Continue to support five schools per district to achieve WASH friendliness.

As part of the sustainability aspects, USHA intends to strengthen the capacity of the local government staff in the CLTS implementation process and ensure that the sub counties have capacity to manage and sustain results of USHA project with support from each District.

- Also, USHA will: i) compile private sector actors' inventory such as SCM, Masons, hardware stores, a list of ODF villages and share with the DLGs to sustain achievements. Supported by the grantees, develop clear sustainability strategies, and plans together with the sub counties stakeholders on how SCM, Masons, hardware stores and financial institutions will continue to provide services in each sub county or district. This will also include providing clear linkages between SCMS and private sector actors to sub counties and DLGs for future coordination and support; and iii) Facilitate integration of SCM into VHT system and ensure they start reporting to Health assistant during Phase two implementation period.
- USHA will conduct institutional triggering of local leaders to ensure exemplary leadership is demonstrated in all districts. USHA will also document & share what has worked or not worked implementing CLTS to achieve ODF in the NC together with the end of project reports which will be shared with each sub county and District as part of handover documents.

6. ICCM is an approach for diagnosis and treatment of common ailments at community level and spearheaded by Community Health Workers (CHWs or VHTs).
7. CWS is almost like ICCM but has one of the Covid19 pillars targeting response at community level.